Your Benefits Handbook

Overview

This handbook contains Summary Plan Descriptions (SPDs) of the benefit plans offered by the *company*. The official plan documents are on file with the Edison International Employee Benefits Committee or the Southern California Edison Company Benefits Committee, as applicable. If there are any conflicts between the SPDs and the official plan documents, the plan documents will govern.

We are proud to offer our employees and retirees a competitive benefits package. Our commitment to our people is key to achieving our vision of Leading the Way in Electricity.

The *company* expects to continue the plans and programs described in this handbook indefinitely, but reserves the right to amend or terminate any or all of them at any time.

Continue

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Introduction

As an Edison employee or retiree, you are able to view "Your Benefits Handbook" online.

This handbook contains Summary Plan Descriptions (SPDs) of the benefit plans offered by the *company*. An SPD is a summary of the official plan documents that govern the terms, conditions, and operations of a benefit plan that is subject to the Employee Retirement Income Security Act of 1974 (ERISA). The handbook also includes information about programs that are not subject to ERISA. These programs are described in the Other Time Off and Other Programs sections. You can easily print "Your Benefits Handbook - Summary Plan Descriptions" from the convenience of your home or office work location via the Edison International Portal.

In the Other Important Information section, you will find information about your rights and protections as a benefit plan participant, plus other important information that includes names, addresses, and phone numbers of organizations responsible for administration of the *company's* benefit plans. The Glossary of Terms contains definitions of special terms used in this handbook. Terms defined in the Glossary are italicized when they appear in text.

Eligibility to Participate

The Eligibility section of this handbook lists all of the benefit plans and other programs that are available to each specific employee classification within your *company*. It also contains a descriptive list of individuals who are excluded from coverage under some or all of the *company's* benefit plans and programs.

More information about eligibility can be found in the overview at the beginning of each section of this handbook. Each overview contains the general eligibility rules for all plans described in that particular section. The Health Care Overview, for example, includes the eligibility rules for medical, dental and vision benefits, as well as the Employee Assistance Program (EAP) and the Preventive Health Account (PHA).

Getting Started

Before reviewing "Your Benefits Handbook" **it is important to note**, unless otherwise stated in a specific section, the summaries contained in this handbook describe the features of the plans/programs as of January 1, 2013.

Questions?

If you have general questions about "Your Benefits Handbook," or if you would like to receive a paper copy of the handbook, you can call or e-mail the Employee Information Center.

Table Of Contents

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Eligibility

Eligibility revised December 19, 2012.

Who Is Eligible

Who is eligible for *company* benefit plan coverage and other programs varies from one employee group to another. For example, most *part-time* employees are eligible for Medical Plan coverage but not eligible for Vision Plan coverage. Also, the benefits and programs offered vary by *company*, and for union-represented employees they may be determined by a collective bargaining agreement.

The purpose of this section is to list all of the benefit plans and programs that your *company* offers to eligible employees in each employee group and to eligible retirees and survivors of employees and retirees. Below under Who Is Not Eligible, it also describes in detail the types of individuals who are excluded from coverage under certain benefit plans and programs.

Each benefit plan summary in this handbook includes a Who Is Eligible section which provides further information. To find out whether you are eligible for or excluded from participation in a specific benefit plan, read the Who Is Eligible section of the applicable Overview and summary of that plan.

If you still have questions about your eligibility, contact the *EIX Benefits Connection* by phone or online at:

- (866) 693-4947
- www.eixbenefits.com

You may also access the *EIX Benefits Connection* online by logging on to the Edison International Portal.

Who Is Not Eligible

The following individuals are not eligible to participate in any benefit plan or program of the *company* unless eligibility is specifically provided for in such benefit plan(s) or program(s):

- Individuals whose collective bargaining or other agreement with the *company* does not provide for such benefit coverage
- Independent contractors, non-employee consultants, *contingent workers* and other individuals who are not classified on *company* payroll records, at the *company's* discretion, as common law employees
- *Leased* employees
- Employees of a person or an organization other than the *company*
- *Temporary* employees
- Individuals whose basic compensation for services on behalf of the *company* is not paid directly by the *company*
- Individuals whom the U.S. federal government considers to be non-resident aliens
- Individuals the *company* has determined, on a nondiscriminatory basis, to be ineligible based on their employment at a specific division, group or work site

Southern California Edison Company

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Full-time and *Part-time Plus* Employees

The *company* offers the benefits and programs listed below to eligible *full-time* and *part-time plus* employees. Specific eligibility rules are described under Who Is Eligible in each program's Overview and in each individual plan summary.

Flex

Reimbursement Accounts

- Dependent Care Reimbursement Account (DCRA)
- Health Care Reimbursement Account (HCRA)

Health Care Benefits

- Medical Plan

The *company* offers the following Medical Plan options to *full-time* and *part-time plus* employees. The options available to you depend on where you live and are shown in your enrollment package — when you are first eligible and during each annual enrollment period.

Health Net of California HMO
Kaiser Permanente
UnitedHealthcare HMO

Blue Shield of California EPO

90/70 Blue Shield of California PPO
80/60 Blue Shield of California PPO
70/50 Blue Shield of California PPO

The following are available only to disabled inactive employees who have Medicare as their primary coverage:

Blue Shield of California EPO
Blue Shield of California Medicare Coordinated PPO 90/70
Health Net Seniority Plus Medicare Advantage HMO
Kaiser Senior Advantage Medicare Advantage HMO
UnitedHealthcare Medicare Advantage HMO
UHC Senior Supplement
UHC Senior Supplement 3500

- Preventive Health Account
- Dental Plan

The *company* offers the following Dental Plan options to *full-time* and *part-time plus* employees. The options available to you depend on where you live and are shown in your enrollment package — when you are first eligible and during each annual enrollment period.

Anthem Blue Cross of California Dental Net
Delta Dental PPO
SafeGuard Dental

- Vision
- Employee Assistance Program (EAP)

Life and Accident Insurance Benefits

- Employee Life Insurance
- Dependent Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- Business Travel Accident Insurance (for exempt employees and, in some cases, for non-exempt employees who travel on *company* business)

Disability Program
- Comprehensive Disability Plan (CDP)
- Long Term Disability (LTD) Plan (*part-time plus* employees are not eligible)
- Return to Work Program (*part-time plus* employees are not eligible)
- Workers' Compensation

401(k) Savings Plan

Retirement Plan

Holidays

Vacation

Vacation Buying and Cash Out
Vacation Buying not available to *part-time plus* employees.

Other Time Off

In addition to disability, holidays and vacation, the *company* allows you to take time off from work — with your supervisor's approval — for the following reasons. In some cases you may receive pay for approved time off. See the Other Time off section of this handbook for details.
- California Education Code (available only to employees working in California)
- California Family School Partnership (available only to employees working in California)
- California Pregnancy Disability Leave (available only to employees working in California)
- Death in the Immediate Family
- Family and Medical Leave
- Jury Duty
- Major Disaster or Catastrophe
- Military Leave of Absence
- Personal Leave of Absence
- Subpoenaed Witness
- Voting

Other Programs

You may also be eligible for additional programs. See the Other Programs section of this handbook for more information.

***Part-time* Employees**

The *company* offers the benefits and programs listed below to eligible *part-time* employees unless noted otherwise. Specific eligibility rules are described under Who Is Eligible in each program's Overview and in each individual plan summary.

Flex

If you are regularly scheduled to work at least 16 hours a week, you receive *company* contributions to use toward your *Flex* benefits. If you are regularly scheduled to work less than 16 hours a week, you are eligible for *Flex,* but do not receive *company* contributions.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Reimbursement Accounts

If you are regularly scheduled to work at least 16 hours a week, you are eligible to participate in either or both of the following reimbursement accounts.

- Dependent Care Reimbursement Account (DCRA)
- Health Care Reimbursement Account (HCRA)

Health Care Benefits

- Medical Plan

The *company* offers the following Medical Plan options to *part-time* employees. The options available to you depend on where you live and are shown in your enrollment package — when you are first eligible and during each annual enrollment period.

Health Net of California HMO
Kaiser Permanente
UnitedHealthcare HMO

Blue Shield of California EPO

90/70 Blue Shield of California PPO
80/60 Blue Shield of California PPO
70/50 Blue Shield of California PPO

- Dental Plan

The *company* offers the following Dental Plan options to *part-time* employees. The options available to you depend on where you live and are shown in your enrollment package — when you are first eligible and during each annual enrollment period.

Anthem Blue Cross of California Dental Net
Delta Dental PPO
SafeGuard Dental

- Employee Assistance Program (EAP)

Life and Accident Insurance Benefits

- Employee Life Insurance
- Dependent Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance
- Business Travel Accident Insurance (for exempt employees and, in some cases, for non-exempt employees who travel on *company* business)

Disability Program

- Comprehensive Disability Plan (CDP)
- Workers' Compensation

401(k) Savings Plan

Retirement Plan

Holidays

Vacation

If you are regularly scheduled to work at least 16 hours a week, you are eligible for *company*-paid vacation.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Other Time Off

In addition to disability, holidays and vacation, the *company* allows you to take time off from work — with your supervisor's approval — for the following reasons. In some cases you may receive pay for approved time off. See the Other Time off section of this handbook for details.

- California Education Code (available only to employees working in California)
- California Family School Partnership (available only to employees working in California)
- California Pregnancy Disability Leave (available only to employees working in California)
- Death in the Immediate Family
- Family and Medical Leave
- Jury Duty
- Major Disaster or Catastrophe
- Military Leave of Absence
- Subpoenaed Witness
- Voting

Other Programs

You may also be eligible for additional programs. See the Other Programs section of this handbook for more information.

Temporary Employees

The *company* offers the benefits and programs listed below to eligible *temporary* employees, unless noted otherwise. Specific eligibility rules are described under Who Is Eligible in each program's Overview and in each individual plan summary. You may also be eligible for additional programs – see the Other Programs section of this handbook for more information.

- Employee Assistance Program (EAP)
- Comprehensive Disability Plan (CDP)

  You are eligible only if you were hired for at least two weeks and are regularly scheduled to work at least 16 hours per week.
- Workers' Compensation
- Retirement Plan
- Holidays
- Military Leave of Absence
- California Education Code (available only to employees working in California)
- California Family School Partnership (available only to employees working in California)
- California Pregnancy Disability Leave (available only to employees working in California)
- Family and Medical Leave

Retirees and Survivors of Employees and Retirees

The *company* offers the benefits and programs listed below to eligible retirees and eligible survivors of employees and retirees. Specific eligibility rules are described under Who Is Eligible in each program's Overview and in each individual plan summary.

Health Care Benefits

- Medical Plan

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The *company* offers the following Medical Plan options to retirees and survivors. The options available to you depend on where you live and are shown in your enrollment package during each annual enrollment period.

Health Net HMO (not available if a covered family member includes a retiree, survivor or spouse who has, or is eligible for, Medicare as their primary coverage)
Kaiser Permanente (not available if a covered family member includes a retiree, survivor or spouse who has, or is eligible for, Medicare as their primary coverage)
UnitedHealthcare HMO (not available if a covered family member includes a retiree, survivor or spouse who has, or is eligible for, Medicare as their primary coverage)

90/70 Blue Shield of California PPO
80/60 Blue Shield of California PPO
70/50 Blue Shield of California PPO
Blue Shield of California EPO

The following are available only to those who have, or are eligible for, Medicare as their primary medical coverage:

Blue Shield of California EPO
Blue Shield of California Medicare Coordinated PPO 90/70
Health Net Seniority Plus Medicare Advantage HMO
Kaiser Senior Advantage Medicare Advantage HMO
UnitedHealthcare Medicare Advantage HMO
UHC Senior Supplement
UHC Senior Supplement 3500

- Dental Plan

The *company* offers the following Dental Plan options to retirees and survivors. The options available to you depend on where you live and are shown in your enrollment package during each annual enrollment period.

Anthem Blue Cross of California Dental Net
SafeGuard Dental
Delta Dental PPO

- Vision
- Employee Assistance Program (EAP)

Life Insurance Benefits

- Retiree Life Insurance

Other Programs

You may also be eligible for additional programs. See the Other Programs section of this handbook for more information.

Leased* Employees and *Contingent Workers

Leased employees and *contingent workers* are not eligible for any benefit plans or programs.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Events Affecting Your Benefits

Events Affecting Your Benefits revised December 19, 2012.

The *Flex* options and coverage category you choose during annual enrollment or when you begin your employment with the *company* normally remain in effect through December 31. However, if you have a *qualified life event*, you may be able to change your affected benefits coverage before the end of the year—if you make your request within the required time period.

If you don't request your change within the required time period, you can make your change during annual enrollment and your new election will take effect on January 1 of the next year.

Your *Flex* changes must generally be on account of and be consistent with the *qualified life event*. For example, if the number of your eligible dependents changes, your *spouse* begins or stops working, or there is a significant change in the medical coverage provided by your *spouse's* employer, you may be able to choose a different coverage category or enroll for coverage if you had waived coverage.

Examples of the changes you may make to the various *Flex* plans because of a *qualified life event* are summarized in this section of the handbook. This section also briefly summarizes the effect these events can have on your Edison 401(k) Savings Plan and Retirement Plan, if you're eligible.

Qualified Life Event

Qualified life events are events that allow you to make changes to your *Flex* benefits during the year, and include the following events:

- Your *child's* birth, adoption, or placement for adoption
- Your marriage
- Your divorce, legal separation, or annulment
- Your domestic partnership ends
- Death of your *spouse*, *domestic partner* or *child*
- You or your dependent has a change in employment status that is a:
  - Termination or commencement of employment,
  - Strike or lockout,
  - Commencement or return from an unpaid leave,
  - Change in worksite, or
  - Other change in employment status that results in a change of coverage or eligibility under an employer's plan
- Your *spouse*, *domestic partner* or *child* ceases to be a qualified dependent or, for purposes of the DCRA, ceases to be a qualified individual
- Your *spouse*, *domestic partner* or *child* becomes newly eligible
- You or your former *spouse* or *domestic partner* are ordered (such as through a Qualified Medical Child Support Order (QMCSO) or other court order) to provide health care coverage to your *child(ren)*
- You, your *spouse*, your *domestic partner* or *child* loses other coverage
- You, your *spouse*, your *domestic partner* or your *child* becomes entitled to Medicare or Medicaid
- You, your *spouse*, your *domestic partner* or your *child* loses Medicare or Medicaid eligibility
- You return from or take a FMLA leave
- A benefit option in which you participate is deleted by the *company*
- You incur a significant cost increase or decrease by your current dependent care provider (the provider cannot be your relative)
- You change your dependent care provider (the provider cannot be your relative)
- Midyear expiration of your, your *spouse's*, your *domestic partner's* or *child's* COBRA coverage by another employer
- Loss of subsidized health care from another employer
- Your *spouse's*, your *domestic partner's* or *child's* annual enrollment does not correspond with your annual enrollment

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- You move out of your Medical or Dental plan's service area. You may choose new options within 30 days of your move. Your changes take effect the first day of the month that falls within the 30 days after you notify the *company*. If you don't elect new Medical and Dental options, you'll be enrolled by default in the same coverage category and the lowest cost plans available for your home ZIP code — effective the first day of the month after the date you notify the *company*

Reporting a *Qualified Life Event*

If you have a *qualified life event*, log on to www.eixbenefits.com or contact the *EIX Benefits Connection* toll-free at (866) 693-4947. If you don't report a *qualified life event* within the required time period (see below), the *Flex* coverage you had before the change or event will stay in effect for the remainder of the calendar year, with one notable exception. Once your covered dependent ceases to be an eligible dependent for purposes of a *company* plan, he or she is no longer eligible for coverage under that plan. You are required to contact the *EIX Benefits Connection* within 30 days and report this *qualified life event.* Please note that **you will be responsible** for all costs and expenses incurred by the *company* or its plans with respect to any non-eligible dependent if you fail to timely report the *qualified life event*.

If you drop your Dental or Vision coverage after you retire because you have coverage under another group plan and you subsequently lose that coverage, you can re-enroll in the Dental or Vision plan within 30 days of losing coverage under the other group plan. You must call the *EIX Benefits Connection* to re-enroll.

You may be required to affirm and/or provide **supporting documentation** when you make your request to change your *Flex* elections. You will be instructed where to send supporting documentation when you contact the *EIX Benefits Connection*.

Required Time Period

You have 30 days to report your *qualified life event* to the *company* and make related changes in your *Flex* benefits. Changes you make within 30 days are, in most cases, effective on the date of the *qualified life event*. If you wait more than 30 days to report a *qualified life event*, you will not be able to change your *Flex* coverage until annual enrollment. Any benefit changes you make during annual enrollment will not become effective until January 1 of the next year.

The only exception to the 30-day required time period is if you or your eligible *child* (1) lose coverage under Medicaid or a state children's health insurance program (SCHIP) due to loss of eligibility, or (2) you or your eligible *child* become eligible for a state premium assistance subsidy under Medicaid or SCHIP. In either case, you must report your change within 60 days after the date (1) your Medicaid or SCHIP coverage is terminated or (2) you or your *child* is determined to be eligible for premium assistance. The effective date for the change in coverage will be the first day of the month after you notify the *company* of this change.

When Benefit Coverage Changes Take Effect

Your new coverage takes effect on the date of your *qualified life event* in most cases. If a change in Employee Life Insurance requires Evidence of Insurability approval, your increased coverage will take effect on the date the insurance company approves the change. Any increase in your Employee Life Insurance coverage will not take effect unless (or until) you are *actively at work* on the date the increase takes effect.

In most cases, changes in *company* contributions or price tags take effect on the first pay period after your *qualified life event* has been processed.

Changes in your payroll deductions reflecting your new coverage will generally be made on a prospective basis.

If you open a new HCRA or DCRA, your participation will begin on the date you make your election or the date of your *qualified life event* — **whichever is later**. The amount you elect to contribute when you are first eligible will be divided among the remaining *deduction periods* for the year.

You cannot decrease your HCRA or DCRA elections to less than the amount you have already contributed for that year. Also, increases in your HCRA or DCRA account elections may be applied only to expenses incurred after the effective date of the change.

Examples of Benefit Changes

The charts in this section provide a general overview of what may happen to your *company* benefits if certain events occur. The charts do not describe every event, and the benefits changes described herein may vary depending on your particular circumstances. In many situations, you must satisfy specific time and notice requirements before a change in your benefits can be made. This section of your handbook provides information about all of the benefit plans that the *company* offers -- including plans that may not apply to you. Refer to the **Eligibility** section to see which benefit plans you are eligible for. For detailed information, read the appropriate plan summary. If you have questions or need assistance regarding a specific event, contact the *EIX Benefits Connection* at (866) 693-4947 or on the Web at www.eixbenefits.com.

- You Marry
- You Become Divorced Or Legally Separated Or Your Marriage Is Annulled
- You Change Your Place Of Residence
- You Go On A Union Leave Of Absence Or An Unpaid Approved Personal Leave Of Absence That Is Not A Family Or *Military Leave Of Absence*
- You Go On An Approved *Military Leave Of Absence*
- You Go On Unpaid Approved Family Leave Of Absence
- You Go On Paid Family Leave Concurrent With FMLA Leave (Applies To Employees Working In California)
- You Become Disabled And Eligible For CDP or LTD Benefits
- You Change To An Ineligible Status
- You Are Laid Off
- You Terminate Employment For Any Reason Except Retirement
- You Retire
- You Die
- Your *Spouse*, *Domestic Partner*, Or Other Eligible Dependent Dies
- Your *Child* Is Born, Adopted Or Placed For Adoption; You Become A *Child's* Legal Guardian Or Stepparent; Or An Unmarried *Child* Is Added With Status Of “Other” Dependent
- Your Covered Dependent Ceases To Be An Eligible Dependent
- Your Eligible *Child* Becomes A Full-Time Student Or Otherwise Gains Dependent Status
- Change In Employment Status For You, Your *Spouse*, *Domestic Partner* Or Eligible Dependent, Resulting In A Loss Of Coverage Under An Employer’s Plan
- Change In Employment Status For You, Your *Spouse*, *Domestic Partner* Or Eligible Dependent, Resulting In New Coverage Under An Employer’s Plan
- You Receive A Judgment, Decree, Or Court Order Resulting From Your Divorce, Legal Separation, Annulment Of Marriage Or Change In Legal Custody Of Your *Child* Or *Children* (Including A Qualified Medical Child Support Order, Or QMCSO) That Requires Accident Or Health Care Coverage For Your *Child(ren)*
- You And/Or Your Eligible Dependent Loses Health Care Coverage
- You Or Your Eligible Dependent Becomes Entitled To Medicare
- You Or Your Eligible Dependent Lose Medicare Eligibility
- Significant Increase Or Decrease In The Cost Of Current Dependent Care Provider, Or A Change In Dependent Care Provider
- Current Benefit Plan Option Is Discontinued
- Significant Change In Coverage Of *Spouse* Or Dependent Under Other Employer's Plan If Change Is Permitted Under Internal Revenue Code Sec. 125 Or If The *Spouse’s* Period Of Coverage Is Different Than Your Period Of Coverage
- Midyear Expiration Of Your, Your *Spouse’s* Or Other Eligible Dependent’s COBRA Coverage By Another Employer
- Loss Of Subsidized Health Care From Another Employer

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- Your *Spouse's* Or Other Eligible Dependent's Annual Enrollment Does Not Correspond With Your Annual Enrollment

You Marry	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• Make any allowable changes to your coverage within 30 days of your marriage • *Company* contributions and your pre-tax contributions may be adjusted
Medical Dental Vision	You may: • Add coverage for yourself, your *spouse* and any eligible dependents • Stop your *company* coverage if you elect coverage with *spouse's* employer
EAP	Your *spouse* is automatically covered
HCRA	You may: • Commence or increase your contributions to be applied to expenses incurred after the event • Stop or decrease contributions if you elect coverage under *spouse's* employer's plan
DCRA	You may: • Commence or increase contributions to be applied to expenses incurred after your marriage • Stop or decrease contributions if any dependent becomes covered by *spouse's* employer's plan or if *spouse* provides your dependent care
Long-Term Disability (LTD)	You may increase or decrease your coverage.
Employee Life Insurance	You may: • Enroll for coverage or increase existing coverage • Decrease your coverage (or stop coverage if the *company* doesn't require coverage) • Want to update your beneficiary designation
Dependent Life Insurance	You may: • Add coverage for your *spouse* and any new dependent *children* • Add or increase coverage for your dependent *children* • Stop coverage for dependent *children*
Accidental Death and Dismemberment (AD&D)	You may: • Enroll for coverage or increase existing coverage • Decrease your coverage (or stop coverage if the *company* doesn't require coverage) • Want to update your beneficiary designation
Dependent AD&D	You may: • Add coverage • Stop coverage
401(k) Savings Plan	• Your participation is not affected • You may want to update your beneficiary designation • Your *spouse* is your beneficiary unless you have his or her written and notarized consent to designate a different beneficiary
Retirement Plan	• Your participation is not affected • You may want to update your beneficiary designation • Your *spouse* is your beneficiary unless you have his or her written and notarized consent to designate a different beneficiary

You Become Divorced Or Legally Separated Or Your Marriage Is Annulled	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• Make any allowable changes to your coverage within 30 days of the effective date of the event • *Company* contributions and your pre-tax contributions may be adjusted
Medical Dental Vision	• Your ex-*spouse* and any stepchildren for whom you are not financially responsible lose coverage but may continue it through COBRA Extended Coverage • You may stop coverage for your *children* who gain coverage with your ex-*spouse's* employer • You may enroll for *company* coverage if you lose coverage with your ex-*spouse's* employer • You may enroll eligible dependents for *company* coverage if they lose coverage with your ex-*spouse's* employer

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	• If the *company* receives a Qualified Medical Child Support Order (QMSCO), the company will add or remove *child(ren*), as directed by the order, as covered participants in your health care plan(s)
EAP	Your ex-*spouse* and any stepchildren for whom you are not financially responsible lose coverage but may continue this benefit through COBRA Extended Coverage
HCRA	You may: • Decrease your contributions • Stop your contributions. You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section • If you lose coverage with your *spouse's* employer, you may commence or increase contributions to be applied to expenses incurred after the effective date of your election change.
DCRA	You may: • Stop or decrease contributions if any of your qualified dependents no longer live with you. If you stop contributions, you may submit claims for eligible expenses incurred during that calendar year if you have funds in your account • Commence or increase contributions if you become responsible for day care expenses for qualified dependents who live with you
Long-Term Disability (LTD)	You may increase or decrease your coverage.
Employee Life Insurance	You may: • Decrease existing coverage (or stop coverage if the *company* doesn't require coverage) • Enroll for coverage or increase existing coverage • Want to change your beneficiary designation
Dependent Life Insurance	Coverage ends for your ex-*spouse* and any stepchildren for whom you are not financially responsible You may: • Stop coverage for dependent *children* • Stop coverage for dependent *children* who gain coverage under the ex-*spouse's* plan
Accidental Death and Dismemberment (AD&D)	You may: • Decrease your coverage (or stop coverage if the *company* doesn't require coverage) • Commence or increase your coverage • Want to update your beneficiary designation
Dependent AD&D	Coverage ends for your ex-*spouse* and any stepchildren for whom you are not financially responsible. You may stop coverage for dependent *children*

401(k) Savings Plan	• If the *company* receives written notice of adverse interest from your *spouse*, former *spouse* or dependents claiming an interest in your benefit, until the matter is settled:
	  ◦ Your account is on administrative hold
	  ◦ You may still contribute to the plan and direct your investments
	  ◦ New loans, withdrawals, distributions, and direct payment of dividends are not allowed
	  ◦ If you have an outstanding loan, your loan repayment deductions will continue
	• If the *company* receives a Qualified Domestic Relations Order (QDRO), any amount payable to your ex-*spouse* or other alternate payees will be placed in a separate account in his or her own name (unless provided otherwise in the QDRO)
	• You may want to update your beneficiary designation

Retirement Plan	• If the *company* receives written notice of adverse interest from your *spouse* or former *spouse* claiming an interest in your benefit, an administrative hold is placed on your benefit until the matter is settled • If the *company* receives a Qualified Domestic Relations Order (QDRO), any amount payable to your ex-*spouse* or other alternate payees will be paid in a lump sum (unless provided otherwise in the QDRO)

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	• You may want to update your beneficiary designation

You Change Your Place Of Residence	
Promptly report any name or address changes to the Employee Information Center	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	*Company* contributions and your pre-tax contributions may change if your medical or dental plan changes
Medical Dental	You may change to a plan in your new ZIP code area if you no longer reside in your plan's service area
Other benefit plans	Your coverage or participation is not affected

You Go On A Union Leave Of Absence Or An Unpaid Approved Personal Leave Of Absence That Is Not A Family Or *Military Leave Of Absence*	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	*Company* contributions and your pre-tax contributions stop Pre-tax contributions will resume if you return to active pay status during the same calendar year. If you return in a different calendar year, you may be able to make new elections under some of the *Flex* options
Medical Dental Vision EAP	You may continue your coverage • The *company* will contribute to the cost for your current Medical Plan option for "You Only" coverage (the *company's* contribution will be based on the lowest cost Medical Plan available in your geographic area). You must pay the rest of the cost for coverage on a post-tax basis, or your coverage will end. See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information. You will be billed for your contributions beginning the first full month after your leave of absence begins • You pay the full cost for Dental and Vision benefits on a post-tax basis. See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information)
HCRA	• Your pre-tax contributions stop • Your YSA card is suspended • You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount • Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section
DCRA	• Your pre-tax contributions stop • You may submit claims for eligible expenses incurred during that calendar year if you have funds in your account
Comprehensive Disability Plan (CDP)	• If you are disabled within the first two weeks of the leave, your CDP benefits will equal California State Disability Insurance benefit amount • You are not covered for disabilities occurring after the first two weeks of the leave
Long-Term Disability (LTD)	• Your pre-tax contributions stop • Your coverage ends when your leave begins
Long-Term Care (LTC)	• Your payroll contributions stop. • You may continue coverage by paying premiums to Prudential
Employee Life Insurance	For *full-time* and *part-time plus* employees, the *company* will continue your *company*-provided or basic coverage • Your pre-tax contributions stop • You may continue supplemental coverage by paying the cost on a post-tax basis. See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information) • If you return from leave in the same calendar year, your pre-tax or post-tax contributions will resume for the coverage in effect prior to your leave of absence. If you return from leave in the next calendar year, you will receive a new *Flex* enrollment package to make new elections
Dependent Life Insurance	Your dependents' coverage continues while you are on leave provided you make timely payments to the administrator. See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information)
Accidental Death and Dismemberment (AD&D)	For *full-time* and *part-time plus* employees, the *company* will continue your *company*-provided or basic coverage • Your payroll contributions stop • You may continue your supplemental and dependent coverage by paying the cost on a post-tax basis. See **Timely Payment of Post-tax Contributions** in the *Flex* section for more

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	• If you return from leave in the same calendar year, your pre-tax or post-tax contributions will resume for the coverage in effect prior to your leave of absence. If you return from leave in the next calendar year, you will receive a new *Flex* enrollment package to make new elections
Business Travel Accident	Coverage is suspended until you return to work
Holidays	• You may defer your unused floating holidays until you return to work or you may request pay for them • *Company* and personal (if applicable) holidays that occur during your leave of absence will not be deferred or paid out
Vacation	• You may defer your unused accrued vacation until you return to work or you may request pay for your unused days of accrued vacation • You do not accrue vacation during the leave
Vacation Buying	You will receive payment for your elective vacation hours if you bought vacation and haven't used all of it by the last pay period of the year
401(k) Savings Plan	• Your contributions stop • If you have an outstanding loan, see Situations Affecting Loans in the 401(k) Plan section for more information
Retirement Plan	• You continue to receive interest credits and transition credits (if applicable) • You do not receive pay credits or retiree health care credits (if applicable) • See the Retirement Plan section for more information

You Go On An Approved *Military Leave Of Absence*	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	*Company* contributions and your pre-tax contributions stop Pre-tax contributions will resume if you return to active pay status during the same calendar year. If you return in a different calendar year, you may be able to make new elections under some of the *Flex* options
Medical Dental Vision EAP	• Your coverage continues; after 12 weeks your premiums may increase depending on your coverage • If you currently pay for your coverage, you must make post-tax payments to the administrator while on your leave of absence or your coverage will end. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information)
HCRA	• Your pre-tax contributions stop • Your YSA card is suspended • You may submit claims for eligible expenses up to your election amount • Your contributions will resume upon your return to work if you return in the same year
DCRA	• Your pre-tax contributions stop • You may submit claims for eligible expenses incurred during that calendar year if you have funds in your account • Your contributions will resume upon your return to work if you return in the same year
Comprehensive Disability Plan (CDP)	• If you are disabled within the first two weeks of the leave, your CDP benefits will equal California State Disability Insurance benefit amount • You are not covered for disabilities occurring after the first two weeks of the leave
Long-Term Disability (LTD)	• Your pre-tax contributions stop • Your coverage ends when your leave begins
Long-Term Care (LTC)	• Your payroll deductions stop • You may continue coverage by paying your premiums directly to Prudential
Employee Life Insurance	For *full-time* and *part-time plus* employees, the *company* will continue your *company*-provided or basic coverage • Your pre-tax contributions stop • You may continue your supplemental coverage by paying the cost on a post-tax basis. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information) • If you return from leave in the same calendar year, your pre-tax or post-tax contributions will resume for the coverage in effect prior to your leave of absence. If you return from leave in the next calendar year, you will receive a new *Flex* enrollment package to make new elections
Dependent Life Insurance	Your dependents' coverage continues while you are on leave provided you make timely payments to the administrator. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information)

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Accidental Death and Dismemberment (AD&D)	For *full-time* and *part-time plus* employees, the *company* will continue your *company*-provided or basic coverage • Your payroll contributions stop • You may continue your supplemental and dependent coverage by paying the cost on a post-tax basis • If you return from leave in the same calendar year, your pre-tax or post-tax contributions will resume for the coverage in effect prior to your leave of absence. If you return from leave in the next calendar year, you will receive a new *Flex* enrollment package to make new elections
Business Travel Accident	Coverage is suspended until you return to work
Holidays	• You may defer your unused floating holidays until you return to work or you may request pay for them • *Company* and personal holidays that occur during your leave of absence will not be deferred or paid out
Vacation	• You may defer your unused accrued vacation until you return to work or you may request pay for your unused days of accrued vacation • You do not accrue vacation during the leave
Vacation Buying	You will receive payment for your elective vacation hours if you bought vacation and haven't used all of it by the last pay period of the year
401(k) Savings Plan	• Your contributions stop • If you return to work with the *company* within the time period specified by law for the guarantee of reemployment rights, you will have the opportunity to make up any missed contributions during your *military leave of absence* as required under federal law • If you have an outstanding loan, see Situations Affecting Loans in the 401(k) Plan section for more information
Retirement Plan	• You continue to receive interest credits and transition credits (if applicable) • You do not receive pay credits or retiree health care credits during your leave. If you return to work with the *company* within the time period specified by law for the guarantee of reemployment rights, you will receive: pay credits (if applicable) for the period of time you were on leave; retiree health care credits (if applicable) for the period of time you were on leave after January 1, 2006; and interest credits that apply to those pay credits and retiree health care credits, if any • See the Retirement Plan section for more information

You Go On Unpaid Approved Family Leave Of Absence	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	*Company* contributions and your pre-tax contributions stop. If you are granted a leave of absence under the Family and Medical Leave Act (FMLA) of 1993 (and state law where applicable), *company* contributions will continue for as long as you timely make your required contributions. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information) Pre-tax contributions will resume if you return to active pay status during the same calendar year. If you return in a different calendar year, you may be able to make new elections under some of the *Flex* options
Medical Dental Vision EAP	Your coverage may continue for up to 12 weeks. If you are granted a leave of absence under the Family and Medical Leave Act (FMLA) of 1993 (and state law where applicable), coverage continues for the duration of the leave. If you currently pay for your coverage as an employee, you make post-tax payments to the administrator while on leave or your coverage ends. (See **Contributions in** the *Flex* section for more information)
HCRA	• Your pre-tax contributions stop • Your YSA card is suspended • You may submit claims for eligible expenses up to your election amount • Your contributions will resume upon your return to work if you return in the same year
DCRA	• Your pre-tax contributions stop • You may continue submitting claims for eligible expenses incurred during that calendar year if you have funds in your account • Your contributions will resume upon your return to work if you return in the same year
Comprehensive Disability Plan (CDP)	• If you are disabled within the first two weeks of the leave, your CDP benefits will equal California State Disability Insurance benefit amount • You are not covered for disabilities occurring after the first two weeks of the leave
Long-Term Disability (LTD)	• Your pre-tax contributions stop

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	• Coverage ends when your leave begins
Long-Term Care (LTC)	You may continue coverage by paying your premiums directly to Prudential
Employee Life Insurance	For *full-time* and *part-time plus* employees, the *company* will continue your *company*-provided or basic coverage • Your pre-tax contributions stop • You may continue supplemental coverage by paying the cost on a post-tax basis. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information) • If you return from leave in the same calendar year, your pre-tax or post-tax contributions will resume for the coverage in effect prior to your leave of absence. If you return from leave in the next calendar year, you will receive a new *Flex* enrollment package to make new elections
Dependent Life Insurance	Your dependents' coverage continues while you are on leave provided you make timely payments to the administrator. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information)
Accidental Death and Dismemberment (AD&D)	For *full-time* and *part-time plus* employees, the *company* will continue your *company*-provided or basic coverage • Your payroll contributions stop • You may continue your supplemental and dependent coverage by paying the cost on a post-tax basis. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information
Business Travel Accident	Coverage is suspended until you return to work
Holidays	• You may defer your unused floating holidays until you return to work or you may request pay for them • *Company* and personal holidays (if applicable) that occur during your leave of absence will not be deferred or paid out
Vacation	• You may defer your unused accrued vacation until you return to work or you may request pay for your unused days of accrued vacation • You do not accrue vacation during the leave
Vacation Buying	You will receive payment for your elective vacation hours if you bought vacation and haven't used all of it by the last pay period of the year
401(k) Savings Plan	• Your contributions stop • If you have an outstanding loan, see Situations Affecting Loans in the 401(k) Plan section for more information
Retirement Plan	• You continue to receive interest credits and transition credits (if applicable) • You do not receive pay credits or retiree health care credits (if applicable) • See the Retirement Plan section for more information

You Go On Paid Family Leave Concurrent With FMLA Leave (Applies To Employees Working In California)	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	Generally, *company* contributions and your pre-tax contributions continue unchanged
Medical Dental Vision EAP	Your pre-tax contributions and coverage continue
HCRA	Your pre-tax contributions and coverage continue
DCRA	Your pre-tax contributions continue
Comprehensive Disability Plan (CDP)	Your coverage continues
Long-Term Disability (LTD)	Your pre-tax contributions and coverage continue
Long-Term Care (LTC)	You may continue coverage by paying your premiums directly to Prudential
Employee Life Insurance	Your coverage continues through payroll deduction
Dependent Life Insurance	If your earnings are sufficient, you may continue your dependents' coverage through payroll contributions; otherwise, you must pay the administrator with post-tax dollars by check or the coverage will end. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information)
Accidental Death and Dismemberment (AD&D)	Your coverage continues through payroll deduction
Business Travel Accident	Your coverage is suspended
Holidays	*Full-time* employees receive holiday pay for personal holidays (if applicable) and all *company* holidays that occur while they're receiving Paid Family Leave benefits *Part-time* and *part-time plus* employees receive holiday pay for personal (if applicable) and

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	company holidays that occur on their regularly scheduled work days while they're receiving Paid Family Leave benefits
Vacation	You continue to accrue vacation
401(k) Savings Plan	• Your contributions continue, but you may voluntarily stop them at any time • Any loan repayments will continue as long as you have sufficient earnings; if you have insufficient earnings, payments for any outstanding loans may be suspended for up to 12 months of authorized leave
Retirement Plan	• You continue to receive pay credits, retiree health care credits, interest credits and transition credits (if applicable)

You Become Disabled And Eligible For CDP or LTD Benefits	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• Generally, your coverage and *company* contributions allocation continues unchanged • Based on your specific disability status, your participation in some *Flex* options and contributions for those options may be affected
Medical Dental Vision EAP	Your coverage continues as long as you remain employed by the *company*
HCRA	• If you have exhausted your CDP benefits, your pre-tax contributions stop • Your YSA card is suspended • You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section
DCRA	• If you have exhausted your CDP benefits, your pre-tax contributions stop • You may continue submitting claims for eligible expenses incurred during that calendar year if you have funds in your account
Comprehensive Disability Plan (CDP)	Benefits are payable as long as you are eligible under the terms of the plan
Long-Term Disability (LTD)	Depending on your circumstances, you may receive benefits under the terms of the plan
Long-Term Care (LTC)	• Depending on your circumstances, you may receive benefits under the terms of the plan • You may continue coverage by paying your premiums directly to Prudential
Employee Life Insurance	• Your coverage and *company* contributions allocation continue • If your earnings are sufficient, you may continue your coverage through payroll contributions; otherwise, you must pay the administrator with post-tax dollars by check or your coverage will end. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information) • If you are under age 60 and are *permanently and totally disabled*, you may apply to have your premium waived • If you are terminally ill, you may be eligible for Living Benefit or Viatical Settlement options
Dependent Life Insurance	If your earnings are sufficient, you may continue your dependents' coverage through payroll contributions; otherwise, you must pay the administrator with post-tax dollars by check or the coverage will end. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information)
Accidental Death and Dismemberment (AD&D)	• Your coverage and *company* contributions allocation continue • If your earnings are sufficient, you may continue your coverage through payroll contributions; otherwise, you must pay the administrator with post-tax dollars by check or the coverage will end. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information)
Business Travel Accident	Your coverage is suspended
Holidays	• *Full-time* employees receive holiday pay for personal holidays (if applicable) and all *company* holidays that occur while they're receiving full-pay sick leave and extended benefits under the Comprehensive Disability Plan • You may not use floating holiday time while you are disabled. If you are receiving short-term disability benefits under the Comprehensive Disability Plan, you can request pay in lieu of your unused floating holidays • If you have exhausted all of your Comprehensive Disability Plan short-term disability benefits, you will be paid for any unused floating holidays, and you will

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	cease to be eligible for *company*, floating and personal (if applicable) holidays
Vacation	• See the **Holidays and Vacation** summary for details.
401(k) Savings Plan	If you are receiving Comprehensive Disability Plan benefits and you remain employed by the *company* or you are participating in the Return to Work program: • Your contributions continue • Any loan repayments will continue as long as you have sufficient earnings; if you have insufficient earnings, payments for any outstanding loans may be suspended for up to 12 months of authorized leave If you are receiving Long Term Disability benefits and have exhausted Comprehensive Disability Plan benefits or are receiving Wage Continuation benefits: • Your contributions stop • Any loan repayments will continue as long as you have sufficient earnings and remain employed by the *company*; if you have insufficient earnings, payments for any outstanding loans may be suspended for up to 12 months of authorized leave If you become *permanently and totally disabled:* • You become 100% vested in your *company* contributions account, regardless of service • Your contributions stop and your account may be distributed to you if you have exhausted your CDP or state disability benefits • If your account is $5,000 or less, and you have exhausted your CDP or state disability benefits, your account balance will automatically be distributed either as a lump sum distribution to you (if your account is $1,000 or less) or as an automatic rollover to an IRA in your name designated by the *company* (if your account is more than $1,000 but no more than $5,000), unless you select another distribution option • If your account is greater than $5,000, you may defer distribution up to the end of the year in which you reach age 70½. Your account will be distributed to you at the end of the year in which you reach age 70½ • Your distribution will not be subject to the 10% early withdrawal tax • As long as you maintain an account balance in the plan, you may change your investment mix • If you do not receive a distribution of your account, your loan repayments (if any) continue • If you receive a distribution of your account, your loan repayments stop and your loan will be in default. To avoid a loan default, you must repay your loan in full prior to the distribution of your account. You can ask an *EIX Benefits Connection* representative for details
Retirement Plan	You continue to receive pay credits, retiree health care credits, interest credits, and transition credits (if applicable) as long as you remain employed by the *company.* See the Retirement Plan summary for more information

You Change To An Ineligible Status	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	*Company* contributions and your pre-tax contributions stop Pre-tax contributions will resume if you return to active pay status during the same calendar year. If you return in a different calendar year, you may be able to make new elections under some of the *Flex* options
Medical Dental Vision EAP	• Your coverage continues until the end of the calendar month • You may extend your coverage as explained in the Continued Health Care Coverage section, under Extended Coverage (COBRA)
HCRA	• Your pre-tax contributions stop • Your YSA card is suspended • You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section
DCRA	• Your pre-tax contributions stop • You may submit claims for eligible expenses incurred during that calendar year, if you have funds in your account

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Long-Term Disability (LTD)	Your coverage ends, but benefits may still be payable if you are disabled, and: • In the LTD qualifying period, or • Already receiving LTD benefits
Long-Term Care (LTC)	• Payroll deductions stop • You may continue coverage by paying your premiums directly to Prudential
Employee Life Insurance	• Your coverage ends when your status changes • You may convert your Employee Life Insurance coverage to an individual policy within 31 days of the day your status changed • You may elect to transfer your Employee Life Insurance coverage to a portable individual policy within 31 days after you leave the *company* • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion or portability forms
Dependent Life Insurance	• Your coverage ends when your status changes • You may convert your Dependent Life Insurance to an individual policy within 31 days of the day your status changes • You may elect to transfer your Dependent Life Insurance coverage to a portable individual policy within 31 days after you leave the *company* • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion or portability forms
Accidental Death and Dismemberment (AD&D)	• Your coverage ends when your status changes • You may continue your coverage by converting to an individual policy within 31 days of the day your status changes • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for a conversion form
Business Travel Accident	Your coverage ends immediately
Vacation Buying	• If you've bought more vacation than you used, you receive cash for the bought vacation hours you did not use • If you used more vacation than you accrued or bought, you reimburse the *company* for the excess taken
401(k) Savings Plan	• Your contributions stop • Your loan repayments continue
Retirement Plan	You have full right to the vested funds in your Cash Balance account; however, you cannot begin payment of your benefit while you are an employee of the *company*, even if your *company* is not participating in this plan

You Are Laid Off	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	*Company* contributions and your pre-tax contributions stop Pre-tax contributions will resume if you return to active pay status during the same calendar year. If you return in a different calendar year, you may be able to make new elections under some of the *Flex* options
Medical Dental Vision EAP	• Your coverage continues until the end of the calendar month • You may extend your coverage as explained in the Continued Health Care Coverage summary, under **COBRA Extended Coverage** • If you involuntarily terminated under a special *company* severance program that provides for extended health care coverage, you may be eligible for extended coverage under that program's terms and conditions
HCRA	• Your pre-tax contributions stop • Your YSA card is suspended • You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section
DCRA	• Your pre-tax contributions stop • You may continue submitting claims for eligible expenses incurred during that calendar year, if you have funds in your account
Comprehensive Disability Plan (CDP)	• Your coverage ends on your last day of employment • You will forfeit any remaining accrued and available FPSL and/or hospital days

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	• If you are receiving CDP benefits, you may continue to receive benefits at the same rate as they would be paid under California's State Disability Insurance (SDI) plan as long as you remain eligible

Long-Term Disability (LTD)	• Your LTD coverage ends
	• Your LTD benefits may still be payable if, at the date of your layoff, you are disabled and:
	  • In the qualifying period, or
	  • Receiving LTD benefits

Long-Term Care (LTC)	• Payroll deductions stop • You may continue coverage by paying your premiums directly to Prudential

Employee Life Insurance	Your coverage ends when you are laid off
	• Within 31 days from the day you are laid off you may:
	  • Extend your supplemental coverage at your own expense on a post-tax basis for up to two years
	  • Convert your Employee Life Insurance to an individual policy
	  • Transfer your Employee Life Insurance to a portable individual policy
	  • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion or portability forms

Dependent Life Insurance	Dependent coverage ends when you are laid off
	• Within 31 days from the day you are laid off you may:
	  • Extend your coverage for up to two years
	  • Convert your Dependent Life Insurance to an individual policy
	  • Transfer your Dependent Life Insurance to a portable individual policy
	  • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion or portability forms

Accidental Death and Dismemberment (AD&D)	• Your insurance ends when you are laid off • You may continue your insurance by converting to an individual policy within 31 days of your layoff • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion forms
Business Travel Accident	• Your coverage ends the day you are laid off • You may convert your insurance to an individual AD&D policy within 31 days of the day your status changes • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion forms
Vacation Buying	• If you bought more vacation than you used, you receive cash for the bought vacation hours you did not use
401(k) Savings Plan	• Your contributions and any loan repayments will stop • If you have an outstanding loan, see Situations Affecting Loans in the 401(k) Savings Plan section for more information • If you are not 100% vested in your *company* contributions account, you will forfeit the unvested portion at the time your account is distributed or, if earlier, after a five-year break in service • If your vested account balance is less than or equal to $1,000, it will automatically be paid directly to you in a single lump sum (subject to mandatory withholding), unless you instead elect to have your vested account balance rolled over to an IRA or another eligible retirement plan • If your vested account balance is greater than $1,000, but less than or equal to $5,000, and you do not elect otherwise, your vested account balance will be automatically rolled over to an IRA in your name designated by the *company* • If your vested account balance is $5,000 or more, you may receive a distribution of your vested account balance or postpone your distribution • As long as your account balance remains in the plan, you can continue to change your investment mix
Retirement Plan	• If the present value of your vested Retirement Plan benefit is less than or equal to $1,000, it will automatically be paid directly to you in a single lump sum (subject to mandatory withholding), unless you instead elect to have your vested account balance rolled over to an IRA or another eligible retirement plan

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	• If the present value of your vested Retirement Plan benefit is greater than $1,000, but less than or equal to $5,000, and you do not elect otherwise, your vested plan benefit will be automatically rolled over to an IRA in your name designated by the *company* • If you are vested and the value of your Retirement Plan benefit is more than $5,000, you may apply to receive distribution of your benefit. If you elect to defer payment of your benefits, you will continue to receive interest credits

You Terminate Employment For Any Reason Except Retirement	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	*Company* contributions and your pre-tax contributions stop Pre-tax contributions will resume if you return to active pay status during the same calendar year. If you return in a different calendar year, you may be able to make new elections under some of the *Flex* options
Medical Dental Vision EAP	• Your coverage continues until the end of the calendar month • Unless terminated for gross misconduct, you may extend your coverage as explained in the Continued Health Care Coverage summary, under **COBRA Extended Coverage**
HCRA	• Your pre-tax contributions stop • Your YSA card is suspended • You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount • Unless terminated for gross misconduct, you may extend your coverage as explained in the Continued Health Care Coverage summary, under **COBRA Extended Coverage**. If you do not extend coverage under COBRA, your coverage terminates
DCRA	• Your pre-tax contributions stop • You may continue submitting claims for eligible expenses incurred during that calendar year, if you have funds in your account
Comprehensive Disability Plan (CDP)	• Your coverage ends on your last day of employment • You forfeit any remaining FPSL and/or hospital days • If you are receiving CDP benefits, you may continue to receive payments in the same amount as California's State Disability Insurance pays—as long as you are eligible

Long-Term Disability (LTD)	• Your coverage ends
	• LTD benefits may still be payable if your termination date is prior to June 7, 2010 and, at the time you terminate, you are disabled and:
	  ◦ In the qualifying period, or
	  ◦ Receiving LTD benefits

Long-Term Care (LTC)	• Payroll deductions stop • You may continue coverage by paying your premiums directly to Prudential
Employee Life Insurance	• Your *company*-sponsored coverage ends when your termination occurs • Within 31 days after you leave the *company*, you may convert your Employee Life Insurance to an individual policy • You may elect to transfer your Employee Life Insurance coverage to a portable individual policy within 31 days after you leave the *company* • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion or portability forms
Dependent Life Insurance	• Dependent coverage ends when your termination occurs • You may convert your Dependent Life Insurance to an individual policy within 31 days of the day you leave the *company* • You may elect to transfer your Dependent Life Insurance coverage to a portable individual policy within 31 days after you leave the *company* • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion or portability forms
Accidental Death and Dismemberment (AD&D)	• Your *company*-sponsored coverage ends when your termination occurs • You may convert your coverage to an individual policy within 31 days of the day you leave the *company* • The insurance company determines your cost and the maximum coverage

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	amounts available to you. Contact the *EIX Benefits Connection* for conversion forms
Business Travel Accident	• Your coverage ends the day you terminate employment • You may convert your insurance to an individual AD&D policy within 31 days of the day your coverage ends • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion forms
Vacation Buying	• If you bought more vacation than you used, you receive payment for the bought vacation hours you did not use
401(k) Savings Plan	• Your contributions and any loan repayments will stop • If you have an outstanding loan, see Situations Affecting Loans in the 401(k) Savings Plan section for more information • If you are not 100% vested in your *company* contributions account, you will forfeit the unvested portion at the time your account is distributed or, if earlier, after a five-year break in service • If your vested account balance is less than or equal to $1,000, it will automatically be paid directly to you in a single lump sum (subject to mandatory withholding), unless you instead elect to have your vested account balance rolled over to an IRA or another eligible retirement plan • If your vested account balance is greater than $1,000, but less than or equal to $5,000, and you do not elect otherwise, your vested account balance will be automatically rolled over to an IRA in your name designated by the *company* • If your vested account balance is $5,000 or more, you may receive a distribution of your vested account balance or postpone your distribution • As long as your account balance remains in the plan, you can continue to change your investment mix
Retirement Plan	• If the present value of your vested Retirement Plan benefit is less than or equal to $1,000, it will automatically be paid directly to you in a single lump sum (subject to mandatory withholding), unless you instead elect to have your vested account balance rolled over to an IRA or another eligible retirement plan • If the present value of your vested Retirement Plan benefit is greater than $1,000, but less than or equal to $5,000, and you do not elect otherwise, your vested plan benefit will be automatically rolled over to an IRA in your name designated by the *company* • If you are vested and the value of your Retirement Plan benefit is more than $5,000, you may apply to receive distribution of your benefit. If you elect to defer payment of your benefits, you will continue to receive interest credits

You Retire	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	*Company* contributions and your pre-tax contributions stop Pre-tax contributions will resume if you return to active pay status during the same calendar year. If you return in a different calendar year, you may be able to make new elections under some of the *Flex* options
Medical Dental Vision EAP	• If you're eligible for retiree health care benefits, you may continue your coverage by making required contributions. (See **Timely Payment of Post-tax Contributions** in the *Flex* section for more information) • If you're not eligible for retiree health care coverage, your coverage continues until the end of the calendar month in which you terminate employment • You may extend your coverage as explained in the Continued Health Care Coverage summary under **COBRA Extended Coverage**
HCRA	• Your pre-tax contributions stop • Your YSA card is suspended • You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section
DCRA	• Your pre-tax contributions stop • You may continue submitting claims for eligible expenses incurred during that calendar year if you have funds in your account
Comprehensive Disability Plan	• Your coverage ends on your last day of employment

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

(CDP)	• You forfeit any remaining FPSL and/or hospital days • If you are receiving CDP benefits, you may continue to receive payments in the same amount as California's State Disability Insurance pays—as long as you are eligible
Long-Term Disability (LTD)	Your coverage and benefits end
Long-Term Care (LTC)	• Payroll deductions stop • You may continue coverage by paying your premiums directly to Prudential
Employee Life Insurance	• If you are (i) a *full-time* or *part-time plus* employee with at least five *years of service* in the Southern California Edison Company Retirement Plan and are at least age 55, (ii) a *full-time* or *part-time plus* employee under Edison Mission Group (EMG) or any of the EMG *companies* with at least five *years of service* in the Edison 401(k) Savings Plan and are at least age 55, or (iii) retiring under a special *company* retirement program, the *company* provides $5,000 of retiree life insurance • Your Employee Life Insurance stops when you terminate employment • You may convert your Employee Life Insurance coverage in excess of any retiree life insurance to an individual policy within 31 days of your retirement date • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion forms
Dependent Life Insurance	• Your coverage ends when you terminate employment • You may convert your Dependent Life Insurance to an individual policy within 31 days of the day you retire • You may transfer your Dependent Life Insurance to a portable individual policy within 31 days of the day you retire • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion or portability forms
Accidental Death and Dismemberment (AD&D)	• Your coverage ends when you terminate employment • You may convert to an individual policy within 31 days of the day you retire • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion forms
Business Travel Accident Insurance	• Your coverage ends when you terminate employment • You may convert your insurance to an individual AD&D policy within 31 days of the day your coverage ends • The insurance company determines your cost and the maximum coverage amounts available to you. Contact the *EIX Benefits Connection* for conversion forms
Vacation Buying	• If you bought more vacation than you used, you receive cash for the bought vacation hours you did not use
401(k) Savings Plan	• Your contributions stop • If you have an outstanding loan, see Situations Affecting Loans in the 401(k) Savings Plan section for more information • If you retire before age 65 and you are not 100% vested in your *company* contributions account, you will forfeit the unvested portion at the time your account is distributed or, if earlier, after a five-year break in service • If your vested account balance is less than or equal to $1,000, it will automatically be paid directly to you in a single lump sum (subject to mandatory withholding), unless you instead elect to have your vested account balance rolled over to an IRA or another eligible retirement plan • If your vested account balance is greater than $1,000, but less than or equal to $5,000, and you do not elect otherwise, your vested account balance will be automatically rolled over to an IRA in your name designated by the *company* • If your vested account balance is $5,000 or more, you may receive a distribution of your vested account balance or postpone your distribution • As long as your account balance remains in the plan, you can continue to change your investment mix
Retirement Plan	• If the present value of your vested Retirement Plan benefit is less than or equal to $1,000, it will automatically be paid directly to you in a single lump sum (subject to mandatory withholding), unless you instead elect to have your vested account balance rolled over to an IRA or another eligible retirement plan • If the present value of your vested Retirement Plan benefit is greater than $1,000,

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	but less than or equal to $5,000, and you do not elect otherwise, your vested plan benefit will be automatically rolled over to an IRA in your name designated by the *company* • If you are vested and the value of your Retirement Plan benefit is more than $5,000, you may apply to receive distribution of your benefit. If you elect to defer payment of your benefits, you will continue to receive interest credits

You Die	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	Pre-tax contributions stop
Medical Dental Vision EAP	• Your surviving dependents may be eligible for continued coverage based on your age, your length of service, and the *company* you worked for • Your eligible survivors may extend coverage through COBRA Extended Coverage (See **Continued Health Care Coverage** summary)
HCRA	• Pre-tax contributions stop • Your YSA card is suspended • Claims for qualifying expenses incurred through the last day of the month of your death are paid to your estate • Funds remaining in your account and not claimed are forfeited • Your surviving dependents may extend coverage for only the current year under COBRA Extended Coverage
DCRA	• Pre-tax contributions stop • To the extent you have funds in your account, claims for qualifying expenses incurred during the calendar year are paid to your estate • Funds remaining in your account and not claimed are forfeited
Comprehensive Disability Plan (CDP)	Benefits end
Workers' Compensation	Benefits end
Long-Term Disability (LTD)	Benefits end
Long-Term Care (LTC)	Benefits end
Employee Life Insurance	• A certified copy of your death certificate is required to claim benefits • Your beneficiary should contact the Employee Information Center for assistance
Dependent Life Insurance	• Dependent coverage ends • Your dependents may elect conversion or portability of their coverage to individual policies within 31 days of your death • The insurance company determines the cost and the maximum coverage amounts available. Contact the *EIX Benefits Connection* for conversion or portability forms
Accidental Death and Dismemberment (AD&D)	• If you die from a covered accident, your beneficiary should contact the Employee Information Center for assistance in claiming benefits. • Any covered dependents over age 16 may convert their coverage to individual policies within 31 days of your death • The insurance company determines the cost and the maximum coverage amounts available. Contact the *EIX Benefits Connection* for conversion forms
Business Travel Accident	If you die from an accident while traveling on *company* business, your beneficiary should contact the Employee Information Center for assistance in claiming benefits
Vacation	Your estate will receive a cash-out of unused vacation hours
Vacation Buying	If you bought more vacation than you have used, your estate receives cash for the bought vacation hours you did not use
401(k) Savings Plan	• If you are an active employee, your account becomes fully vested • Your account is paid to your named beneficiary(ies) • If you have not designated a beneficiary (with spousal consent if your *spouse* or *domestic partner* is not your beneficiary), your *spouse*, *same-sex spouse, or registered domestic partner* is your beneficiary • If you die and have no surviving *spouse*, *same-sex spouse*, *registered domestic partner*, or other beneficiary, your account balance will be paid to your estate • The taxable portion of the distribution payable to your surviving *spouse* may be eligible for rollover to an IRA or other eligible retirement plan • The taxable portion of the distribution payable to an individual beneficiary (or a trust that meets certain requirements) other than the surviving *spouse* may be eligible for a direct rollover to an inherited IRA established to receive a

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	direct rollover on behalf of a non-*spouse* beneficiary • If you have an outstanding loan: o Your loan defaults 60 days after your death o Your surviving *spouse* or beneficiary cannot repay the outstanding loan balance o Your beneficiary should contact a tax advisor to determine the tax advantages, if any, of depositing an amount equal to your outstanding loan balance into an IRA and possibly avoiding immediate taxation
Retirement Plan	If you die before retirement benefits are paid: • If you were an active employee or on an approved leave of absence, you are 100% vested on the date of death • Your designated beneficiary(ies) receives the value of your benefit If you die without a valid beneficiary form on file, your surviving *spouse*, *same-sex spouse*, or *registered domestic partner* is automatically your beneficiary for any death benefits payable or, if you die without a surviving *spouse*, *same-sex spouse*, or *registered domestic partner*, any death benefits due will be paid to your estate. • If you were eligible for grandfathered benefits, the amount payable to a surviving *spouse* is no less than the survivor benefit provided by the grandfathered formulas (see Grandfathering in the Appendix to the Retirement Plan section)

Your *Spouse*, *Domestic Partner*, Or Other Eligible Dependent Dies	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision EAP	• Deceased *spouse's*/*domestic partner's*/ dependent's coverage ends • You may enroll for coverage if you lost coverage with your *spouse's*/*domestic partner's* employer • You may add any eligible dependents who lost coverage with your *spouse's*/*domestic partner's* employer
HCRA	If deceased is your *spouse* or dependent for federal tax purposes, you may: • Decrease your contributions to an amount not less than the amount already contributed for the year • Stop your contributions. You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. • Commence or increase contributions to be applied to expenses incurred after the event—if you lost coverage with *spouse's* employer
DCRA	• If deceased is a dependent for whom day care expenses are payable from the DCRA, you may stop or decrease your contributions to an amount not less than the amount already contributed for the year • If deceased is your *spouse* or *domestic partner* who either provided day care to your eligible dependent(s) or provided day care reimbursement account coverage through his or her employer, you may commence or increase contributions to be applied only to expenses incurred after the date of his or her death
Long-Term Disability (LTD)	You may increase or decrease your coverage.
Employee Life Insurance	You may: • Decrease coverage (or stop coverage if the *company* doesn't require coverage) • Commence or increase coverage • Want to update your beneficiary designation
Dependent Life Insurance	• Deceased dependent's coverage ends • If dependent was covered at death, contact the Employee Information Center for assistance with claiming benefits
Accidental Death and Dismemberment (AD&D)	You may: • Decrease your coverage (or stop coverage if the *company* doesn't require coverage) • Commence or increase coverage • Want to update your beneficiary designation
Dependent AD&D	You may: • Commence or increase your coverage • Decrease or stop your coverage • If dependent died from an accident, contact the Employee Information Center for

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	assistance in claiming benefits
401(k) Savings Plan	If deceased is your *spouse* or other beneficiary, name a new beneficiary
Retirement Plan	If deceased is your *spouse* or other beneficiary, name a new beneficiary

Your *Child* Is Born, Adopted Or Placed For Adoption; You Become A *Child's* Legal Guardian Or Stepparent; Or An Unmarried *Child* Is Added With Status Of "Other" Dependent	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	You may add coverage for yourself or any eligible dependent
EAP	New eligible dependent is automatically covered
HCRA DCRA	• You may commence or increase your contributions to an amount to be applied to expenses incurred after the date of the event
Long-Term Disability (LTD)	You may increase or decrease coverage
Employee Life Insurance	You may commence or increase coverage
Dependent Life Insurance	You may enroll or increase coverage
Accidental Death and Dismemberment (AD&D)	You may enroll or increase coverage
401(k) Savings Plan	Your participation is not affected
Retirement Plan	Your participation is not affected

Your Covered Dependent Ceases To Be An Eligible Dependent	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision EAP	• Your dependent's coverage ends • Your dependent may continue benefits for a certain period of time through **COBRA Extended Coverage** summary)
HCRA	You may: • Decrease your contributions • Stop your contributions. You may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount.
DCRA	• You may stop or decrease your pre-tax contributions depending on the reason your dependent is no longer eligible Examples of circumstances allowing you to stop or decrease your pre-tax contributions include: if your dependent no longer resides in your home or no longer requires day care while you and your *spouse* work or attend school, if your dependent child turns age 13, etc. See the **Reimbursement Accounts** section of this handbook for more information about qualified individuals
Long-Term Disability (LTD)	You may increase or decrease your coverage.
Employee Life Insurance	• You may increase or decrease coverage • You may decrease your coverage (or stop coverage if the *company* doesn't require coverage)
Dependent Life Insurance	• Coverage for the dependent stops • Your dependent may elect conversion or portability of his or her coverage to an individual policy within 31 days of the event • The insurance company determines your cost and the maximum coverage amounts available. Contact the *EIX Benefits Connection* for conversion or portability forms
Accidental Death and Dismemberment (AD&D)	You may: • Enroll for coverage or increase existing coverage • Decrease your coverage (or stop coverage if the *company* doesn't require coverage)
Dependent AD&D	• Coverage for the dependent stops • You may add coverage or stop coverage
401(k) Savings Plan	Your participation is not affected
Retirement Plan	Your participation is not affected

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Your Eligible *Child* Becomes A Full-Time Student Or Otherwise Gains Dependent Status	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	If the gain in dependent status is due to your *child* becoming a full-time student: • See the appropriate plan summary for eligibility requirements for full-time student *children* • Certify that your *child* is a full-time student. You may be required to submit proof of enrollment. • Make any allowable change in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	You may add or continue coverage for the dependent *child*
EAP	Coverage for the dependent *child* continues
HCRA	If your *child* was not previously a dependent for purposes of HCRA and becomes a dependent for purposes of HCRA, you may commence or increase your contributions to be applied to expenses incurred after the event
DCRA	In limited situations, you may commence or increase contributions to be applied only to subsequently incurred expenses
Long-Term Disability (LTD)	You may increase or decrease your coverage.
Employee Life Insurance	You may increase or decrease coverage
Dependent Life Insurance	You may add coverage for the dependent *child*
Accidental Death and Dismemberment (AD&D)	You may increase or decrease coverage
Dependent AD&D	You may add coverage
401(k) Savings Plan	Your participation is not affected
Retirement Plan	Your participation is not affected

Change In Employment Status For You, Your *Spouse*, *Domestic Partner* Or Eligible Dependent, Resulting In A Loss Of Coverage Under An Employer's Plan	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	You may add coverage for yourself, your *spouse*, and/or any eligible dependents
HCRA	You may commence or increase contributions to be applied to subsequently incurred expenses
DCRA	You may: • Commence or increase contributions to be applied to expenses incurred subsequent to your *spouse* or dependent losing eligibility under the other employer's dependent care plan • Stop or decrease contributions if your *spouse* stops working or you otherwise lose or decrease eligibility for DCRA coverage
Long-Term Disability (LTD)	You may increase existing coverage
Employee Life Insurance	You may enroll for coverage or increase existing coverage
Dependent Life Insurance	You may enroll for coverage or increase existing coverage
Accidental Death and Dismemberment (AD&D)	You may enroll for coverage or increase existing coverage
Dependent AD&D	You may enroll for coverage

Change In Employment Status For You, Your *Spouse*, *Domestic Partner* Or Eligible Dependent, Resulting In New Coverage Under An Employer's Plan	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	You may stop coverage for yourself, your *spouse*, or any eligible dependents, if you, your *spouse*, or your eligible dependents become covered by the other employer's plan
HCRA	You may stop or decrease contributions if you become covered by other employer's plan. If you stop contributions, you may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA**

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	Extended Coverage in the Continued Health Care Coverage section
DCRA	You may: • Commence or increase contributions to be applied to subsequently incurred expenses • Stop or decrease contributions if any dependent becomes covered by other employer's plan
Long-Term Disability (LTD)	You may decrease coverage
Employee Life Insurance	You may stop or decrease coverage
Dependent Life Insurance	You may stop or decrease coverage
Accidental Death and Dismemberment (AD&D)	You may stop or decrease coverage
Dependent AD&D	You may stop or decrease coverage

You Receive A Judgment, Decree, Or Court Order Resulting From Your Divorce, Legal Separation, Annulment Of Marriage Or Change In Legal Custody Of Your *Child* Or *Children* (Including A Qualified Medical Child Support Order, Or QMCSO) That Requires Accident Or Health Care Coverage For Your *Child(ren)*	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must generally make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	• Add coverage for the *child(ren)* if the order requires you to provide coverage for the *child(ren)* • Remove the *child(ren)* if the order requires someone else to cover the *child(ren)*
HCRA	• Commence or increase contributions if the order makes you responsible for the *child(ren)* • Stop or decrease contributions if the order makes someone else responsible for the *child(ren)*. If you stop contributions, you may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount.
Dependent AD&D	Add coverage for the *child(ren)*

You And/Or Your Eligible Dependent Loses Health Care Coverage*	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	Add coverage for yourself and/or dependent(s) who lost other coverage, pursuant to special enrollment rights
HCRA	Commence or increase your contributions, pursuant to special enrollment rights

* The Health Insurance Portability and Accountability Act (HIPAA) covers "special enrollment rights" under health care plans and does not apply to other benefit plans.

You Or Your Eligible Dependent Becomes Entitled to Medicare	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical	Remove coverage for Medicare enrollee
HCRA	• Stop or decrease contributions. If you stop contributions, you may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section • Commence or increase contributions

You Or Your Eligible Dependent Lose Medicare Eligibility	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical	Add coverage for yourself, *spouse*, or dependent who lost eligibility
HCRA	• Stop or decrease contributions. If you stop contributions, you may submit claims for eligible expenses incurred through the month in which your contributions end,

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section • Commence or increase contributions

Significant Increase Or Decrease In The Cost Of Current Dependent Care Provider, Or A Change In Dependent Care Provider	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	You must make any allowable changes in coverage within 30 days of the even
DCRA	Commence, increase, stop or decrease contributions, as appropriate for the change in cost, but only if your dependent care provider is not your relative. If you stop contributions, you may continue submitting claims for eligible expenses incurred during that calendar year if you have funds in your account

Current Benefit Plan Option Is Discontinued	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	• Elect a different option • Drop coverage, if eligible
HCRA	You may commence, increase, decrease or stop contributions. If you stop contributions, you may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section
Employee Life Insurance	• Elect a different option • Drop coverage, if eligible
Dependent Life Insurance	• Elect a different option • Drop coverage, if eligible
Accidental Death and Dismemberment (AD&D)	• Elect a different option • Drop coverage, if eligible
Dependent AD&D	• Elect a different option • Drop coverage, if eligible

Significant Change In Coverage Of *Spouse* Or Dependent Under Other Employer's Plan If Change Is Permitted Under Internal Revenue Code Sec. 125* Or If The *Spouse's* Period Of Coverage Is Different Than Your Period Of Coverage	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	Add or remove coverage for yourself, *spouse*, or dependent if corresponding change is made in coverage under the other employer's plan
HCRA	You may commence, increase, decrease or stop contributions. If you stop contributions, you may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section
DCRA	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan. If you stop contributions, you may continue submitting claims for eligible expenses incurred during that calendar year if you have funds in your account
Long-Term Disability (LTD)	Decrease or increase coverage if corresponding change in coverage is made under the other employer's plan
Employee Life Insurance	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan
Dependent Life Insurance	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan
Accidental Death and Dismemberment (AD&D)	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan
Dependent AD&D	Add or remove coverage for *spouse* or dependent if corresponding change is made in

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	coverage under the other employer's plan

* Internal Revenue Code Sec. 125 covers flexible benefit plans.

Midyear Expiration Of Your, Your *Spouse's* Or Other Eligible Dependent's COBRA Coverage By Another Employer	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	Commence coverage for yourself, *spouse*, and any eligible dependent
HCRA	Commence or increase your contributions

Loss Of Subsidized Health Care From Another Employer	
Benefit Plan/Program	**Effect on Your Benefit**
Flex	• You must make any allowable changes in coverage within 30 days of the event • *Company* contributions and your contributions may be adjusted
Medical Dental Vision	Commence coverage for yourself, *spouse*, and any eligible dependent
HCRA	Commence or increase your contributions

Your *Spouse's* Or Other Eligible Dependent's Annual Enrollment Does Not Correspond With Your Annual Enrollment	
Benefit Plan/Program	**Effect on Your Benefit**
Medical Dental Vision EAP	Commence coverage for yourself, *spouse*, and any eligible dependent, or stop your *company* coverage if corresponding change in coverage is made under the other employer's plan
HCRA	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan. If you stop contributions, you may submit claims for eligible expenses incurred through the month in which your contributions end, up to your election amount. Your coverage terminates unless you extend your coverage as explained under **COBRA Extended Coverage** in the Continued Health Care Coverage section
DCRA	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan. If you stop contributions, you may continue submitting claims for eligible expenses incurred during that calendar year if you have funds in your account
Long-Term Disability (LTD)	Increase or decrease coverage if corresponding change in coverage is made under the other employer's plan
Employee Life Insurance	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan
Dependent Life Insurance	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan
Accidental Death and Dismemberment (AD&D)	Stop, decrease, commence or increase coverage if corresponding change in coverage is made under the other employer's plan

Supporting Documentation for *Qualified Life Events*

Within 30 days of this event occurring...	**You may be required to provide this documentation upon request...**
Divorce, annulment or legal separation	Copy of the final judgment or decree showing the effective date
Children newly eligible as full-time students	Class schedule or letter from school on school letterhead indicating the effective date and full-time status
Significant change in medical coverage of eligible dependent	Copy of employee communication or letter from employer stating the change
Increase your Employee Life Insurance coverage because of a *qualified life*	A personalized Evidence of Insurability form will be provided by the *EIX Benefits Connection*. If you do not complete and return the form, coverage

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

event by or up to any of the following amounts • Increase by more than one times annual pay • Choose coverage of at least five times annual pay • Choose coverage of $300,000 or more	will be at the highest level allowed without Evidence of Insurability.
Increasing, decreasing, starting or stopping DCRA contributions because of a change in the work schedule of yourself or your *spouse*, with an expected duration of more than six months	Letter from employee's or *spouse's* supervisor explaining the work schedule and expected duration of change

If required, you will be instructed where to send supporting documentation.

For More Information

If you think you have a *qualified life event* and you would like to change your coverage, contact the *EIX Benefits Connection* by phone or online at:

- (866) 693-4947
- www.eixbenefits.com

A representative can help you determine whether your *qualified life event* qualifies under current law and, if so, will let you know what kinds of changes you can make.

Quick Contact List

If You Need to Obtain…

If you need to obtain...	Contact...	Or on the Web at...
A printed copy of this handbook, or any portion of it	Benefits Administration • PAX 23456 • 626-302-3456 • 800-500-4723 Select the option for the Employee Information Center	infocntr@sce.com
A beneficiary designation form for the 401(k) Savings Plan, retirement plan or life/accident insurance plans	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com
Dependent Care Reimbursement Account (DCRA) or Health Care Reimbursement Account (HCRA) claim forms	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com
Preventive Health Account (PHA) claim forms	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com and on the Edison International Portal
An Evidence of Insurability (EOI) form to increase your life and/or accident insurance coverage	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com
A 401(k) Savings Plan • Rollover Request Form • Distribution • Hardship withdrawal form • Special Tax Notice	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com
401(k) Savings Plan/Retirement Plan calculations based on a Qualified Domestic Relations Order (QDRO)	*EIX Benefits Connection* (866) 693-4947	
An estimate of a future date value of your benefit payable from the Retirement Plan	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com

If You Need Information About…

If you need information about…	Contact…	Or on the Web at…
Electric Service Discount/Reimbursement	Benefits Administration • PAX 23456 • 626-302-3456 • 800-500-4723 Select the option for the Employee Information Center	infocntr@sce.com
Time off work for voting, jury duty, serving as a subpoenaed witness, a major disaster or catastrophe, military training, pregnancy and other medical issues, death in your family	Benefits Administration • PAX 23456 • 626-302-3456 • 800-500-4723 Select the option for the Employee Information Center	infocntr@sce.com
Dental Plan	**Your Dental Plan option(s)**	
Medical Plan	**Your Medical Plan option(s)**	
Vision Plan	VSP (800) 877-7195	www.vsp.com
Prescription Drug Coverage	Express Scripts (800) 955-1181 (Members only. Non-members contact your medical plan.)	www.express-scripts.com
Employee Assistance Program (EAP)	Resources for Living (800) 443-4474 within the United States	www.HorizonCareLink.com

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	(858) 571-1698 outside the United States (800) 733-0373 if you are hearing impaired	Login: edison Password: eap
The 401(k) Savings Plan • Your account balance • Change allocation of your current funds • Amount available for withdrawal • Investment Options	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com
Your Cash Balance account feature of the Retirement Plan	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com
Applying for your retirement plan benefit	*EIX Benefits Connection* (866) 693-4947 and Benefits Administration • PAX 23456 • 626-302-3456 • 800-500-4723 Select the option for the Employee Information Center	www.eixbenefits.com
Pension Benefit Guaranty Corporation (PBGC) insurance program	PBGC Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, DC 20005-4026 • (202) 326-4000 (not a toll-free number) • TTY/TDD users may call the federal relay service toll-free at (800) 877-8339 and ask to be connected to (202) 326-4000	www.pbgc.gov
Qualified Domestic Relations Order (QDRO)	*EIX Benefits Connection* (866) 693-4947	
Advising the *company* of an address/bank change	Benefits Administration • PAX 23456 • 626-302-3456 • 800-500-4723 Select the option for the Employee Information Center	infocntr@sce.com and on the Edison International Portal
Qualified life events	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com
Reimbursement Accounts • Dependent Care Reimbursement Account (DCRA) • Health Care Reimbursement Account (HCRA) Preventive Health Account (PHA)	*EIX Benefits Connection* (866) 693-4947	www.eixbenefits.com
Reporting an absence from work of more than three consecutive days due to illness or injury	Sedgwick, CMS (866) 925-6789	

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

***Flex* revised December 19, 2012.**

Overview and Important Features

Flex, the *company's* flexible benefits program, allows you to choose the type and level of benefits that best meet the needs of you and your family, year after year. *Flex* options offered to most employees include:

- Health care (Medical, Dental, Vision and Employee Assistance Program [EAP])
- Long term disability coverage
- Life insurance
- Accident insurance
- Health care and dependent care reimbursement accounts
- Vacation buying

The *Flex* benefit options available to you are listed in the personalized enrollment kit that you receive when you are first eligible and each subsequent year at annual enrollment. The summaries in this handbook explain how each plan works and provide other important details about participation and coverage.

Each *Flex* option has a price tag, which reflects the cost of coverage. In general, the higher the level of benefit you choose, the higher the price tag.

The *company* provides contributions toward the cost of coverage to most employees. You allocate your *company* contributions toward the cost of the *Flex* choices you select when you enroll.

If you have any *company* contributions left over after allocating them to your *Flex* benefit options and you are a *full-time* or *part-time plus* employee, you will receive them in your paychecks throughout the year as additional taxable income. If you are a *part-time* employee, you will forfeit any unused *company* contributions.

If your benefit price tags total more than your *company* contributions, you will pay the additional cost for most benefit options through pre-tax payroll contributions—as permitted under Internal Revenue Code Section 125.

Who Is Eligible

Employees

Full-time, *part-time* and *part-time plus* employees of the *companies* listed in the **Eligibility** section of this handbook are eligible to participate in *Flex* and receive *company* contributions. Most eligible employees are assigned default benefits if they don't enroll in their own benefit choices. The following chart shows how different employee groups participate in *Flex*.

***Flex* Employee Eligibility Summary**	
Eligible Employees	***Flex* Participation**
Full-time employees	• Eligible for all *Flex* benefits • Receive a certain amount of *company* contributions allocated toward each health care plan, Long Term Disability coverage, life insurance coverage and

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	accident insurance coverage • Required to enroll in certain *Flex* benefits
Part-time Plus employees	• Eligible for all *Flex* benefits except Long Term Disability coverage and Vacation Buying • Receive a certain amount of *company* contributions allocated toward each health care plan, life insurance coverage and accident insurance coverage • Required to enroll in certain *Flex* benefits
Part-time employees working 16 hours or more per week on an on-going basis	• Eligible for all *Flex* benefits except the Vision Plan, Long Term Disability coverage, Vacation Buying • Receive an annual lump sum of *company* contributions to spend on all their *Flex* options • Not required to enroll in any *Flex* benefits

The following employees have limited or no *Flex* participation:

- *Part-time* employees regularly scheduled to work less than 16 hours per week are eligible for the same *Flex* plans as listed above for *part-time* employees regularly scheduled to work 16 hours or more per week, with the exception of the Dependent Care Reimbursement Account and Health Care Reimbursement Account. They do not receive *company* contributions
- *Temporary* and *leased* employees and *contingent workers* are not eligible to participate in *Flex* and do not receive *company* contributions

Dependents

Dependent eligibility may vary among *Flex* benefit options. The rules for dependent eligibility are explained within the Health Care, Reimbursement Accounts, Life and Accident Insurance and Glossary sections of this handbook.

Once your dependent ceases to be an eligible dependent for purposes of a *company* plan, he or she is no longer eligible for coverage under that plan. You are required to contact the *EIX Benefits Connection* and report this type of *qualified life event* within 30 days after the date of the event. Please note that **you will be responsible** for costs and expenses incurred by the *company* or its plans with respect to any of your dependents that are not eligible after this type of *qualified life event*.

You may be required to provide proof of your dependent's eligibility in the following cases:

- ***Domestic Partner* Declaration** - *Domestic partners* include *same-sex* and opposite-sex couples who live together in a committed relationship and meet the requirements described in the Glossary section of this handbook. The employee must certify that a *domestic partner* relationship exists. If you have a *domestic partner*, you must complete the benefit plan's Declaration of Domestic Partnership by calling the *EIX Benefits Connection* at (866) 693-4947.

  A *domestic partner* must be removed from coverage within 30 days after he or she no longer qualifies as a *domestic partner*.

- **Proof of a *Child's* Incapacity** — You must affirm your *child* is eligible prior to the end of the month in which the dependent reaches age 26 on a form approved by the *company* (or if you become initially eligible for coverage after your *child's* 26th birthday, you must affirm your *child* is eligible due to disability upon your initial enrollment). Continued coverage of an incapacitated *child* is subject to periodic re-certification when requested by, and on a form approved by, the SCE Benefits Committee. If you fail to provide a *physician's* certification upon request, your *child's* coverage will end coincident with the due date of the re-certification request. See Who Is Eligible in the **Health Care** and **Life and Accident Insurance Overview** sections of this handbook for details about coverage for incapacitated dependent *children*.

Enrolling for Coverage

When you are first eligible, you have 30 days to enroll in the *Flex* options of your choice. The benefits you elect at that time will stay in effect for the remainder of that calendar year. From then on, you will have the opportunity to change your *Flex* benefit coverage each year during annual enrollment. The personalized enrollment kit you

receive when first eligible and at annual enrollment shows the price tags and *company* contributions for the benefit options and coverage levels available to you. It also explains how to enroll.

Enrollment Deadlines

If you don't enroll within 30 days of first becoming eligible, you will be assigned default coverage and you'll have to wait until annual enrollment to make changes. *Flex* benefit options stay in place until December 31 unless you have a *qualified life event* during the year as explained in this summary. If you don't enroll yourself or your dependents because you have other coverage, you may enroll in *Flex* benefits in the future if you request enrollment within 30 days after your other coverage ends.

Annual Enrollment

Each year during annual enrollment, you'll have the opportunity to select benefits and allocate your *company* contributions accordingly. Changes you make during annual enrollment take effect on January 1 of the following year and remain in effect for the whole calendar year. If you don't make an election during annual enrollment, you will receive default coverage as described in this summary and as shown on your personalized enrollment kit. You won't be able to make changes until the next year's annual enrollment period—unless you have a *qualified life event* as explained in the **Events Affecting Your Benefits** section of this handbook.

When Participation Begins

Most employees may begin participating in *Flex* immediately upon hire or when they are transferred to an eligible status.

Coverage under two *Flex* options — Life Insurance and Long Term Disability — require that you be *actively at work* in order for coverage to take effect. If you are not *actively at work*, your coverage or coverage change will take effect on your first full day of work.

Participation in the Dependent Care Reimbursement Account and the Health Care Reimbursement Account is effective the later of the date of your election or the date of your eligibility.

Cost of Coverage

The cost of coverage or participation in various *Flex* options is detailed in the summary of each plan. Following is an explanation of how *company* contributions, price tags and employee contributions work.

Company Contributions

Every year, the *company* gives a certain amount of *company* contributions to each eligible employee. You may use your *company* contributions toward the cost (price tags) of your benefit options.

Company contributions are allocated to you throughout the year. They are equally divided among your payroll *deduction periods*. Your *company* contributions may be adjusted during the year if you have a *qualified life event* and make an election change request within 30 days after the date of the change.

The *company* periodically reviews the amount of contributions it provides and may change the amount provided from year to year. The amount of *company* contributions provided to represented employees is determined by the collective bargaining process.

Medical Waive Dividends

In addition to *company* contributions, you may be entitled to receive a Medical Waive Dividend in place of Medical *company* contributions (see Your Benefits Options and *Company* Contributions in this summary for more information).

Unused *Company* Contributions

Full-time and *part-time plus* employees who do not use all of their *company* contributions for their *Flex* choices will receive the balance as taxable income. *Part-time* employees forfeit any *company* contributions not used for benefit choices.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Price Tags

Each *Flex* option has a price tag that represents your annual cost of that option. In general, the higher the level of coverage you choose, the higher the price tag. For example, higher amounts of life insurance will have higher price tags. Also, the coverage category you select (covered dependents) may affect your price tags.

The *company* reviews price tags and may change them from year to year. The personalized enrollment kit you receive when first eligible and at the annual enrollment show your price tags for the benefit options and coverage levels available to you.

If your *company* contributions aren't enough to cover the price tags for the *Flex* options you choose, you pay the difference. Depending on the benefits you select, the amount you contribute may be deducted from your pay on a pre-tax or post-tax basis.

Pre-tax Contributions

Pre-tax dollars are deducted for most *Flex* benefits. Pre-tax dollars are not subject to Social Security tax or to federal and, in most states, state income tax. As a result, when you use pre-tax dollars to pay for your benefits, you lower your taxes.

When you are receiving pay, Comprehensive Disability Plan benefits, or Long Term Disability Plan benefits directly from the *company*, contributions are deducted from your paychecks.

The amount of any Social Security benefit you become eligible to receive for retirement or disability is based on the amount of your annual pay taxed for Social Security purposes. Pre-tax dollars used to pay for *Flex* choices may reduce the income that is taxed for Social Security each year. As a result, your Social Security benefits may also be reduced.

Post-tax Contributions

Tax laws currently require post-tax dollars to be used to pay for:

- Dependent life insurance
- Health care coverage for *domestic partners* and *same-sex spouses* (for employees at California work locations, the cost of coverage for a *same-sex spouse* or a *domestic partner* who is registered with the Secretary of the State of California is paid with post-tax deductions for federal tax purposes, and with pre-tax deductions for California state tax purposes)

In addition, the difference between an employee's cost and the fair market value of the health care coverage provided for a *domestic partner* will be included as taxable income on the employee's W-2 form.

If you don't receive enough pay during a pay period to cover your *Flex* price tags, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. If you are in arrears after four consecutive pay periods, you will receive a written notice that you are being changed from payroll deduction to direct billing and you will be billed for future contributions you owe. If you fail to pay your contributions, your coverage will be terminated. Any amount that you have in arrears for payroll deductions during *deduction periods* prior to your change to direct billing that could not be collected at the end of the calendar year will be added to your W-2 statement as taxable income. If you leave the *company* or cease to be eligible for benefits, you will be billed for any outstanding deduction amounts.

If you're not receiving income directly from the *company* and payroll deductions are not possible (for example, you're on an unpaid leave of absence), you will be billed and expected to pay for your *Flex* options with post-tax dollars. As discussed in **Timely Payment of Post-tax Contributions**, if payment is not timely received, your *Flex* benefits may be terminated retroactively to the end of the month for which your last payment applied.

If you die, the *company* may continue to pay some of the cost of coverage for your surviving *spouse* and eligible *children* under some *Flex* benefit options. See each individual plan summary for the specific provisions of the plan. Any contributions from your survivors will be paid on a post-tax basis.

Timely Payment of Post-tax Contributions

If you are participating in a plan and you are required to make contributions on a post-tax basis to continue coverage (for example, you're on an unpaid leave of absence), your payment for each month's coverage is due on the first day of that month, and will be considered timely if received within 30 days after the first day of that

month. Failure to make timely payments will result in termination of coverage as of the last day of the latest month for which payment was received.

Your Benefits Options and *Company* Contributions

Through *Flex*, you may choose the benefits and levels of coverage for you and your family for the calendar year. Your elections stay in place until you make a change during the annual enrollment or you have a *qualified life event* and request a change within the required time limits.

The following information outlines the benefit plans included under *Flex* and how the *company* allocates its contributions for each plan to most eligible *full-time* and *part-time plus* employees. The *company* provides an annual lump sum amount of *company* contributions to eligible *part-time* employees.

Medical

Several Medical options are available in most locations. The options available to you are based on your home ZIP code.

Medical *company* contribution amounts vary by employee group.

Currently, *full-time* and *part-time plus* employees will receive Medical *company* contributions to pay a portion of the price tag for the Medical Plan and coverage level they choose.

Actual *company* contribution amounts appear on your personalized enrollment statement (provided when you are first eligible and each year during annual enrollment). Refer to your personalized enrollment statement for the amount of *company* contributions available to you.

Medical Waive Dividends

If you are a *full-time* or *part-time plus* employee and you are not enrolled in a *company*-sponsored Medical option because you have other medical coverage, the *company* will provide an annual Waive Dividend in lieu of regular Medical *company* contributions allocated over your *deduction* periods. The amount is shown in your personalized enrollment materials. *Part-time* employees are not eligible for the Waive Dividend.

Dental

Several dental coverage options are available based on your home ZIP code. If you do not enroll in a *company*-sponsored Dental option, Dental *company* contributions are not provided.

Currently, *full-time* and *part-time plus* employees will receive Dental *company* contributions to pay a portion of the price tag for the Dental Plan and coverage level they choose.

Vision

Currently, the *company* provides enough contributions to pay the full cost of Vision coverage for *full-time* and *part-time plus* employees.

Employee Life Insurance

Several coverage options are offered for most employees. Life Insurance *company* contributions are based on the *company* you work for and are calculated on your age and, in some cases, *annualized base pay*.

Dependent Life Insurance

Term life insurance for a *spouse* and/or dependent *children* is available to most employees. You pay for this coverage through payroll deduction on a post-tax basis. Enrollment is optional and no *company* contributions are provided for this coverage.

Accidental Death and Dismemberment (AD&D) Insurance

Several coverage options are available; you choose whether to purchase coverage for yourself only or for you and your family. *Company* contributions are based on the *company* you work for and are calculated on your *annualized base pay*.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Health Care Reimbursement Account (HCRA)

Enrollment in the HCRA is voluntary. This account allows you to use tax-free dollars to be reimbursed for certain eligible health care expenses. *Part-time* employees who are not eligible for *company* contributions are not eligible to participate.

Dependent Care Reimbursement Account (DCRA)

Enrollment in the DCRA is voluntary. This account allows you to use tax-free dollars to be reimbursed for certain eligible dependent care expenses. *Part-time* employees who are not eligible for *company* contributions are not eligible to participate.

Vacation Buying

This option allows you to buy additional vacation days. It is only available during annual enrollment and only available to eligible employees hired on or before December 1 of the preceding year. Elections must be made prior to January 1.

Part-time and *part-time plus* employees are not eligible to buy vacation.

Default Coverage

The *company* will assign *Flex* default coverage to most *full-time* employees who are eligible for *Flex* but don't enroll when first eligible as shown on your personalized enrollment worksheet. *Part-time* employees do not receive default coverage - if they don't enroll when first eligible, they will have no coverage.

Newly Eligible Employees

When you are first eligible, default coverage generally includes the lowest cost *Flex* options available to cover you alone as shown on your personalized enrollment worksheet. Default coverage remains in effect until you make a new election during the next annual enrollment or upon your approved benefit change request when you have a *qualified life event*.

Annual Enrollment

Default coverage for annual enrollment is generally the same coverage you had in effect the prior year.

Enrollment for DCRA, HCRA, and Vacation Buying and Cash-Out require a new enrollment each year.

Employees who do not receive *company* contributions must re-enroll each year in all benefits in which they want coverage. For more information about default coverage, see the following charts.

Default Coverage for Newly Eligible *Full-Time* Employees					
Medical and Dental	**Vision**	**LTD**	**Employee Life Insurance**	**Dependent Life Insurance**	**Accident Insurance**
Coverage for you alone under the lowest cost option in your home ZIP code; no dependent coverage	Coverage for you alone; no dependent coverage	60% option	1 times *annualized base pay* (up to $50,000)	No coverage	$50,000

Default Coverage for Newly Eligible *Part-Time* Employees			
Medical and Dental	**Employee Life Insurance**	**Dependent Life Insurance**	**Accident Insurance**
No coverage	No coverage	No coverage	No coverage

Default Coverage for *Full-Time* and *Part-Time Plus* Employees at Annual Enrollment					
Medical and Dental	**Vision**	**LTD**	**Employee Life Insurance**	**Dependent Life Insurance**	**Accident Insurance**
Same plan (if available) and coverage category you had at the end of the prior calendar	Same coverage you had at the end of prior calendar year	Same coverage you had at the end of the prior calendar year (*part-time plus* employees are not eligible to participate in	Same coverage you had at the end of the prior calendar year	Same coverage you had at the end of the prior calendar year	Same coverage you had at the end of the prior calendar year

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

year No coverage if you waived coverage in the prior calendar year If prior option not available, the same coverage category for the lowest cost option in your home ZIP code		the LTD plan)		No coverage if you waived coverage in the prior calendar year	

Default Coverage for *Flex-Dollar* Eligible *Part-Time* Employees at Annual Enrollment			
Medical and Dental	**Employee Life Insurance**	**Dependent Life Insurance**	**Accident Insurance**
Same plan (if available) and coverage category you had at the end of the prior calendar year No coverage if you waived coverage in the prior calendar year If prior option not available, the same coverage category for the lowest cost option in your home ZIP code	Same coverage you had at the end of the prior calendar year No coverage if you waived coverage in the prior calendar year	Same coverage you had at the end of the prior calendar year No coverage if you waived coverage in the prior calendar year	Same coverage you had at the end of the prior calendar year No coverage if you waived coverage in the prior calendar year

Default Coverage for *Part-Time* Employees with No *Flexdollars* at Annual Enrollment			
Medical and Dental	**Employee Life Insurance**	**Dependent Life Insurance**	**Accident Insurance**
No coverage	No coverage	No coverage	No coverage

Note that the default participation for the Health Care Reimbursement Account, Dependent Care Reimbursement Account, Vacation Buying and Vacation Cash-Out is "No coverage."

Making Changes During the Year

The *Flex* options you've chosen for the year normally remain in effect through December 31. However, if you have a *qualified life event*, you may be able to change your affected benefits coverage before the end of the year — if you make your request within 30 days after the effective date of the *qualified life event*.

If you don't request your change within the required time period, you can make your change during annual enrollment and your new election will take effect on January 1 of the next year.

Your *Flex* changes must generally be on account of and correspond with the *qualified life event*.

See the **Events Affecting Your Benefits** section of this handbook for more information on the types of events that are treated as *qualified life events*, and the changes you can make to your *Flex* elections as a result of those events.

Reporting a *Qualified Life Event*

If you have a *qualified life event*, log on to www.eixbenefits.com or contact the *EIX Benefits Connection* toll-free at (866) 693-4947. If you don't report a *qualified life event* within 30 days after the change, the *Flex* coverage you had before the change will stay in effect for the remainder of the calendar year, with one notable exception. Once your dependent ceases to be an eligible dependent for purposes of a *company* plan, he or she is no longer eligible for coverage under that plan. You are required to timely contact the *EIX Benefits Connection* and report this type of *qualified life event*. Please note that **you will be responsible** for costs and expenses incurred

by the *company* or its plans with respect to any of your dependents that are not eligible after this type of *qualified life event*.

See the **Events Affecting Your Benefits** section of this handbook for the supporting documentation you may be required to provide in connection with your request to change your *Flex* elections.

When Benefit Coverage Changes Take Effect

Your new coverage takes effect on the date of your *qualified life event* in most cases. If a change in Employee Life Insurance requires Evidence of Insurability approval, your increased coverage will take effect on the date the insurance company approves the change.

In most cases, changes in *company* contributions or price tags take effect on the first pay period after your *qualified life event* has been processed.

If you open a new HCRA or DCRA, your participation will begin on the date you make your election or the date of your *qualified life event* — **whichever is later**. The amount you elect to contribute when you are first eligible will be divided among the remaining *deduction periods* for the year. More information is provided in the **HCRA** and **DCRA** summaries in this handbook.

Situations Affecting *Flex* Benefits

There are a number of situations that may affect your *Flex* benefits. See **Events Affecting Your Benefits** for situations that may affect your benefits.

Other Changes to *Flex* Participation

Non-Discrimination Rules

Under Section 125 of the Internal Revenue Code (IRC), as amended from time to time, and any related regulations, the plans covered under the *Flex* program are subject to discrimination testing rules and may not discriminate in favor of highly compensated employees. The *company* has the right to change the elections of certain employees to comply with the provisions of Section 125 and any related regulations.

Under Section 79 of the Internal Revenue Code, as amended from time to time, and any related regulations, the Employee Life Insurance Plan is subject to further discrimination testing rules. If the plan does not pass the applicable test under Section 79, certain higher-paid employees may have to pay income taxes on the value of the first $50,000 of *company*-provided life insurance coverage. The value of *company*-provided coverage in excess of $50,000 is already considered "imputed income" to employees and subject to income taxes (see **How Employee Life Insurance is Taxed** in the Employee Life Insurance summary).

Under IRC Section 129 for the DCRA and IRC Section 105(h) for the HCRA, additional discrimination testing rules apply. These rules may require the *company* to reduce the amount that certain employees can contribute to the plan(s), and affected employees may have to pay income taxes on their DCRA and/or HCRA contributions.

If the discrimination testing requirements of Sections 105(h), 125, and/or 129 of the Internal Revenue Code, or any related regulations affect you, the *company* will notify you individually.

Claims and Appeals

Refer to the **Other Important Information** section of this handbook for details about the formal claims and appeals process.

For More Information

The *EIX Benefits Connection* handles day-to-day administrative responsibilities for *Flex*. To get information about *Flex*, or if you think you have a *qualified life event* and you would like to change your *Flex* coverage, contact the *EIX Benefits Connection* by phone or online at:

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- (866) 693-4947
- www.eixbenefits.com

A representative can help you determine whether your *qualified life event* qualifies under current law and, if so, will let you know what kinds of changes you can make.

Reimbursement Accounts

Reimbursement Accounts revised December 19, 2012.

Reimbursement Account Overview

Reimbursement accounts help you stretch the dollars you spend on health care and dependent care by allowing you to pay them with pre-tax dollars from your paychecks.

The savings can be significant. With a reimbursement account, you can get a discount on certain qualifying expenses that's equal to your marginal tax rate. For example, say that you owe $100 for a medical bill that is not covered by your Medical Plan and assume that 30% of your pay usually goes for income taxes. Paying that bill with pre-tax dollars would save you $30.

The company offers two types of reimbursement accounts:

- **The Health Care Reimbursement Account (HCRA)** lets you set aside up to $2,500 a year to pay eligible expenses that are not covered by any health care plan
- **The Dependent Care Reimbursement Account (DCRA)** lets you set aside up to $5,000 a year for dependent care expenses you incur while you work ($2,500 if you are married and file individual income tax returns)

These two reimbursement accounts are entirely separate from each other. You cannot use money from a HCRA to pay dependent care expenses, nor can you use money from a DCRA to pay health care expenses.

As you read about the HCRA and DCRA in this section of your handbook, be aware that you need to estimate your eligible expenses very carefully before you enroll. The IRS requires that you forfeit any money left in either reimbursement account after you have reimbursed yourself for all eligible expenses incurred during a calendar year.

- Health Care Reimbursement Account
- Dependent Care Reimbursement Account

Health Care Reimbursement Account

Health Care Reimbursement Account revised December 19, 2012.

Overview and Important Features

You can save money on your *out-of-pocket* health care expenses by making pre-tax contributions to a Health Care Reimbursement Account (HCRA) and submitting claims to receive reimbursements for qualifying expenses. You pay no federal income tax or Social Security tax on your contributions or your reimbursements. Contributions are subject to state income tax in some states, but not in California.

Effective January 1, 2013, you can set aside up to $2,500 each calendar year for expected medical, dental, vision, and hearing expenses not covered or not fully reimbursed by any health care plan. Qualifying expenses for yourself or your dependents must meet IRS rules and must be for services performed in the same calendar year in which you make your HCRA contributions.

Who Is Eligible

Employees

All *full-time* and *part-time* employees who receive *company* contributions are eligible to participate in the HCRA when hired. *Part-time plus* employees are also eligible to participate in the HCRA.

The following employees are not eligible to participate in the HCRA:

- *Part-time* employees who do not receive *company* contributions
- Temporary and leased employees, and contingent workers

See the **Eligibility** section at the beginning of this handbook for the specific employee groups eligible to participate in this plan.

Dependents

In general, dependents whose health care expenses qualify for reimbursement from your HCRA include your *spouse*, those who qualify as your dependents for federal income tax purposes (or who would qualify if their earnings didn't exceed the IRS earnings limitation), and your *children* who will not have attained age 27 as of the end of the year.

Dependents do not have to be covered or be eligible for coverage under your health care plans in order for their expenses to qualify for reimbursement from your HCRA.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Before You Enroll

Tax Deduction vs. Tax-Free HCRA

Two kinds of tax savings may be available to you if you have eligible *out-of-pocket* health care expenses: the HCRA or an income tax deduction at the time you file your federal income tax return. You cannot take a tax deduction for the same expenses reimbursed through the HCRA.

To qualify for an income tax deduction, you must itemize deductions. Also, your qualifying health care expenses must exceed the percentage of adjusted gross income specified by tax law.

If you think your *out-of-pocket* health care expenses will be less than the percentage of adjusted gross income allowed, or if you don't itemize tax deductions, you may want to consider a HCRA. You may wish to consult a personal tax advisor before making your decision.

Estimating Your HCRA Qualifying Expenses

It is important to accurately estimate your qualifying expenses before establishing a HCRA. That's because IRS rules require that you use the money you deposit in your account during a particular calendar year only to pay qualifying expenses incurred within that same calendar year. In other words, funds in your HCRA do not carry over from year to year. However, you have until March 31 of the following year to submit HCRA claims.

When you are first eligible and during the annual enrollment period, the *EIX Benefits Connection* provides a toolkit to help you determine how much to contribute to your account. To access the toolkit, go to the *EIX Benefits Connection* Web site at www.eixbenefits.com.

Following the March 31 deadline for filing claims, after all claims and appeals have been processed, all funds that remain in participant accounts from the prior year will be forfeited. The forfeitures will be used to help fund administrative costs (or for any other purpose permitted by law).

Enrolling For Coverage

Enrollment Deadlines

In the year you are hired, you may open a HCRA within 30 days of first becoming eligible. Your participation begins on your eligibility date or the date you make your election, whichever is later. Elections for the current year cannot be made after December 7. Unless you have a *qualified life event* during the year (see the **Events Affecting Your Benefits** section of this handbook), you'll have to wait until annual enrollment if you don't enroll within 30 days of first becoming eligible. Your participation will then become effective on January 1 of the following year.

Annual Enrollment

Each year during annual enrollment, you'll have the opportunity to open a HCRA for the following year. Your HCRA election from the prior year does not automatically remain in effect from year to year. If you don't sign up during annual enrollment, you won't be able to establish a HCRA until the next year's annual enrollment period, unless you have a *qualified life event* during the year and you make a timely election (see **Events Affecting Your Benefits**).

Your Contributions

The minimum annual contribution you can make to your HCRA is $96, and the maximum amount is $2,500 (in whole dollar amounts). Your contributions will be deducted from your paychecks on a pre-tax basis. If you're eligible for *company* contributions and have not used them to purchase other *Flex* benefits, you may contribute your unused *company* contributions to your HCRA.

Your total annual pre-tax contribution by payroll deductions and *company* contributions is divided equally among all *deduction periods* throughout the year. (See the ***Flex*** section of this handbook for more information on *company* contributions.) For more details about HCRA contributions, see **When Your Contributions Stop** in this summary.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Situations Affecting HCRA Benefits

There are a number of situations that may affect your HCRA benefits. See **Events Affecting Your Benefits** for situations that may affect your benefits.

How the HCRA Works

Qualifying Health Care Expenses

You may use your HCRA to reimburse yourself for health care expenses you have incurred and paid that have not been reimbursed through any other source and for which you will not seek reimbursement through any other source. In general, qualifying health care expenses include charges for diagnosis, cure, treatment, and prevention of an illness or injury and include related supplies and equipment. Certain over-the-counter drugs are also eligible for reimbursement from your HCRA if prescribed by an authorized health care provider. Insulin is eligible for reimbursement without a prescription. Expenses for treatments or items that are merely beneficial to your general health, but not specifically related to health care, such as health club memberships or vitamins, are not qualifying expenses.

Qualifying expenses are considered incurred on the day treatment is provided or products are purchased, regardless of when you are billed or when you pay for them.

All submitted claims and HCRA debit card transactions must be verified in writing or electronically by an independent third party such as a health plan's explanation of benefits statement or a provider's invoice. The HCRA debit card cannot be used to purchase over-the-counter medicines or drugs, even if prescribed by an authorized health care provider.

HCRA debit card expenses may be automatically verified electronically. See **Validation of HCRA Debit Card Transactions** in this summary for more information. By signing your name on the claim form or using the HCRA debit card, you are certifying that the expense has not been reimbursed and that you will not seek reimbursement under another plan or by a third party. You may also be required to provide a statement from a medical practitioner verifying that the expense was incurred for the treatment of a specific medical condition, or to provide other documentation deemed necessary to substantiate your claim. Qualifying expenses must have been incurred in the same year and during the time you were a HCRA participant. For example, if you are a newly eligible employee who opened your account in June of this year, expenses incurred in May of this year are not eligible for reimbursement. For more information on the HCRA debit card, see **Your HCRA Debit Card** in this summary.

A list of qualifying expenses is available through the *EIX Benefits Connection*. Qualifying expenses for health care reimbursement account plans must be consistent with Sections 125 and 213(d) of the Internal Revenue Code.

Examples of Qualifying Expenses

Not all health care expenses are eligible for reimbursement from your HCRA. Here are examples of expenses that are eligible for reimbursement:

- *Deductibles* and copayments for medical, dental, vision and hearing care
- Covered health care costs that exceed the reasonable payment amount or *reasonable and customary* fee
- Services or supplies not covered by most health care plans, such as adult orthodontia or an extra pair of eyeglasses
- Smoking cessation programs and medications designed to alleviate nicotine withdrawal
- Weight loss programs for the treatment of a specific disease, including obesity, as diagnosed by a doctor. The cost of purchasing diet food items is not a qualifying expense
- Mileage to and from health care appointments
- Over-the-counter medicines (other than insulin) are eligible for reimbursement only if prescribed by your medical provider
- Insulin

Examples of Expenses That Don't Qualify

Here are examples of expenses that do not qualify for reimbursement from your HCRA:

- Wages for household help, even if assistance is necessary or recommended because of physical inability to do housework
- Any payments for group health care premiums or HMO membership fees
- Premiums for group or private life insurance, income protection or accidental death and dismemberment policies, or for medical coverage under your automobile insurance policy
- Fees paid to participate in recreational, athletic, or educational programs or activities, including health club dues, even if recommended by your doctor
- Tuition for programs and workshops, such as stop smoking (except for those to alleviate nicotine withdrawal), even if recommended by your doctor
- Expenses for cosmetic procedures that are not *medically necessary*
- Over-the-counter dietary supplements and other items that merely promote general health, such as vitamins, even if recommended by a doctor

Your HCRA Debit Card

How It Works

If you choose to contribute $150 or more to your HCRA, you will receive a HCRA debit card which you can use to directly access your HCRA to pay for eligible health care expenses at the time you incur the expense. The card can be used as long as your HCRA is not in an overpayment status, you continue to participate in the HCRA, and you remain actively employed with Edison. Your card will be suspended if you have an overpayment balance greater than $100, and it will be cancelled upon employment termination.

The HCRA debit card has been designed for use at merchants and providers that primarily sell health care products and services, such as pharmacies, *physician's* offices and hospitals. When you or one of your eligible dependents uses a HCRA debit card at approved merchants for eligible expenses, you or the dependent will be required to select the "credit" option (if prompted) and to provide a signature, similar to a credit card transaction. With each HCRA debit card purchase, your HCRA balance is reduced by the amount of the purchase. Non-eligible expenses such as over-the-counter medicines, cosmetics or food items, may not be purchased with the HCRA debit card. Dependent care expenses are not eligible for reimbursement through the HCRA debit card.

Upon your initial enrollment in HCRA and during annual enrollment each year thereafter, you will certify that you will use the HCRA debit card only for your and your eligible dependents' qualifying health care expenses. You will also certify that any expense paid with the HCRA debit card is not payable or reimbursable under any other plan. In addition, each time you or one of your eligible dependents uses the HCRA debit card, you or the dependent will be reaffirming the certification printed on the back of the HCRA debit card that the card is being used only for eligible health care expenses in accordance with the provisions of HCRA, and that the expenses are not otherwise payable or reimbursable under any other plan.

You will not receive a new card every year - your HCRA debit card will be updated for the new plan year based on the amount you select during the respective year's annual enrollment.

Validation of HCRA Debit Card Transactions

You must obtain and retain itemized receipts and be sure they display the date of service, name of the service provider or merchant, name of the product or service, and the amount paid. The Internal Revenue Service requires that HCRA debit card transactions be verified as eligible health care expenses and you may be required to provide the *EIX Benefits Connection* with supporting documentation to validate your expense.

The *EIX Benefits Connection* will validate certain HCRA debit card transactions automatically. There are three procedures covering automated validation:

- **Recurring Transactions** - If you purchase a health care product or service regularly at the same cost, and it has previously been approved by the *EIX Benefits Connection*, the product or service may be validated automatically each time you subsequently purchase it using your HCRA debit card.
- **Copayments** - Your HCRA debit card will be programmed to recognize the amount of a *physician's* office or health care facility's copayment amount. Expenses incurred at a *physician's* office or health care facility that exactly match the programmed amount may be approved without any additional validation required. The current expense amount must exactly match any previous expense for the item.

- **Prescription Drugs Covered by Express Scripts** - If your prescription drug requirements are serviced by Express Scripts, your prescription purchases may be validated automatically.

If your expense is not automatically validated, you will receive a letter notifying you of additional required information to validate your expense. You must submit the documentation required by the due date or the purchase will be considered not eligible and result in an overpayment and possible suspension of your card. After December 31 of each year, the HCRA debit card cannot be used for expenses incurred in the prior plan year. Claims for these expenses can only be submitted manually (see **How to File a HCRA Claim When You Don't Use Your HCRA Debit Card** in this summary).

Overpayments

If you purchase products or services with your HCRA debit card that are not qualifying health care expenses or that cannot be validated, you will receive notification from the *EIX Benefits Connection* that the transaction is deemed an overpayment. Once an overpayment is determined, the following will occur:

- The HCRA debit card may be suspended
- You'll be notified that you must refund the overpayment by mailing a check to the *EIX Benefits Connection*
- Subsequent valid manual claims will be applied to the outstanding overpayment. Payment will not be made for any claim until the overpayment has been fully repaid
- If you provide required validation of the expense, the overpayment will be cancelled

If the overpayment amount is not validated or fully repaid by the end of the applicable plan year's grace period, your HCRA debit card will be suspended until the end of the plan year and will continue to be suspended in the new plan year until the overpayment is refunded. The *company* will adjust your Form W-2 for the tax year in which the grace period ends by increasing the amount of your taxable income by the amount of the outstanding overpayment.

A similar process will be used for other plan corrections to the extent appropriate.

Lost or Stolen Cards

If the HCRA debit card is lost or stolen, or you believe that there has been an unauthorized use of your card, you must contact the *EIX Benefits Connection* immediately at (866) 693-4947. Representatives are available to assist you Monday through Friday, 7:30 AM – 5:30 PM, Pacific time.

How to File a HCRA Claim When You Don't Use Your HCRA Debit Card

To receive reimbursement of qualified expenses incurred during the calendar year when you don't use the HCRA debit card, you must submit a claim to the *EIX Benefits Connection* at (866) 693-4947. At www.eixbenefits.com, choose Submit Claim to get started. After entering your claim information, print the page, sign it, and mail it to the *EIX Benefits Connection* with the required documentation for processing. For faster processing, you can fax the signed claim and receipts to the *EIX Benefits Connection* at (866) 918-9713. You may also sign up for direct deposit reimbursement.

Your HCRA Claim-Filing Deadline

The deadline for filing claims and documents for reimbursement of qualifying expenses under your HCRA is March 31 of the year following the calendar year during which the expense was incurred. Claims received by the claims processor after the March 31 deadline will be denied. If you have a HCRA appeal pending on March 31 of the year after your expense was incurred, your account will be maintained until a final determination has been made regarding your appeal. See the **Other Important Information** section of this handbook for more information about appeals.

What to Include with Each HCRA Claim

To facilitate reimbursement of qualifying expenses, you must include the following documentation with each HCRA claim:

- A copy of an itemized statement that includes the patient's name, the name and address of the provider, a description of the service, date of the service, and amount of the expense. For prescription drugs, submit the receipt attached to the prescription by the pharmacist, in place of the cash register receipt
- Your signed confirmation, as noted on the claim form, that the qualifying expense has not been reimbursed and is not reimbursable under another plan or by a third party
- For over-the-counter medicines, you will be required to also submit a prescription or a completed Statement of Medical Necessity

Where to Send Your HCRA Claim

Send your HCRA claim and all necessary attachments to:

Reimbursement Center
P.O. Box 25172
Lehigh Valley, PA 18002-5172

Payment of Your HCRA Claims

Reimbursements of your approved claims are paid up to the annual amount you elected for that calendar year.

The *EIX Benefits Connection* processes HCRA reimbursements on a daily basis. Once your claim and receipts have been received, a decision will generally be made on your claim within five days. If approved, a reimbursement from your account will generally be made within two to three business days if you signed up for direct deposit, or within two business days by U.S. mail (allow an additional three days for postal delivery).

Claims and Appeals

Refer to the **Other Important Information** section of this handbook for additional details about the formal claims and appeals process.

Making Changes During the Year

You may be able to make changes during the year to your HCRA if you have a *qualified life event.* See the **Events Affecting Your Benefits** section of this handbook for more information.

When Your HCRA Contributions Stop

Your pre-tax HCRA contributions will stop if any of the following events occur:

- You begin receiving Long Term Disability (LTD) benefits and:
  - You have exhausted benefits under any short term disability plan with the *company* or under any state-required disability plan, or
  - You are not covered under a *company* short-term disability plan or a state-required disability plan
- You go on an approved unpaid leave of absence
- You change to an ineligible status
- You are laid off
- Your employment terminates for any reason, including retirement or your death

Your coverage will end at the end of the month in which your contributions stop. Claims may be submitted for qualified expenses incurred through the month in which your coverage ends.

If your contributions stop due to you going on an approved unpaid Family or *Military Leave of Absence*, you may continue submitting claims for qualifying expenses incurred through the end of the plan year as long as you remain employed by the *company*. Your contributions will resume upon your return to work.

When HCRA Contributions Resume

Your pre-tax contributions will automatically resume if you return to active pay status during the same year that your contributions stopped (if your contributions stopped due to you going on an approved unpaid Family or *Military Leave of Absence*). When pre-tax contributions stop and resume in the same calendar year, the resumed payroll deduction amounts are increased, based on the number of *deduction periods* remaining in the year — so your total annual HCRA contribution can be taken. If you return to active pay status in a later year, you will be given an opportunity to enroll in the HCRA for the remainder of that year.

Extended Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides extended coverage for the HCRA. This extended coverage is available on a post-tax basis if you request it after your pre-tax contributions end and within the COBRA election period. See the **Continued Health Care Coverage** section of this handbook for more information about COBRA extended coverage.

For More Information

The *EIX Benefits Connection* handles day-to-day HCRA administration. To get information about the HCRA, or if you can't access claim forms online, please contact the *EIX Benefits Connection* at (866) 693-4947, or by logging on to www.eixbenefits.com.

Dependent Care Reimbursement Account

Dependent Care Reimbursement Account revised December 19, 2012.

Overview and Important Features

If you have qualifying expenses for the care of your dependent(s) while you work, you can save money by using pre-tax contributions to fund a Dependent Care Reimbursement Account (DCRA). You can use the money set aside in your DCRA to reimburse yourself for those expenses on a tax-free basis. You pay no federal income tax or Social Security tax on your contributions or your reimbursements. Contributions are subject to state income tax in some states, but not in California.

Each year you can set aside up to $5,000 (subject to IRS limits described in **Your Contributions** below) to cover your qualifying dependent care costs. Qualifying dependent care expenses must meet IRS rules. You may receive reimbursements from your DCRA only for dependent care services performed during the calendar year in which you make your DCRA contributions.

Who Is Eligible

Employees

All *full-time* and *part-time* employees who receive *company* contributions may participate in the DCRA when hired. *Part-time plus* employees are also eligible to participate in the DCRA.

The following employees are not eligible to participate in the DCRA:

- *Part-time* employees who do not receive *company* contributions
- Temporary and leased employees, and contingent workers

See the **Eligibility** section at the beginning of this handbook for the specific employee groups eligible to participate in this plan.

Dependents

Dependent care expenses may be submitted for dependents who live with you for more than one-half of the year and who are:

- Your *child(ren)* under age 13 for whom you may claim an income tax exemption
- Your *spouse*, if your *spouse* is mentally or physically unable to care for himself or herself
- Any persons who are mentally or physically unable to care for themselves and qualify as your dependents for federal income tax purposes

Before You Enroll

Tax Credit vs. Reimbursement Account

There are two kinds of tax savings available to you if you have qualifying dependent care expenses: the DCRA, or an income tax credit at the time you file your federal income tax return. You cannot take a tax credit for the same expenses that are reimbursed through your DCRA. Furthermore, your allowable tax credit amount is reduced by $1 for every $1 reimbursed through your DCRA. The decision to take a tax credit, a DCRA, or both depends on your personal situation. You may wish to consult a personal tax advisor before making your decision.

Estimating DCRA Qualifying Expenses

When you are first eligible and during the annual enrollment period, the *EIX Benefits Connection* provides a toolkit to help you determine how much to contribute to your account. To access the toolkit, go to the *EIX Benefits Connection* Web site at www.eixbenefits.com.

It is important that you accurately estimate your qualifying dependent care expenses before establishing a DCRA. That's because IRS rules require that you use the money you deposit in your account during a particular calendar year only to pay qualifying expenses incurred within that same calendar year and that you forfeit any unused money. In other words, funds in your DCRA do not carry over from year to year. However, you have until March 31 of the following year to submit DCRA claims.

Following the March 31 deadline for filing claims, after all claims and appeals have been processed, all funds that remain in participant accounts from the prior year will be forfeited. The forfeitures will be used to help fund administrative costs.

Enrolling For Coverage

Enrollment Deadlines

In the year you are hired, you may open a DCRA within 30 days of first becoming eligible. Your participation begins on your eligibility date or when you make your election, whichever is later. Elections for the current year cannot be made after December 7. If you don't enroll within 30 days of first becoming eligible, you'll have to wait until annual enrollment to sign up. Then your participation will become effective on January 1 of the following year.

Annual Enrollment

Each year during annual enrollment, you'll have the opportunity to open a DCRA for the following year. If you don't sign up during annual enrollment, you won't be able to establish a DCRA until the next year's annual enrollment period. Exceptions are made only if you have a *qualified life event* during the year. See the **Events Affecting Your Benefits** section of this handbook for more information about *qualified life events.*

Your Contributions

The minimum annual contribution you can make is $96, and the maximum amount (in whole dollar amounts) is the lesser of:

- $5,000 ($2,500 if you are married but file separate tax returns)
- 100% of your earned income
- 100% of your *spouse's* earned income *

* If your *spouse* is a full-time student or is incapable of self-care, the IRS allows you to assume a monthly "earned income" of $250 to pay for the care of one eligible dependent and $500 to pay for the care of two or more eligible dependents.

Your DCRA contributions will be deducted from your paychecks on a pre-tax basis. If you're eligible for *company* contributions and have not used them to purchase other *Flex* benefits, you may contribute your unused *company* contributions to your DCRA. Your total annual pre-tax contribution by payroll deductions and *company* contributions is divided equally among all *deduction periods* throughout the year. (See the ***Flex*** section in this handbook for more information on *company* contributions.)

For more information about your DCRA contributions, see **When Your Contributions Stop** in this summary.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Situations Affecting DCRA Benefits

There are a number of situations that may affect your DCRA benefits. See **Events Affecting Your Benefits** for situations that may affect your benefits.

How the DCRA Works

Qualifying Dependent Care Expenses

To qualify to participate in a DCRA, you must meet the eligibility requirements described in the Who Is Eligible section in this summary. Obviously, you must also have dependents who are eligible for coverage, as defined in the Who Is Eligible section.

Your DCRA reimburses you for eligible dependent care expenses that enable you to work. For example, if you are unmarried and have small *children* or an elderly parent who is dependent upon you for support, you may need to pay someone to care for your *children* or parent while you work. You may also have qualifying dependent care expenses if you are married with *children* and your *spouse* works, is a full-time student, or is physically or mentally unable to care for himself or herself.

Qualifying expenses are considered incurred on the date care is provided, regardless of when you are billed or pay for that care. They must have been incurred in the same year and during the time you were a participant in the DCRA. Also, you must report the name, address, and Social Security or employer identification number of your dependent care provider on your federal income tax return. Qualifying expenses are defined by the IRS and must be consistent with Internal Revenue Code Section 125 regulations. For more details, refer to IRS Publication 503, "Child and Dependent Care Credit and Employment Taxes for Household Employers," available from your local IRS office or on the IRS website at www.irs.ustreas.gov.

Examples of Qualifying Dependent Care Expenses

Not all dependent care expenses are eligible for reimbursement under the provisions of your DCRA. Here are examples of expenses that are eligible for reimbursement:

- Care provided in your home, even when household services are also provided; you must, however, separate expenses for care from expenses for household services
- Care provided outside your home for persons who regularly spend at least eight hours a day in your home; dependent care centers that provide care for more than six people who don't live at the center must comply with applicable state and local regulations
- Expenses for a baby sitter or day care facility
- After school care for a *child* under age 13
- Care at a nursery school, or a dependent care center, even if lunch and educational services are provided as part of a preschool child care service
- The portion of expenses for boarding or private day school attributable to the cost of caring for the eligible dependent
- Elder care for a parent who qualifies as a dependent

Examples of Expenses That Don't Qualify

Here are examples of expenses that do not qualify for reimbursement under the provisions of your DCRA:

- Amounts paid for food or schooling that can be separated from necessary care expenses
- Overnight camps
- Care provided by your *spouse*, a relative you can claim as a dependent, or by your *child* under 19 years of age
- The cost of transportation to and from the care location
- Expenses that are not work-related (baby-sitting while you attend a social event, for example)

How to File a DCRA Claim

To receive reimbursements for qualified expenses incurred during the calendar year, you must submit a claim to the *EIX Benefits Connection*, the DCRA claims processor, by March 31 of the following year. Forms are

available online at www.eixbenefits.com or by calling the *EIX Benefits Connection* at (866) 693-4947. At www.eixbenefits.com, choose "Submit Claim" to get started. After entering your claim information, print the page, sign it, and mail it to the *EIX Benefits Connection* with the required documentation for processing. For faster processing, you can fax the signed claim and receipts to the *EIX Benefits Connection* at (866) 918-9713.

Your DCRA Claim-Filing Deadline

The deadline for filing claims and documents for reimbursement of qualifying expenses under your DCRA is March 31 of the year following the calendar year during which the expense was incurred. Claims received by the claims processor after the March 31 deadline will be denied. If you have a DCRA appeal pending on March 31 of the year after your expense was incurred, your account will be maintained until a final determination has been made regarding your appeal. See the **Other Important Information** section of this handbook for more information about appeals.

What to Include with Your DCRA Claim

To facilitate payment of your DCRA claim, you must include with your completed claim, dates of service, name of service provider, name of dependent for whom services were rendered, and the amount paid. This information can be provided through a generic receipt booklet or on a day care letterhead. It may be handwritten if the service provider's signature is included. The claim also requires the provider's Social Security or employer identification number.

Where to Send Your DCRA Claim

Send or fax your DCRA claim and all necessary attachments to:

Reimbursement Center
P.O. Box 25172
Lehigh Valley, PA 18002-5172

Payment of Your DCRA Claims

Reimbursements of your approved claims are paid up to your account balance on the date your claim is processed. Any remainder will automatically be reimbursed as additional funds are contributed to your account.

The *EIX Benefits Connection* processes DCRA reimbursements on a daily basis. Once your claim and receipts have been received, a decision will generally be made on your claim within five days. If approved, a reimbursement from your account will generally be made within two to three business days if you signed up for direct deposit, or within two business days by U.S. mail (allow an additional three days for postal delivery). Reimbursements can only be made if there are sufficient funds in your account.

Claims and Appeals

Refer to the **Other Important Information** section of this handbook for additional details about the formal claims and appeals process.

Making Changes During the Year

You may be able to make changes during the year to your DCRA if you have a *qualified life event.* See the Events Affecting Your Benefits section of this handbook for more information.

When Your DCRA Contributions Stop

Your pre-tax DCRA contributions will stop if any of the following events occur:

- You are receiving Long Term Disability (LTD) benefits and:
  - You have exhausted benefits under any short term disability plan with the *company* or state-required disability plan, or
  - You are not covered under a *company* short-term disability plan or a state-required disability plan

- You go on an approved family, military, personal, or union leave of absence
- You change to an ineligible status
- You are laid off
- Your employment terminates for any reason, including retirement or death

After your contributions stop, you may continue submitting claims for qualifying expenses incurred that calendar year. However, you may not receive reimbursement for more than you had contributed before your pre-tax contributions stopped.

When DCRA Contributions Resume

Your pre-tax contributions will automatically resume if you return to active pay status during the same year that your contributions stopped (if your contributions stopped due to you going on an approved unpaid Family or *Military Leave of Absence*). When pre-tax contributions stop and resume in the same calendar year, the resumed payroll deduction amounts are increased, based on the number of *deduction periods* remaining in the year—so your total annual DCRA contribution can be taken. If you return to active pay status in a later year, you will be given an opportunity to enroll in the DCRA for the remainder of that year.

For More Information

The *EIX Benefits Connection* handles day-to-day DCRA administration. To get information about the DCRA, or if you can't access claim forms online, please contact the *EIX Benefits Connection* at (866) 693-4947, or by logging on to www.eixbenefits.com.

Health Care Overview

Health Care Overview revised December 19, 2012.

The *company* offers a comprehensive program of health care coverage to employees and retirees who meet the eligibility requirements.

Health care coverage includes the Medical, Dental, Vision and EAP plans described in this section of your handbook.

General eligibility requirements, the enrollment process, and other information regarding these benefits are explained in this Health Care Overview. Individual plan summaries follow this overview. The individual summaries describe the specific benefits provided under each health care plan. They also include any eligibility and enrollment details that are specific to each individual health care plan.

Who Is Eligible

Employees

Full-time and *part-time plus* employees are eligible for the Medical, Dental, Vision and EAP benefits described in this handbook. Most *part-time* employees are eligible for the Medical, Dental and EAP benefits.

Exceptions are specifically noted in each individual plan summary under Who Is Eligible. *Temporary* and *leased* employees and *contingent workers* are not eligible to participate in the *company's* health care plans.

Most employees may participate in the *company's* health care plans as soon as they are hired.

Dependents

You may enroll your eligible dependents in the health care plans in which you participate.

In general, your eligible dependents include your:

- *Spouse*, *same-sex spouse*, or *domestic partner*. The difference between the fair market value of the health care coverage provided for your *same-sex spouse* or *domestic partner* and the cost you pay for this coverage will be included as taxable income for federal taxes on your W-2 form
- *Children* up to the end of the month in which they reach age 26
- Unmarried mentally and physically disabled *children* of any age, if coverage under this benefit program and disability began before age 26. The disability must be such that the *child* is incapable of sustaining himself or herself and must depend upon you for support. You must affirm your *child* is eligible prior to the end of the month in which the dependent reaches age 26 on a form approved by the *company* (or if you become initially eligible for coverage after your *child's* 26th birthday, you must affirm your *child* is eligible due to disability upon your initial enrollment). If an extension of coverage is approved by the *company*, coverage will be allowed beyond age 25 as long as the *child* meets the remaining eligibility requirements.

  Continued coverage of an incapacitated *child* is subject to periodic re-certification when requested by, and on a form approved by, the SCE Benefits Committee. If you fail to provide a *physician's* certification upon request, your *child's* coverage will end coincident with the due date of the re-certification request.

Dependents serving in the military are not eligible for Dental and Vision coverage.

Survivors of Employees

If you die while an employee, health care coverage may be continued for your surviving dependents. See **Continued Health Care Coverage** at the end of this section of your handbook.

Retirees

Based on your *years of service*, age, and certain other factors, you and your eligible dependents may be eligible for retiree health care coverage when your employment terminates. For details about eligibility for retiree health care coverage see **Continued Health Care Coverage** at the end of this section of your handbook.

Survivors of Retirees

If you die as a retiree participating in retiree health care coverage, this coverage may continue for your *spouse* throughout his or her lifetime.

See **Continued Health Care Coverage** at the end of this section of your handbook for more information.

Enrolling for Coverage

Each year, you may enroll in the health care plans and the coverage category of your choice. If you do not enroll, you will receive default coverage as described in each plan summary. Under certain circumstances, you can change your coverage category before the end of the year. Most *full-time*, *part-time* and *part-time plus* employees pay their share of the plan cost with pre-tax dollars.

Enrollment Deadlines

When First Eligible

In the year you become eligible, you may enroll for the remainder of the calendar year. Your coverage generally begins on the date you become eligible.

If you don't enroll within 30 days of first becoming eligible, you will be assigned default coverage and will have to wait until annual enrollment to make changes. (See **Default Coverage** in the *Flex* summary of this handbook.) Health care benefit options stay in place until December 31 unless you have a *qualified life event* during the year. See the **Events Affecting Your Benefits** section of this handbook for information regarding changes permitted mid-year.

If you elect dependent coverage when you are first eligible, coverage for your dependents begins on the same day your coverage begins.

Waiving Health Care Coverage

Most *full-time* and *part-time plus* employees may elect to waive Medical coverage if they have Medical coverage under a non-Edison group Medical plan. Most *full-time* and *part-time plus* employees may elect to waive Dental coverage for any reason. Your options will be listed on your personalized benefit worksheet that you receive during your election period. If you waive health care coverage because you have other coverage under another group health plan, and you (or your eligible dependents) lose the other coverage, you may enroll in the applicable *company* health care plan within 30 days after the date you lose your other coverage. This special enrollment right is available only if you lose coverage because it is no longer available – not because of failure to pay for it or for cause, such as making a fraudulent claim. You are not required to elect COBRA continuation coverage under another plan in order to have a special enrollment right under the *company's* health care plans. However, if you currently have COBRA coverage under another plan, you must continue it for the entire period it is available to you in order to preserve this special enrollment right. See the **Events Affecting Your Benefits** section of this handbook for more information.

Employees who are not eligible for *company* contributions may elect to waive health care coverage for any reason.

The following are special rules for waiving health care coverage:

- If you and your *spouse*, *domestic partner* and/or *child* are employees of the *company* and are eligible for *company* contributions, you each must have your own Medical coverage. You cannot elect to waive your Medical coverage and be covered as a dependent of your *spouse*, *domestic partner* and/or *child*
- If you are an employee of the *company* and are eligible for *company* contributions and your *spouse* is eligible for *company* retiree health care coverage, you each must have your own Medical coverage. You cannot elect to waive your own Medical coverage and be covered as a dependent of the other person
- If you and your spouse are both eligible for *company* retiree health care coverage, either of you may elect to waive your own Medical coverage and be covered as the other person's dependent. However, you and your *spouse* cannot be enrolled for Medical coverage as both a retiree and a dependent

Annual Enrollment

In future years, you may make changes during each annual enrollment period. Coverage changes made during annual enrollment take effect on January 1 of the following year and remain in effect for the whole calendar year.

If you don't make an election during annual enrollment, you won't be able to make changes until the next year's annual enrollment period-unless you have a *qualified life event*. See the **Events Affecting Your Benefits** section of this handbook for information regarding changes permitted mid-year.

If you do not make a change during annual enrollment, you and your currently enrolled dependents who remain in an eligible status will remain in the same plan you had the prior year, unless that plan is no longer available, in which case you will receive default coverage. (See **Default Coverage** in the *Flex* summary of this handbook.) Employees who do not receive *company* contributions and who do not enroll will receive no coverage.

Coverage Categories

The first time you enroll in a health care plan and during each subsequent annual enrollment period, you have a choice of coverage categories. You may also be able to change your coverage category during the year if you have a *qualified life event*. The following chart shows coverage categories for Medical (which includes Behavioral Health benefits), Dental and Vision plans.

Coverage Categories for Medical, Dental and Vision Plans	
Your coverage category is...	**If you are enrolling as the...**
You Only	• Employee only • Former employee only under COBRA • Retiree only • Retiree only under COBRA • *Spouse* only of a former employee under COBRA • *Spouse* only of a retiree under COBRA • Former *spouse* only of an employee or retiree under COBRA • Surviving *spouse* only of an employee or a retiree • Surviving *spouse* only of an employee or retiree under COBRA • *Child* only under COBRA • Surviving *child* only of an employee or a retiree • Surviving *child* only of an employee or a retiree under COBRA
You and *spouse*	• Employee and *spouse* (or *domestic partner*) • Former employee and *spouse* under COBRA • Retiree and *spouse* • Retiree and *spouse* under COBRA
You and *child(ren)*	• Employee and *children* • Former employee and *children* under COBRA • Retiree and *children* • Retiree and *children* under COBRA • *Spouse* and *children* of a former employee, under COBRA • *Spouse* and *children* of a retiree, under COBRA • Former *spouse* and *children* of an employee or a retiree, under COBRA • Surviving *spouse* and surviving *children* of an employee or a retiree • Surviving *spouse* and surviving *children* of an employee or a retiree under COBRA • *Children* of an employee who terminates or retires under COBRA (when

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	employee and/or *spouse* do not enroll under COBRA) • Surviving *children* of an employee or a retiree • Surviving *children* of an employee or a retiree under COBRA
You and family	• Employee, *spouse* or *domestic partner* and *children* • Former employee, *spouse* and *children* under COBRA • Retiree, *spouse* and *children* • Retiree, *spouse* and *children* under COBRA

During each annual enrollment period, you may choose the coverage categories that match the make-up of your family, as shown in the charts above, and that will best meet your needs in the coming year

Special Rules for Dual Coverage

If your *spouse*, *domestic partner** or *child* also works for the *company* or is an eligible retiree, special rules apply when enrolling in health care plans. As a general rule, dual coverage (for example, being eligible for coverage as the dependent of a retiree and as an employee) is allowed under all health care plans except Medical.

* A *domestic partner* is eligible for health care coverage as a dependent of a retiree only if the *domestic partner* is a *same-sex spouse* or a same-sex *registered domestic partner*.

The following chart describes dual coverage options for employees and retirees

Dual Coverage Options for Employees and Retirees		
Eligible Family Members	**Medical Coverage**	**Dental, Vision and EAP Coverage**
You, your *spouse*, *domestic partner* or *child* is an employee who is eligible for *company* employee/retiree coverage	He or she is not eligible for dual coverage.	He or she may be covered as both an employee and as a dependent for dual coverage

Geographic Medical and Dental Service Areas

The Medical and Dental plan options available to you depend on the geographic area in which you live and, in some cases, the *company* you work for or your union representation. The geographic service area is determined by the plan administrator based on your home ZIP code on file. See the applicable health care plan summary in this section of your handbook for details.

Situations Affecting Health Care Coverage

Employees' Health Care Coverage

There are a number of situations that could affect your coverage-for example, if you go on a leave of absence or you leave the *company*. Your dependents' coverage may also be affected. See **Events Affecting Your Benefits** for more information on how specific situations could affect your coverage.

In certain circumstances, the *company* offers you the opportunity to extend your health care coverage after it would normally end. This provision is in accord with the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. See **COBRA Extended Coverage** in the Continued Health Care Coverage section of this summary for details.

When Your Dependents' Health Care Coverage Ends

Your dependents' coverage normally ends when:

- You choose to discontinue their coverage
- Your dependent stops meeting the eligibility requirements
- When your coverage ends

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Your dependents may have the opportunity to extend their health care coverage after it would normally end through COBRA Extended Coverage. See **COBRA Extended Coverage** in the Continued Health Care Coverage section of this summary. Under federal law, *domestic partners* and *same-sex spouses* are not eligible for COBRA Extended Coverage but may be eligible to continue their health care through the plan's **Continued Coverage for *Domestic Partners* and *Same-Sex Spouses***.

Coordination of Benefits

When you are covered by two group health care plans, their benefits will be coordinated with one another. An order of benefit determination is established making one plan the primary coverage and the other plan the secondary coverage. A "group health care plan" means any plan providing benefits or services for or by reason of medical care or treatment where such benefits or services are provided by (i) group, association, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage under labor-management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans, or (iv) Medicare or other coverage under governmental programs or coverage provided by any applicable state or federal statute as permitted by applicable law. The term "group health care plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of group health care plans into consideration in determining its benefits and that portion which does not.

When this plan is primary, it will pay benefits according to the terms of the plan. When the plan is secondary, it will first determine the benefits it would have paid if it were primary and subtract the amount that the other plan paid, and then pay the difference, if any.

It is very important that you inform all of your health care plans about any other related group health care plans that cover you and your dependents. Coordination of benefits is also an important factor when considering enrollment in two health care plans. For instance, when two medical plans have comparable benefits, depending upon how those plans coordinate their benefits, there may be little likelihood of the secondary plan paying any additional benefits.

Order of Benefit Determination for Coordination with Other Group Health Care Plans, except Medicare

The rules of this section apply to coordination of benefits between this plan and other group health care plans, except Medicare. If the other plan does not provide for the coordination of its benefits with the benefits of this plan, its benefits will always be determined before this plan. Otherwise, the rules establishing the order of benefit determination are:

1. A plan which covers the individual on whose expenses a claim is based other than as a dependent shall determine its benefits before a plan which covers the individual as a dependent.
2. In a situation where the parents are neither separated (whether or not ever married) nor divorced, if a claim for benefits is for a *child* who is a dependent, the plan of the parent whose birthday comes first in the year shall be determined before the benefits payable under the other parent's plan. In a situation where the parents are neither separated (whether or not ever married) nor divorced, if a claim for benefits is for a *child* who is a dependent and both parents have the same birthday (excluding the year of birth), the benefits of the plan which has covered either parent the longest shall be determined first.
3. In the case of a claim for a dependent *child* whose parents are separated (whether or not ever married) or divorced and the parent with custody of the *child* has not remarried, the plan which covers the *child* as a dependent of the parent with custody will determine its benefits before the plan which covers the *child* as a dependent of the parent without custody or, if the parents share joint custody without a court decree stating that one of the parents is responsible for the health care expenses of the *child*, the plan of the parent whose birthday occurs earlier in the year will determine its benefits first.
4. In the case of a claim for a dependent *child* whose parents are separated (whether or not ever married) or divorced and the parent with custody of the *child* has remarried, the plan which covers the *child* as a dependent of the parent with custody shall determine its benefits before the plan which covers that *child* as a dependent of the stepparent, and the plan which covers that *child* as a dependent of the stepparent

will determine its benefits before the plan which covers that *child* as a dependent of the parent without custody.

5. In the case of a claim for a dependent *child* whose parents are separated (whether or not ever married) or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical or other health care expenses with respect to the *child*, then notwithstanding paragraphs 3. and 4. above, the plan which covers the *child* as a dependent of the parent with such financial responsibility shall determine its benefits before any other plan which covers the *child* as a dependent *child*.
6. The benefits of a plan which covers the individual on whose expenses a claim is based as an employee (or as a dependent of an employee) shall be determined before the benefits of a plan which covers the individual as a retired or laid-off employee (or as a dependent of a retired or laid-off employee).
7. The benefits of a plan which covers the individual as a participant on whose expenses a claim is based other than pursuant to continuation coverage required under federal or state law, shall be determined first.
8. When an individual on whose expense claim is based is covered by this plan or another plan under the terms of the continuation coverage requirements of COBRA, the following order of benefit determination shall be used:

The plan covering the person on a basis other than that of a qualified beneficiary under the terms of COBRA (or a dependent of a qualified beneficiary) pays benefits before the plan covering the person as a qualified beneficiary (or a dependent of a qualified beneficiary);

When both plans cover the person as a qualified beneficiary under the terms of COBRA (or a dependent of a qualified beneficiary), the plan which has covered the person for the longer period of time pays benefits before the plan which has covered such individual for a shorter period of time.

9. In the case of a claim for an individual who is covered under this plan, and under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act, and for which the state provides premium assistance subsidy for such individual (pursuant to Section 2105(c) of the Social Security Act), this plan shall be the primary plan and determine its benefits first and the state Medicaid or child health plan shall be the secondary plan.
10. When any of the above rules do not establish an order of benefit determination, the benefits of a plan which has covered the individual on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such individual for the shorter period of time.
11. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

Order of Benefit Determination for Coordination with Medicare

The rules of this section apply only to coordination of benefits with Medicare. This plan will take into consideration any Medicare benefits for which a participant is eligible and enrolled under Part A (Hospital Insurance) and Part B (Supplemental Medical Insurance) of Medicare. The rules establishing the order of benefit determination if a participant on whose expenses a claim is based is at least age 65 or is otherwise eligible for Medicare is as follows:

1. If such a participant is neither covered by another group health care plan as an active employee (or as a dependent of an active employee) of another employer nor as a retired employee (or as a dependent of a retired employee), Medicare shall be the primary plan and determine its benefit first and this plan shall be the secondary plan and determine its benefits based on Medicare.
2. If such a participant is covered by another group health care plan as an active employee (or as a dependent of an active employee), the other group health care plan will be the primary plan and Medicare will be the secondary plan for such participant. In such circumstances, this plan will coordinate benefits only after the benefits of both the primary plan and secondary plan have been determined.
3. If such a participant is covered by another group health care plan as a retired employee, Medicare shall be the primary plan and the other group health care plan shall be the secondary plan. In such circumstances, this plan will coordinate benefits only after the benefits of both primary plan and the secondary plan have been determined.

Notwithstanding the preceding, with respect to a participant who has End Stage Renal Disease, Medicare will not be considered to be the primary plan to the extent required by applicable federal law.

Qualified Medical Child Support Order (QMCSO)

Under the provisions of the Omnibus Budget Reconciliation Act of 1993 and related state law, state courts and state child support agencies may require the *company* to add dependent *children* as covered participants to health care plans. If the plan is served with such an order you and the affected dependent *child* (or the *child's* representative) will be promptly notified. Additional information about when the *child* will be covered, the process involved, and the additional cost you will be responsible for (if any) will be mailed to you.

You may obtain a copy of the QMCSO procedures relating to your health care plans without charge by contacting:

EIX Benefits Connection
(866) 693-4947
www.eixbenefits.com

Non-Discrimination Rules

The *company's* health care plans are subject to rules that prevent the plans from discriminating in favor of highly compensated employees. The Benefits Committee reserves the right to change the elections of certain employees to comply with these rules. If the plans do not pass a non-discrimination test, certain higher-paid employees may have to pay income taxes on the value of the benefits they receive from the health care plans. If you are affected, you will be notified.

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants about its policies and practices to protect the confidentiality of participants' health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Edison International Welfare Benefit Plan (the "Plan").

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your medical, prescription drug, dental, vision, hearing, behavioral health, employee assistance program and/or health care reimbursement account benefits. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information.

Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to:

- make sure that health information that identifies you is kept private,

- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you, and
- follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI:

- **For Treatment.** The Plan may disclose your PHI for the provision, coordination or management of health care and related services. For example, if you are unable to obtain resolution regarding your treatment issue, medical information you provide to the Plan may be conveyed to the carrier to assist you in resolving your issue.
- **For Payment.** The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may share information about medical expenses you have incurred in order to process your claim for benefits from your Health Care Reimbursement Account.
- **For Health Care Operations.** The Plan may use and disclose your PHI to enable the Plan to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to Southern California Edison Company (the "Plan Sponsor") in summary fashion so the Plan Sponsor can decide what coverages the Plan should provide. The Plan may remove information that identifies you from health information disclosed to the Plan Sponsor so it may be used without the Plan Sponsor learning who the specific participants are. The Plan may disclose PHI for the payment, treatment or health care operations of an "organized health care arrangement" in which the Plan participates.
- **To the Plan Sponsor.** The Plan may disclose your PHI to designated personnel or agents of the Plan Sponsor so they can carry out their Plan-related administrative functions. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information will not be used by the Plan Sponsor for any employment-related actions or decisions. Health information collected by the Plan Sponsor from other sources, for example, under the Family and Medical Leave Act, Americans with Disabilities Act or workers' compensation, is not protected under HIPAA.
- **To a Business Associate.** Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.
- **Treatment Alternatives.** The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** The Plan may use and disclose your PHI to tell you about health related benefits or services that may be of interest to you.
- **Individual Involved in Your Care or Payment of Your Care.** The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.
- **As Required by Law.** The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.
- **Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description or location of the person who committed the crime.

- **Workers' Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.
- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.
- **To Avert Serious Threat to Health or Safety.** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
- **Public Health Risks.** The Plan may disclose health information about you for public heath activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting abuse, neglect or domestic violence; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.
- **Health Oversight Activities.** The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.
- **Research.** Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.
- **National Security, Intelligence Activities and Protective Services.** The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence and other national security activities authorized by law, and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.
- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, Medical Examiners, and Funeral Directors.** The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

- **Right to Inspect and Copy.** You have the right to inspect and copy your PHI. This includes information about your Plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes or information compiled for civil, criminal or administrative proceedings. To inspect and copy health information maintained by the Plan, submit your request in writing to the Privacy Official at the address listed below. The Plan may charge a fee for the cost of copying and/or mailing your request. The requested information will be provided within 30 days if the information is maintained on site (60 days if the information is maintained offsite). The Plan may notify you that a 30-day extension is needed to review your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial or file a complaint. Certain denials are final and you will not be provided an opportunity for review.

- **Right to Amend**. If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, send a detailed request in writing to the Privacy Official at the address listed below. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy. Within 60 days of receipt of your request, the Plan will either make the amendment, notify you that a 30-day extension is required to review your request, or deny your request and notify you in writing of the reasons for denial. If denied, you may file a written statement disagreeing with the denial or you may file a complaint.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, except for those disclosures necessary to carry out health care treatment, payment, or operations; disclosures made to you; or disclosures made in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Official at the address listed below. Your request must state the time period for which you are requesting an accounting, which may not be longer than six years prior to the

date of your request. Within 60 days of your request, the Plan will provide you the list of disclosures or will notify you that a 30-day extension is needed to comply with your request. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- **Right to Request Restrictions.** You have the right to request a restriction on the health information the Plan uses or disclosure about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, make your request in writing to the Privacy Official at the address listed below. You must advise: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. The Plan is not required to agree to your request. If the Plan does agree, the Plan may later terminate the restriction after notifying you.
- **Right to Request Confidential Communications.** If disclosure of your PHI by the usual means could endanger you, you have the right to request that the Plan communicates with you about health matters by alternative means or at an alternative location. To request confidential communications, make your request in writing to the Privacy Official at the address listed below. You must indicate that the normal form of communication could endanger you, and you must specify how or where you wish to be contacted. The Plan will make every attempt to accommodate all reasonable requests.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may write to the Privacy Official to request a written copy of this notice at any time.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed provisions effective for all PHI maintained by the Plan, including health information that was previously created, received or maintained by the Plan. If changes are made to the Plan's privacy policies, a revised version of this notice will be distributed to all Plan participants by either interoffice mail or by U.S. mail.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclosure your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Questions and Complaints

If you have any questions about this notice, you may call the Employee Information Center at (800) 500-4723. If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Official:

Privacy Official
P.O. Box 800
Rosemead, CA 91770

Alternatively, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

Medical Plan

Medical Plan revised December 19, 2012.

Overview And Important Features

The Medical Plan provides a choice of Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO) and Health Maintenance Organization (HMO) plan options. Where you live, the *company* you work for and, in some cases, union representation determine which options are available to you.

If you have Medicare as your primary medical coverage, you may be eligible to participate in a Medicare Advantage or Medicare Coordinated plan.

Here are some key features of the Medical Plan:

- Most employees and their dependents are eligible to participate in the Medical Plan
- Most employees generally pay for Medical coverage with pre-tax dollars; retirees pay for Medical coverage with post-tax dollars
- All Medical Plan options cover similar medical expenses. They may differ in price tags, *company* contributions, the amount you pay in *out-of-pocket* expenses (like *deductibles*, copayments or coinsurance in some cases) and in the ways you may access medical care (such as through your primary care *physician* vs. self directed or by using in-network vs. out-of-network providers)
- If the Medical Plan option you enroll in has a provider network, contact your plan's Member Services department for a list of providers in your area. A list of providers is also available on your plan's Web site

The Medical Plan Options Comparison charts on the following pages summarize benefits under each Medical Plan option. These charts cover some significant information, including some limitations and other plan option features. The information in the charts, however, is a general overview, is not all-inclusive and may not exactly match each Medical Plan option's designation of covered services and supplies. Read the full description of each Medical Plan option later in this summary for more complete information — for example, what expenses count toward meeting a *deductible* or an *out-of-pocket* maximum, what conditions apply for coverage of some of the benefits shown, and what items are excluded.

The following comparison charts cover:

- Blue Shield of California PPO
- Health Net of California HMO
- Kaiser Permanente
- UnitedHealthcare HMO

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- Blue Shield of California EPO

Please note the following difference between the in-network and out-of-network benefits shown for the PPO options:

- In the "In-Network" column, the chart shows what percentage of the provider's charge the plan will pay for *covered expenses*; you pay the remaining percentage
- In the "Out-of-Network" column, the chart shows what percentage of the plan's maximum allowable charge or maximum allowance the plan will pay for *covered expenses*; you pay the remaining percentage of that charge or allowance plus any difference between the allowable charge and the billed charge

Copays, *deductibles*, *out-of-pocket* maximums, etc., in the following chart may adjust annually and are subject to the terms of a collective bargaining agreement, when applicable.

Medical Plan Options Comparison – Effective January 1, 2013

Benefit Description	Blue Shield PPO 90/70		Blue Shield PPO 80/60		Blue Shield PPO 70/50		Health Net HMO Kaiser Permanente UnitedHealthcare HMO Blue Shield EPO
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**PCP Coordinated (excluding Blue Shield EPO)**
Calendar Year *Deductible*							
Individual	Member pays $300		Member pays $600		Member pays $1,700		None
Family	Member pays $600		Member pays $1,200		Member pays $3,400		None
Maximum Calendar Year *Out-of-Pocket* (excluding pharmacy) (includes *deductible*)							
Individual	$3,995		$3,995		$5,990		$1,995
Family	$7,990		$7,990		$11,980		$3,990
Lifetime Maximum Benefit	None		None		None		None
Hospital Admission *Deductible* (per admission)	Member pays $250 *deductible*		Member pays $250 *deductible*		Member pays $250 *deductible*		None
Hospital							
Inpatient Care	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Outpatient Facility Services	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Outpatient Surgery	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Emergency Room Copay	Member pays $130 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient or for observation as an outpatient)		Member pays $130 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient or for observation as an outpatient)		Member pays $130 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient or for observation as an outpatient)		Member pays $130 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient or for observation as an outpatient)
Ambulance Services	Plan pays 90%	Plan pays 90%	Plan pays 80%	Plan pays 80%	Plan pays 70%	Plan pays 70%	No copay
***Physician* Services**							
Office Visits	$25 copay	Plan pays 70%	$25 copay	Plan pays 60%	$25 copay	Plan pays 50%	$20 copay
Inpatient Hospital Visits	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Outpatient Hospital Visits	$25 copay	Plan pays 70%	$25 copay	Plan pays 60%	$25 copay	Plan pays 50%	$20 copay; No copay for Health Net HMO
Urgent Care Visits	$25 copay	Plan pays 70%	$25 copay	Plan pays 60%	$25 copay	Plan pays 50%	$20 copay
Periodic Health Exam/Preventive Care	No charge (*deductible* waived)	Plan pays 70%	No charge (*deductible* waived)	Plan pays 60%	No charge (*deductible* waived)	Plan pays 50%	No copay
Gynecological Exam (for well woman)	No charge (*deductible* waived)	Plan pays 70%	No charge (*deductible* waived)	Plan pays 60%	No charge (*deductible* waived)	Plan pays 50%	No copay
Immunization/Inoculation	No charge (*deductible* waived)	Plan pays 70%	No charge (*deductible* waived)	Plan pays 60%	No charge (*deductible* waived)	Plan pays 50%	No copay
Well-*Child* Care	No charge (*deductible* waived)	Plan pays 70%	No charge (*deductible* waived)	Plan pays 60%	No charge (*deductible* waived)	Plan pays 50%	No copay
Pregnancy and Maternity Care (includes pre-natal and post-natal care visits, screening for gestational diabetes, breastfeeding support, supplies and counseling)	Plan pays 90%; gestational diabetes, and breastfeed-ing support, supplies and counseling covered at 100%	Plan pays 70%	Plan pays 80%; gestational diabetes, and breastfeed-ing support, supplies and counseling covered at 100%	Plan pays 60%	Plan pays 70%; gestational diabetes, and breastfeed-ing support, supplies and counseling covered at 100%	Plan pays 50%	No copay
Allergy Testing	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Allergy Treatment	Plan pays	Plan pays	Plan pays	Plan pays	Plan pays	Plan pays	No copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	90%	70%	80%	60%	70%	50%	
Vision Exam/Screening (preventive or refractive)	Not covered		Not covered		Not covered		Health Net – No copay (birth through age 17 only) UnitedHealthcare – $20 copay Kaiser; Blue Shield EPO – Not covered
Hearing Exam/Screening (preventive care – not associated with a condition)	No charge (*deductible* waived)	Plan pays 70%	No charge (*deductible* waived)	Plan pays 60%	No charge (*deductible* waived)	Plan pays 50%	No copay
Surgery/Anesthesia	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay Health Net – No copay (for professional services only)
Family Planning (sterilizations, abortions)	Plan pays 90%; tubal ligation covered at 100%	Plan pays 70%	Plan pays 80%; tubal ligation covered at 100%	Plan pays 60%	Plan pays 70%; tubal ligation covered at 100%	Plan pays 50%	$150 copay (for professional services only); tubal ligation - no copay
Diagnostic x ray/Lab	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Prescription Drugs (provided through Express Scripts, with the exception of Kaiser HMO)							
Retail Pharmacy (34-day supply)	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs		Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs		Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs		Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs
Mail Order Pharmacy (90-day supply) (Contracted provider only)	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs; Approved prescribed contraceptives covered at 100%		Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs; Approved prescribed contraceptives covered at 100%		Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs; Approved prescribed contraceptives covered at 100%		Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs; Approved prescribed contraceptives covered at 100%
Maximum co-payment/coinsurance per calendar year	$1,160 individual/ $2,320 family		$1,160 individual/ $2,320 family		$1,160 individual/ $2,320 family		$1,160 individual/ $2,320 family
Durable Medical Equipment	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Infertility	Plan pays 50% of covered charges		Plan pays 50% of covered charges (coinsurance		Plan pays 50% of covered charges		Health Net - $20 copay for basic

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Testing/Treatment	(coinsurance does not apply to Maximum Calendar Year Co-pay) (limited to three cycles per lifetime of advanced infertility treatments)		does not apply to Maximum Calendar Year Co-pay) (limited to three cycles per lifetime of advanced infertility treatments)		(coinsurance does not apply to Maximum Calendar Year Co-pay) (limited to three cycles per lifetime of advanced infertility treatments)		services and treatment (professional services only); no copay for infertility injections and inpatient confinement; advanced infertility treatments are not covered Kaiser; Blue Shield EPO - $20 copay for office visits; no copay for basic services and treatment; advanced infertility treatments are not covered UnitedHealthcare - $20 copay for office visits; basic services by primary *physician* only; advanced infertility treatments are not covered
Substance Abuse Treatment							
Inpatient	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Outpatient	$25 copay	Plan pays 70%	$25 copay	Plan pays 60%	$25 copay	Plan pays 50%	Health Net; Kaiser; Blue Shield EPO - $20 copay UnitedHealthcare – no copay
Behavioral Health							
Inpatient	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Outpatient	$25 copay	Plan pays 70%	$25 copay	Plan pays 60%	$25 copay	Plan pays 50%	$20 copay
Home Health Services (prior authorization required; custodial care not covered)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
	(up to 100 visits per calendar year)		(up to 100 visits per calendar year)		(up to 100 visits per calendar year)		(up to 100 visits per calendar year)
Skilled Nursing Care (custodial care not covered)							
Inpatient (hospital or skilled nursing facility)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
	(up to 100 days per		(up to 100 days per		(up to 100 days per		(up to 100 days per

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	calendar year)		calendar year)		calendar year)		calendar year)
Outpatient	Not covered		Not covered		Not covered		Not covered
Occupational Therapy							
Inpatient (hospital or skilled nursing facility)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Outpatient (office and home visits)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
	(combined calendar year maximum of $5,000 for physical/occupational therapy)		(combined calendar year maximum of $5,000 for physical/occupational therapy)		(combined calendar year maximum of $5,000 for physical/occupational therapy)		
Physical Therapy							
Inpatient (hospital or skilled nursing facility)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Outpatient (office and home visits)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Speech Therapy							
Inpatient (hospital or skilled nursing facility)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Outpatient (office and home visits)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
	($5,000 lifetime maximum for outpatient benefits)		($5,000 lifetime maximum for outpatient benefits)		($5,000 lifetime maximum for outpatient benefits)		
Hospice	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	No copay
Acupuncture	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay	$20 copay
	(30 visit maximum per calendar year)		(30 visit maximum per calendar year)		(30 visit maximum per calendar year)		(30 visit maximum per calendar year)
Chiropractic	$25 copay	Plan pays 70%	$25 copay	Plan pays 60%	$25 copay	Plan pays 50%	$20 copay
	(30 visit maximum per calendar year)		(30 visit maximum per calendar year)		(30 visit maximum per calendar year)		(30 visit maximum per calendar year)
Podiatry	$25 copay	Plan pays 70%	$25 copay	Plan pays 60%	$25 copay	Plan pays 50%	$20 copay
Orthotics (braces and supports) (may be subject to office visit copay)	Plan pays 90%	Plan pays 70%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%	May be subject to office visit copay
Blood and Blood	Plan pays	Plan pays	Plan pays	Plan pays	Plan pays	Plan pays	No copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Products	90%	90%	80%	80%	70%	70%	
Hearing Aid Services							
Audiological Exam	$25 copay	Plan pays 70%	$25 copay	Plan pays 60%	$25 copay	Plan pays 50%	Health Net; Kaiser – no copay UnitedHealthcare; Blue Shield EPO - $20 copay
Hearing Aids	Plan pays 90% ($1,500 maximum in a 36-month period)	Plan pays 90%	Plan pays 80% ($1,500 maximum in a 36-month period)	Plan pays 80%	Plan pays 70% ($1,500 maximum in a 36-month period)	Plan pays 70%	UnitedHealthcare - $5,000 benefit maximum every three years; limited to a single hearing aid (including repair/replacement) Health Net; Kaiser; Blue Shield EPO - Not covered

Who Is Eligible

You are eligible to participate in the Medical Plan if you are a *full-time*, *part-time* or *part-time plus* employee, eligible retiree, eligible dependent, or survivor of an eligible employee or retiree, unless you are otherwise excluded in this document or in the Eligibility section of this handbook. *Temporary* and *leased* employees and *contingent workers* are not eligible to participate in the Medical Plan.

Only *full-time* and *part-time plus* employees are eligible for the Preventive Health Account.

If you or your *spouse* qualify for premium-free Medicare Part A – either in your own right or through a current, former or deceased *spouse* – you must enroll in Medicare Part B at age 65 (or earlier if you qualify due to a disability) to continue your medical coverage through the *company*. You may defer enrollment in Part B of Medicare if you are actively employed and covered by a company medical program by virtue of that employment. If you do not elect Medicare Part B coverage on initial eligibility, or if you fail to maintain your Part B coverage, the *company* reserves the right to terminate your *company* Medical coverage.

See the **Eligibility** section of this handbook for the specific employee groups eligible to participate in this program. See the **Health Care Overview** section in this handbook for specific eligibility requirements for employees, retirees and dependents. For more information about benefits after you retire, see **Medical Benefits When You Retire** later in this summary and **Who Is Eligible** under the "Retirees" section in the Health Care Overview section.

Enrolling For Coverage

If you are a *full-time*, *part-time* or *part-time plus* employee, each year you may enroll in any one of the Medical Plan options offered in your geographic area and in the coverage category of your choice.

If you are a disabled employee receiving Long Term Disability (LTD) benefits through the *company* LTD Plan and Medicare is your primary medical coverage, you will be eligible for available Medicare plan options in lieu of other plan options. See **Medical Benefits When You Retire** for more information about Medicare options.

Waiving Coverage

If you are an eligible *full-time* or *part-time plus* employee and you do not have group coverage other than the coverage offered to you through the *company's* Medical Plan, you must elect (or you will be assigned) a Medical Plan option and level of coverage under the Medical Plan.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

However, if you are covered under another non-Edison group medical policy, you can waive coverage in this plan and receive a Waive Dividend. In order to waive coverage you must, as part of your enrollment process, affirm that you have other group coverage. You cannot waive your own Medical coverage to be the dependent of another Edison-covered person. See Waiving Coverage in the Health Care Overview section.

If you lose your other group coverage during the year, you may be able to enroll in the *company* Medical Plan as the result of your *qualified life event*, however your Waive Dividend will be discontinued upon the effective date of your enrollment in a Medical Plan option. See the **Medical Waive Dividends** section in this summary for more about waiving coverage and the Waive Dividend.

Part-time employees are not required to enroll in a Medical Plan option, and as such, are not eligible for a Waive Dividend.

Enrollment Deadlines

In the year you are hired, you may enroll for the remainder of the calendar year, and your coverage begins on your date of hire.

If you do not enroll within 30 days of the date you become eligible and you are:

- A *full-time* employee, you will be enrolled, by default, in the lowest-cost Medical Plan option available in your home ZIP code area for coverage for yourself only. The Medical Plan administrator will assign you a primary care *physician* (PCP), unless a PCP is not required by the plan option you are enrolled in to receive the full benefits available. You will have no dependent coverage.
- A *part-time* employee, your default medical coverage will be no coverage. You will not be eligible for Medical coverage for the remainder of the year unless you have a *qualified life event* during the year. For more information, see the ***Flex*** summary.

If you elect dependent coverage, coverage for your dependents begins on the same day your coverage begins. If you don't enroll yourself or your dependents because you have other group coverage, you may enroll in the future if you request enrollment within 30 days after the effective date your other coverage ends. For more information, see **Events Affecting Your Benefits** in this handbook.

Annual Enrollment Period

You have the opportunity to choose your Medical Plan option coverage during each annual enrollment period. The coverage you select begins on January 1.

If you do not choose a Medical Plan option during annual enrollment and you are:

- A *full-time* or *part-time plus* employee or retiree who was enrolled in the prior year:
  - You and your currently enrolled eligible dependents will remain in the same Medical Plan option you had in the prior year, unless that option is no longer offered
  - If the option is no longer offered, you and any currently enrolled eligible dependents will be enrolled, by default, in the lowest cost Medical Plan option available in your home ZIP code area. The Medical Plan option administrator will assign a primary care *physician* (PCP) unless a PCP is not required by the plan option you are enrolled in to receive the full benefits available
- A *full-time*, *part-time plus* or *part-time* employee eligible for *company* contributions or retiree who waived coverage in the prior year:
  - You will not be enrolled in the Medical Plan for the upcoming year unless you elect a Medical Plan option through the annual enrollment process. For information about who may waive coverage, see **Waiving Coverage** in this summary.
  - If you have a *qualified life event* during the year, you may be able to enroll at that time
- A *part-time* employee not eligible for *company* contributions:
  - You will not be eligible for Medical coverage beginning on January 1 and lasting through the remainder of the calendar year
  - If you have a *qualified life event* during the year, you may be able to enroll at that time

See the *Flex* summary in this handbook for more information on **default coverage**. Also see **Events Affecting Your Benefits** in this handbook for information if you have a *qualified life event*.

Default Annual Enrollment Medical Elections	
If you are a...	**And if you don't actively enroll during annual enrollment, your default Medical election will be...**
Full-time employee *Part-time Plus* employee *Part-time* employee eligible for *company* contributions	• Same plan (if available) and coverage category you had at the end of the prior calendar year; if prior option not available, the same coverage category for the lowest cost option in your home ZIP code. • No coverage if you waived coverage in the prior calendar year
Part-time employee not eligible for *company* contributions	No coverage

Coverage Categories

You have a choice of four coverage categories:

- You only
- You and child(ren)
- You and *spouse* (or the *domestic partner* of the employee)
- You and family

For more details on coverage categories, see the **Health Care Overview**.

During each annual enrollment period, you choose the coverage category that will best meet your needs in the coming year. Under certain circumstances, you can change your coverage category before the end of the year. See **Events Affecting Your Benefits** in this handbook for more information.

Geographic Service Areas

The administrators for the Medical Plan options independently contract with medical care providers to establish geographic service areas that the administrators can reasonably serve. The Medical Plan options available to you depend on the geographic area in which you live. Your geographic service area is determined by your home ZIP code.

Your personalized enrollment kit lists the plans available in your home ZIP code area. When you enroll, you may choose any Medical Plan option on your list.

If you live in California and your eligible dependent lives outside of California (e.g., your *child* is attending college in another state), there may be restrictions on the Medical Plan option you may select. If you (or your eligible dependents) live outside of the U.S., the Blue Shield of California PPO options may be available to you. Call the *EIX Benefits Connection* toll-free at (866) 693-4947 if you have questions regarding geographic service areas.

Cost of Coverage

Your price tag and *company* contributions for employees for Medical coverage depend on the plan option and coverage category you choose. *Company* contributions and price tags are spread among the *deduction periods* throughout the year and are shown in the personalized information statement you receive when first eligible and during annual enrollment.

Each year the price tags and *company* contributions for the Medical Plan may be adjusted up or down to reflect actual cost experience or changes in the plan options. See the *Flex* section in this handbook for more details on price tags and *company* contributions.

If you are disabled, become Medicare-eligible, participate in Medicare Parts A and B, and choose a Medicare Advantage or Medicare Coordinated option, the *company* will reimburse you for your Medicare Part B premiums.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Price Tags

The annual price tag for each available option is based on the plan option you choose and your coverage category.

***Company* Contributions**

The *company* provides contributions that may be used to help pay the cost of your Medical coverage if you are:

- A *full-time* employee
- A part-time plus employee
- A *part-time* employee regularly scheduled to work 16 or more hours per week on an ongoing basis

Your *company* contributions are based on the *company* you work for and your employee group. They are shown in the personalized information you receive when you're first eligible and during each subsequent annual enrollment.

If you are a *part-time* employee eligible to receive *company* contributions, the *company* provides a lump-sum *company* contribution allocation to help pay the cost of your elected *Flex* coverage, including Medical.

Part-time employees who are not regularly scheduled to work 16 or more hours per week on an ongoing basis do not receive *company* contributions.

Medical *Company* Contributions for *Full-time* and *Part-time Plus* Employees

The amount of *company* contributions allocated to eligible *full-time* and *part-time plus* employees generally will pay most of the price tag for employee only coverage and a large share of the price tag for dependent coverage.

Each year *company* contributions and price tags are spread among *deduction periods*. See the *Flex* summary in this handbook for more information on *company* contributions.

***Company* Contributions for Retirees and Survivors**

The *company* may make contributions toward the cost of Medical coverage for eligible retirees and survivors of employees and retirees. See the **Continued Health Care Coverage** summary for more information.

Medical Waive Dividends

In addition to regular *company* contributions, the *company* may provide a Waive Dividend. If you are a *full-time* or *part-time plus* employee and have other group medical coverage and you elect to waive Medical coverage at the *company*, you will receive a specific amount of Medical *company* contributions as a Waive Dividend for the year. The amount is shown in your personalized *Flex* enrollment materials. You may use the Waive Dividend toward the price tags of other *Flex* benefit options or receive it in your paychecks as additional taxable income. The Waive Dividend is not available to *part-time* employees and to retirees.

Employee Contributions

If the annual price tag of the Medical Plan option you elect is more than the allotted Medical *company* contributions, you make up the difference through pre-tax payroll deductions. If the annual price tag is less than the allotted Medical *company* contributions, you may use those remaining *company* contributions toward other *Flex* choices or receive them as taxable income in your paycheck. The cost of coverage for a *domestic partner* must be paid with post-tax dollars. The portion of the value of a *domestic partner's* coverage that exceeds the employee's contribution is reported on the employee's paychecks and W-2 form as imputed income.

If you don't receive enough pay during a pay period to cover your price tags, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. If you are in arrears after four consecutive pay periods, you will receive a written notice that you are being changed from payroll deduction to direct billing and you will be billed for future contributions you owe. If you fail to pay your contributions, your coverage will be terminated. Any amount that you have in arrears for payroll deductions during *deduction periods* prior to your change to direct billing that could not be collected at the end of the calendar year will be added to your W-2 statement as taxable income. If you leave the *company* or cease to be eligible for benefits, you will be billed for any outstanding deduction amounts.

If you're not receiving income directly from the *company* and payroll deductions are not possible (for example, if you're on an unpaid leave of absence or are receiving Workers' Compensation benefits), you will be billed for your Medical coverage.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The Primary Care *Physician*

Before you choose a Medical Plan option, you should understand the role of a primary care *physician* (PCP) in the HMO option.

When you enroll in a HMO option, you must choose a PCP for yourself and each family member. The role of the PCP is to coordinate all medical care received by each patient.

The role of the PCP is generally to:

- Learn your medical history. Your PCP will know about the treatment you are receiving and will work with specialists to help you get the most appropriate care considering your medical history
- Provide most of the medical care for you and enrolled family members, including preventive care services such as physicals, well-*child* care, and immunizations
- Coordinate all of your care with other providers in the Medical Plan's network, including lab tests, x rays, and care from specialists
- Handle all claims filing and administrative procedures on your behalf for any care that is coordinated through your PCP

Choosing a PCP

You may choose from four different types of PCPs:

- **Internists**, who focus on internal medicine and are able to treat more complicated medical problems, as well as provide regular care. Internists treat adults only
- **Family practitioners,** who are trained in many aspects of medicine, including pediatrics, adult care, OB/GYN care, and other areas such as geriatrics. Family practitioners are capable of treating your entire family
- **General practitioners,** who are trained in adult medicine, pediatrics, geriatrics, and obstetrics. General practitioners are different from family practitioners in that they do not have advanced, specialized training. General practitioners treat patients of all ages
- **Pediatricians,** who provide care for infants and children (usually up to age 18) only

When you enroll in one of the HMO options, you select a PCP for you and each enrolled family member at annual enrollment and when you first enroll in the option. You may choose a different PCP for each person you enroll. If you do not select a PCP, the administrator for the Medical Plan option you have selected will assign a PCP to you. If you need to change your PCP after you've enrolled, call your plan option's Member Services department. The Member Services department telephone number is shown on the Medical Plan identification card you receive after enrollment.

Individual Case Management

The plan provides a case management program to assist you if you become catastrophically ill or injured. A catastrophic illness or injury is one that is potentially associated with a large dollar amount of claims and any of the following:

- Long term treatment
- Substantial disability that markedly affects your normal daily activities
- Terminal illness

Examples of catastrophic illnesses or injuries include spinal cord injuries or other traumatic injuries, certain neurological diseases, AIDS or other immune system diseases, cancer, multiple sclerosis, serious heart or lung disease, and severely ill premature *children*.

The administrator for your Medical Plan option may, at its discretion, work with you, your *physician* and other care providers to ensure that the most appropriate type, level and setting of health care services and supplies will be coordinated for you. The administrator for your Medical Plan option may, at its sole discretion, authorize coverage for alternative services and supplies that do not otherwise constitute *covered expenses* if the administrator determines the services are *medically necessary*, cost effective, and that the total benefits paid for

such procedures do not exceed the total benefits to which you would otherwise be entitled under the Medical Plan in the absence of alternative benefits.

Blue Shield of California Preferred Provider Organization (PPO) Medical Plan Option

A PPO offers flexibility, allowing you to visit the doctor of your choice without having to be referred through a designated primary care *physician* (PCP). It also offers opportunities for controlling your costs by giving you economic incentives for using health care providers that participate in the PPO network.

How the PPO Option Works

The PPO puts you in charge of controlling your health care costs. You enroll in one of three cost-sharing options;

- 90/70
- 80/60
- 70/50

The PPO option you select during your enrollment period determines your *deductible*, coinsurance and *deduction period* contributions for coverage. To choose which option is right for you, consider the following:

- Pay more each paycheck and less when you get care
- Pay less each paycheck and more when you get care

The PPO option with the highest benefit level (90/70) will cost you the most in *deduction period* contributions and the least when you receive services. The option with the lowest benefit level (70/50) will cost you the least in *deduction period* contributions and the most when you receive services.

The PPO offers you the freedom to go to any doctor, including a specialist, without a referral. When you use an in-network provider, the plan will pay a higher percentage of the cost and there are no claim forms to submit. If you use an out-of-network provider, your costs will be higher and you may need to submit a claim form.

Each time you or an enrolled family member needs medical care you can choose whether to use the services of a provider participating in the network or go outside the network.

In-network and out-of-network benefits differ in the amount you and the plan pay for *covered expenses*. In addition, some items are not covered out-of-network.

The **Medical Plan Options Comparison chart** in the front of this summary shows benefits paid under each of the three cost-sharing options and in-network vs. those paid out-of-network.

In-Network Benefits

You pay less *out-of-pocket* when you use in-network benefits:

- You must meet a calendar year *deductible* before the plan pays for most in-network benefits. If two family members each meet the individual *deductible*, no other family members will need to meet the *deductible* that calendar year
- Depending on the cost-sharing option in which you enroll, for most covered services, once you satisfy the *deductible*, you pay 10%, 20% or 30% of the charge, up to the maximum allowance, and the plan pays the remaining 70%, 80% or 90%
- You pay a flat copayment for office visits to *physicians*
- Providers participating in the network have agreed to accept the plan's maximum allowances for covered services as payment in full, so you will be responsible only for your copayment or your share of the coinsurance

You can find participating providers online by logging on to your PPO's website. You may also request a list of providers in your area by calling the PPO's toll-free number. Because the network changes over time, you are encouraged to check with your provider before undergoing treatment to make certain the provider is still participating in the network.

Out-of-Network Benefits

You pay more out of your own pocket if you use a provider outside of the network:

- You must meet a calendar year *deductible* before the plan pays for most out-of-network benefits. If two family members each meet the individual *deductible*, no other family members will need to meet the *deductible* that calendar year
- Depending on the cost-sharing option in which you enroll, for most covered services, once you satisfy the *deductible*, you pay 30%, 40% or 50% of the charge, up to the maximum allowance, and the plan pays the remaining 50%, 60% or 70%. Out-of-network providers may balance bill you for amounts over and above the maximum allowance
- Since out-of-network providers do not have discount arrangements with the PPO that reduce their charges, you may have a greater percentage of a larger expense to pay. This is in contrast to the in-network arrangement, where providers have discounted the fees they charge for the services provided and cannot balance bill you

Out-of-Pocket Maximum

Each PPO cost-sharing option has a different *out-of-pocket* maximum. Once your eligible *out-of-pocket* expenses reach the maximum annual amount, the plan pays 100% of *covered expenses* for the rest of the plan year.

The following expenses do **not** apply toward the calendar year *out-of-pocket* maximum, nor are they covered in full after you reach it:

- Amounts exceeding the plan's eligible charge or maximum allowance
- Amounts you pay for services that have their own dollar limits for benefits payable
- Amounts you pay for services that have their own limit on the number or frequency of treatments that are covered in a given period of time
- Hospital emergency room copayments
- Amounts you pay for prescription drugs
- Amounts you pay for failure to comply with the plan's requirements regarding review of hospitalizations
- Copayments for advanced fertility services

PPO *Emergency* Care

In a true medical *emergency*, use your best judgment — call 911 or go immediately to the nearest emergency room. Both in- and out-of-network benefits cover true medical *emergencies* after you pay a copayment for a visit to an emergency room.

The emergency room copay is waived if you are admitted to the hospital directly from the emergency room.

The PPO options have a specific definition of a true *emergency*. The PPO options define an *emergency* as the sudden and unexpected onset of a medical condition that would likely result in serious and permanent medical consequences if immediate medical attention were not rendered. Examples of such medical conditions are severe chest pains, convulsions, and persistent, severe abdominal pains.

In the case of mental illness, an *emergency* is the sudden and unexpected onset of a mental condition that would likely result in serious and permanent medical consequences to oneself or others if immediate medical treatment were not rendered. Examples of such mental conditions are major depression with significant suicidal intent, psychosis with associated homicidal intent, and a manic episode resulting in inability to care for oneself.

Precertification

Precertification/prior authorization is required for selected inpatient and outpatient services, supplies, and *durable medical equipment*; PKU (phenylketonuria) related formulas and special food products; admission into an approved hospice program; and certain radiology procedures. Preadmission review is required for all inpatient hospital and skilled nursing services (except for *emergency* services).

You or your *physician* must call (800) 343-1691 for prior authorization for the services listed in this section, except for outpatient radiological services. For prior authorization of radiological services you or your *physician* must call (888) 642-2583 for services received in California:

- admission into an approved hospice program
- clinical trial for cancer benefits

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- select injectable drugs administered in the *physician* office setting
- home health care benefits from a non-preferred provider
- home infusion/home injectable therapy from non-preferred providers
- *durable medical equipment*, including, but not limited to, motorized wheelchairs, insulin infusion pumps, and CPAP (continuous positive air pressure) machines
- surgery services which may be considered to be cosmetic in nature, rather than constructive, e.g., eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction; and those reconstructive surgeries which may result in only minimal improvement in function or appearance. Reconstructive surgery is limited to *medically necessary* surgeries.
- arthroscopic surgeries of the temporomandibular joint (TMJ)
- PKU related formulas and special food products
- special transplant benefits (see transplant section)
- all bariatric surgery
- outpatient speech therapy services
- hospital and skilled nursing facility admissions that are not the result of an *emergency*
- outpatient radiological procedures when performed in an outpatient setting on a non-*emergency* basis: CT (computerized tomography scans), MRIs (magnetic resonance imaging), MRAs (magnetic resonance angiography) PET (positron emission tomography) scans, and any cardiac diagnostic procedure utilizing nuclear medicine.

For retirees with Medicare for whom Medicare is primary, Medicare is the certifying body (since they are the first payer), so those members are not subject to these same pre-certification requirements, as long as Medicare pays first.

How to Obtain Precertification

To obtain precertification, call the telephone number for your PPO provided on your Medical Plan identification card. A nurse or *physician* reviewer in the PPO's precertification unit will then review the medical information provided. The reviewer will approve the services, deny the services, recommend a second opinion or recommend that services be performed on an outpatient basis in order to receive the maximum available benefit.

What the PPO Options Cover

The PPO options provide benefits for the services described below when they are *medically necessary*. The *covered expense* is limited to the contract fee for in-network providers and the maximum allowance for non-contracted (out-of-network) providers. All charges above the maximum allowance amount are your responsibility. Some benefits are covered at different coinsurance levels and/or have their own annual and lifetime maximums.

The PPO options define maximum allowance as the amount determined by Blue Shield of California which participating providers have agreed to accept as payment in full for a particular covered service. All benefit payments for covered services rendered by professional providers, whether participating or non-participating will be based on the Schedule of Maximum Allowances maintained by Blue Shield of California. A participating provider is a provider that has a written agreement with Blue Shield of California or a Blue Cross Blue Shield plan in another state to provide services to Blue Shield members.

For more details about these and other covered services, you may contact the PPO's Member Services department at the telephone number on your Medical Plan identification card.

The PPO options cover the following services and supplies, when *medically necessary*, at the benefit levels shown in the **Medical Plan Options Comparison chart**:

- Allergy shots and allergy surveys
- Ambulance services for *emergency* local transportation (air ambulances and transportation via ambulance for long distances is not covered)
- Bariatric surgery is covered when pre-authorized by Blue Shield, meets medical necessity guidelines and is performed at a Center of Excellence
- Blood and blood components
- Visits by a *physician*, including office visits and visits to your home, hospital and skilled nursing facility visits, and visits to a substance abuse treatment facility

- Clinical trials for cancer. Benefits are provided for routine patient care for members who have been accepted into an approved clinical trial for cancer when pre-authorized by Blue Shield
- Consultations requested by your attending *physician* when you are an inpatient in a hospital or skilled nursing facility and another *physician's* advice is needed for diagnosis or treatment of a condition that requires special skill or knowledge (not covered if done solely because of hospital regulations or by a *physician* who renders surgery or maternity service during the same admission)
- Hospital room and board and general nursing care in a semi-private room, in a private room or in an intensive care unit
- Ancillary hospital services (such as operating rooms, drugs, and lab work)
- Preadmission testing for scheduled inpatient surgery
- Partial hospitalization treatment programs approved by Blue Shield of California
- Hospital services for outpatient surgery (outpatient surgery is also covered if performed at an ambulatory surgical facility)
- *Physician* (or dentist or podiatrist) services for surgery, including sterilization (even if elective) and oral surgery. Benefits for oral surgery are limited to the following services:
  - Accidental injury to natural teeth
  - Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth
  - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth
  - Excision of exotoses of the jaws and hard palate (provided this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints

    The plan also pays benefits for an assistant surgeon (*physician*, dentist, or podiatrist) if a hospital intern or resident is not available for such assistance
- Anesthesia services if administered at the same time as a covered surgical procedure in a hospital or ambulatory surgical facility or by a *physician* other than the operating surgeon or by a Certified Registered Nurse Anesthetist (benefits will, however, be provided for anesthesia services administered by oral and maxillofacial surgeons in the surgeon's office or ambulatory surgical facility)
- Additional surgical opinion: one consultation and related diagnostic service by a *physician* (you may request an additional consultation if you believe the need for surgery is not resolved by the first arranged consultation)
- Medical and surgical dressings, supplies, casts and splints
- Radiation therapy treatments and chemotherapy
- Renal dialysis treatments in a hospital, dialysis facility, or in your home under the supervision of a hospital or dialysis facility
- Shock therapy treatments
- Diagnostic service related to surgery or medical care for an illness or injury
- Physical therapy to restore a useful physical function when provided by a registered professional physical therapist under the supervision of a *physician* and furnished under a written plan established by the *physician* before treatment begins (does not include educational training or services designed and adapted to develop a physical function)
- Occupational therapy to restore a useful physical function when rendered by a registered occupational therapist under the supervision of a *physician* and furnished under a written plan established by the *physician* before treatment begins (does not include educational training or services designed and adapted to develop a physical function)
- Speech therapy when rendered by a licensed speech therapist for the correction of a speech impairment resulting from disease, trauma, corrective surgery, congenital anomalies, or previous therapeutic processes and designed and adapted to restore a useful physical function (does not include educational training or services designed and adapted to develop a physical function). Not covered on an inpatient basis if speech therapy is the sole reason for admission
- Cardiac rehabilitation services within six months after hospital admission for myocardial infarction, coronary artery bypass surgery or percutaneous transluminal coronary angioplasty when provided through a program approved by Blue Shield of California

- Diabetes self-management training and education and one visit for medical nutrition therapy rendered by a *physician* or duly certified, registered or licensed nutritionist, dietician or nurse. Benefits are also available for regular foot care examinations of diabetes patients by a *physician* or podiatrist
- Maternity services incurred by an employee or the *spouse* or *domestic partner* of an employee, including covered services for normal pregnancies and complications of pregnancy as well as routine hospital nursery charges and a routine examination of the newborn by a *physician* other than the *physician* who delivered the baby or administered the anesthesia. Benefits will also be provided for covered services rendered by a certified nurse-midwife.
- Family planning services, including tubal ligation and vasectomy, elective abortions, contraceptive devices (diaphragms and intrauterine devices) and fittings, and prescription contraceptives
- Coordinated home health care services, subject to Blue Shield of California's criteria for a coordinated home care program. To be eligible, you must be homebound and require skilled nursing service on an intermittent basis under the direction of your *physician*. Home health care can include the following:
  - Skilled nursing service by or under the direction of a registered professional nurse
  - The services of physical therapists and hospital laboratories
  - Necessary medical supplies

  Benefits for coordinated home health care services are limited to 40 visits per calendar year.
- Private duty nursing when Blue Shield of California determines that the services provided are of such a nature or degree of complexity or quantity that they cannot be provided by the regular nursing staff of the facility where you are an inpatient or — in your home — by non-professional personnel. *Custodial care* is not covered
- Skilled nursing facility care (bed, board, general nursing care, and ancillary services such as drugs and surgical dressings or supplies); facility must be certified
- Hospice care services and supplies (in the home, a skilled nursing facility, or a special hospice care unit) in cases of terminal illness for a member who is experiencing the last phases of life, as certified by the attending *physician*, and the patient will no longer benefit from standard medical care or has chosen to receive hospice care rather than standard care. The following services are covered:
  - Coordinated home care
  - Medical supplies and dressings
  - Medication
  - Nursing services (skilled and non-skilled)
  - Occupational therapy
  - Pain management
  - Physical therapy
  - *Physician* visits
  - Social and spiritual services
  - Respite care services (short term)

  A family member or friend should be available to provide custodial-type care between visits from hospice care program providers if hospice is being provided in the home.

  In addition, benefits for bereavement counseling will be provided to family members if a member is in the Hospice Care Program at the time of death.
- *Medically necessary durable medical equipment* (DME) for activities of daily living, supplies needed to operate DME oxygen and its administration and ostomy and medical supplies. Other covered items include peak flow monitor, glucose monitor, and apnea monitor. Benefits will also be provided for the rental (not to exceed the total cost of equipment) or purchase of *durable medical equipment* required for temporary therapeutic use, provided this equipment is primarily and customarily used to serve a medical purpose
- Prosthetic devices, special appliances, and surgical implants required to replace all or part of an organ or tissue of the human body or all or part of the function of a nonfunctioning or malfunctioning organ or tissue. Benefits also include adjustments, repair and replacements when required because of wear or change in a patient's condition (except for dental appliances other than intra-oral devices used to treat TMJ or related disorders and cataract lenses when a prescription change is not required)
- Dental accident care (dental services from a dentist or *physician* required as the result of an accidental injury)
- Leg, back, arm, and neck braces

- Breast reconstruction after a mastectomy. Coverage is available in a manner determined in consultation between the patient and the *physician* for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and physical complications for all stages of mastectomy, including lymphedemas. Such coverage is subject to all the terms and provisions of the plan, including any relevant *deductibles* and copayment or coinsurance provisions
- Gender reassignment services when prescribed by a *physician*, subject to the following conditions (available only to employees and their dependents; retirees and dependents of retirees are not eligible). Coverage for gender reassignment services shall be limited to treatment plans that conform to World Professional Association for Transgender Health's standards, which may include psychotherapy, pre- and post-surgical hormone therapy, and sex reassignment surgery performed by a qualified professional. The services must be pre-certified with the Medical Plan administrator and be performed at a Center of Excellence or other designated facility approved by the Medical Plan administrator. The benefits for gender reassignment services shall be subject to the Plan's provisions and coverage levels, except that benefits for these services shall be capped at a maximum lifetime benefit of $75,000 per participant.

About Childbirth

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

The PPO requires precertification of a maternity stay if the length of stay will exceed 48 hours (or 96 hours in cases where a cesarean section is performed). An admission exceeding these times requires authorization and is subject to review for medical appropriateness. You are responsible for obtaining any required authorization.

Any pregnancy-related hospital stay will be treated like any other illness.

Preventive Care

The PPO options pay benefits for wellness care. Wellness care is defined as services based on the Guide to Preventive Services of the U.S. Preventive Services Task Force:

- Well *child* care for *children* up to age three:
  - Immunizations
  - Routine physical examinations
  - Routine diagnostic tests
- Wellness care for persons age three and over:
  - Immunizations
  - Routine physical examinations
  - Routine diagnostic tests
- Preventive care for women
  - Routine mammograms
  - Routine cervical smear or Pap smear
  - Breast-feeding support, supplies and counseling
  - FDA-approved contraception methods and contraceptive counseling
  - Screening and counseling for interpersonal and domestic violence
  - Gestational diabetes screening
  - HIV screening and counseling
  - Human papillomavirus (HPV) testing (beginning at age 30 and every three years thereafter)
  - Sexually transmitted infections counseling
  - Well-woman visits
- Routine prostate-specific antigen test and digital rectal examinations for males
- Colorectal cancer screening with sigmoidoscopy/colonoscopy or fecal occult blood tests

Organ Transplant Services

Hospital and professional services provided in connection with human organ transplants to the extent that they are both:

- Provided in connection with the transplant of a cornea, kidney or skin, and
- You or your eligible dependent is the recipient of such transplant

Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank will be covered. Precertification is required under the PPO.

Special Transplant Services

Benefits are provided for certain procedures listed below, only if

- Performed at a Special Transplant Facility that has an agreement with the PPO to provide the procedure
- Prior authorization is obtained, in writing, from the PPO
- You or your eligible dependent is the recipient of the transplant, and
- The procedure is not *experimental* or *investigational* in nature as determined by the PPO

The PPO reserves the right to review all requests for prior authorization for these Special Transplant Services and to make a decision regarding coverage based on the medical circumstances of each patient, and consistency between the treatment proposed and the medical policy of the PPO.

If you do not obtain prior written authorization from the PPO and/or do not have the procedure performed at a facility and by a *physician* meeting the PPO's medical policy for special transplants, these services are not eligible for coverage.

The following procedures are eligible for coverage under this provision:

- Human heart transplants
- Human lung transplants
- Human heart and lung transplants in combination
- Human liver transplants
- Human kidney and pancreas transplants in combination (pancreas only transplants are not covered)
- Human bone marrow transplants; however, autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high dose chemotherapy is covered only for neuroblastoma in first and second remission without evidence of marrow involvement, glioblastoma when neurologically intact, multiple myeloma, testicular germ cell carcinoma that has progressed after conventional salvage chemotherapy, and for leukemia, lymphoma and Hodgkin's Disease in first or second remission
- Pediatric human small bowel transplants
- Pediatric and adult human small bowel and liver transplants in combination
- Autologous Chondrocyte Implantation/Transplantation

Services incident to obtaining the transplant material from a living donor or an organ transplant bank will be covered.

In connection with transplant procedures for which prior authorization has been obtained from the PPO and which are to be performed at a facility meeting the qualifications of the PPO's medical policy, as described above, travel and lodging expenses will be covered for:

- You or your eligible dependent
- A *spouse* or one other adult, when the transplant procedure is for an adult patient, or two parents, when the transplant procedure is for a dependent *child*
- The organ donor

Organ transplant benefits cover services in connection with the transplant of an organ, bone marrow or tissue for the enrolled person who receives the transplant and his or her donor. Benefits are reduced by any amounts paid or payable by the donor's own coverage.

If you need more information about organ transplant benefits, you may contact the PPO's Member Services department at the telephone number on your Medical Plan identification card.

Mental Illness and Substance Abuse Benefits

Benefits are available for the diagnosis or treatment of mental illnesses classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Benefits can be paid for professional services from a *physician* or from a psychologist, clinical social worker, or clinical professional counselor. Please refer to the **Medical Plan Options Comparison chart** for information concerning benefits and limitations.

Outpatient services include both group therapy and individual visits.

To be eligible for the maximum benefits available for inpatient treatment, you must call your PPO's Member Services at the telephone number provided on your Medical Plan identification card and request pre-certification before your admission..

Benefits for substance abuse rehabilitation will be paid only for covered services in a treatment program approved in writing by Blue Shield of California. This includes partial hospitalization treatment programs where you spend days or nights in a hospital or substance abuse treatment facility. It does not include programs consisting primarily of counseling by individuals other than a *physician* or psychologist; court-ordered evaluations; programs that are primarily for diagnostic evaluations, mental retardation or learning disabilities; care in lieu of detention; or correctional placement or family retreats.

Note: You and your eligible enrolled family members may also be eligible to receive up to five free visits per calendar year through your Employee Assistance Program (EAP). The EAP provides short-term confidential counseling for problems such as marital and family tensions, emotional issues, financial strains, dealing with change or personal or job stress, bereavement, and substance abuse. Refer to the **EAP** summary for additional information.

Prescription Drug Benefits

Prescription drugs are covered at the benefit levels shown in the **Medical Plan Options Comparison chart** at the front of this summary, subject to the restrictions listed below.

Prescriptions may be refilled at a frequency that is considered *medically necessary*.

Mail Order Prescriptions – Select Home Delivery

If you or a covered dependent take long-term or ongoing medication, you will be contacted by Express Scripts to enroll in the Select Home Delivery program. The program encourages you or a covered dependent to obtain a 90-day supply through Express Scripts' mail order prescription service. You or your covered dependent has the option to opt out of the Select Home Delivery program at anytime. For additional information, please contact an Express Scripts' Select Home Delivery representative at (888) 772-5188.

Specialty Drugs - CuraScript

If you or a covered dependent take a specialty medication (oral or injectable) for conditions such as cancer, hemophilia, hepatitis C, multiple sclerosis, HIV/AIDS, rheumatoid arthritis, etc., you will be required to use Express Scripts' specialty pharmacy, CuraScript. For additional information, please contact a CuraScript representative at (866) 848-9870.

Injectable medications (except insulin) may also be available through your *physician* or through the prescription drug benefits program. Check with your Medical plan's Member Services department to get more information.

Your prescription drug benefit does not use a managed formulary. However, certain medications may require prior authorization to ensure that they are medically indicated and prescribed for the specific condition for which they were originally intended to treat.

Prior Authorization Process

The prior authorization program helps to ensure the appropriate use of medications. The program utilizes peer-reviewed guidelines established by Clinical Pharmacists and Physician Specialists. The guidelines are intended to promote the appropriate use of certain medications.

Medications are typically added to the Prior Authorization list due to the concern for patient safety, or limited use established by the FDA, or due to the high cost of the medication.

The prior authorization program provides coverage for some drugs only if they are prescribed for certain uses. If you are prescribed medication that must be pre-authorized, your retail pharmacist or mail service representative should inform you. You will need to ask your doctor to call the **Express Scripts Prior Authorization Line** at **(800) 698-0190**. This line is available to doctors and not Express Scripts' members. The prior authorization review process can generally be completed during the phone call with your doctor. However, if additional information is needed before a decision can be reached, the process can typically take two business days. The patient and doctor will be notified when the review process is completed. If your medication is not approved for coverage, you will have to pay the full cost of the drugs.

Drugs that require prior authorization are:

- Growth hormones
- Anti fungal medications
- Injectible medication for rheumatoid arthritis
- Tretinoin agents used in the treatment of acne and/or for cosmetic purposes, e.g., Retin-A
- Agents used to suppress appetite and control fat absorption
- Other drugs as assigned

The Pharmacy Benefit Program does not cover:

- Any drug provided or administered while you are an inpatient, or in a *physician's* office
- Take home drugs received from a hospital, convalescent home, skilled nursing facility or similar facility
- Except for insulin, drugs which can be obtained without a prescription or have a non-prescription equivalent
- Drugs for which you are not legally obligated to pay, or for which no charge is made
- Medical devices or supplies
- Blood or blood products
- Dietary or nutritional products, unless prescribed by a *physician* and not available over-the-counter
- Any injectable drug, except Insulin, Glucagon, and *medically necessary* Bee Sting Kits. Other injectable medications may be covered under the medical benefit provisions of the PPO option or under Express Scripts' Prior Authorization Program
- Appetite suppressants and other weight loss medications, unless prescribed by a *physician* and not available over-the-counter
- Smoking cessation drugs, unless prescribed by a *physician* and not available over-the-counter
- Drugs used for cosmetic indications only
- Depigmentation products used for skin conditions requiring a bleaching agent
- Implants
- IUDs
- Non-FDA approved drugs or drugs used for indications not approved by the FDA
- Prescription multi-vitamins that have over the counter equivalents
- Supplemental agents
- Prescription homeopathic drugs
- Drugs purchased outside the United States unless in an *emergency* situation

Chiropractic Services

The PPO pays for *medically necessary* chiropractic services at the benefit levels shown in the **Medical Plan Options Comparison chart**. Your copayments do not count toward the plan's *out-of-pocket* maximum. Chiropractic services include visits to a *physician* or chiropractor (D.C.) for chiropractic services in connection with the detection or correction by manual or mechanical means of

- Structural imbalance
- Distortion
- Subluxation

where such care is for the purpose of removing nerve interference and its effects and where interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column.

Acupuncture Services

The PPO pays for *medically necessary* acupuncture services by a licensed acupuncturist. Acupuncture services include any expense related to the puncture of the skin for diagnostic or therapeutic purposes either manually

through the use of needles or electrically through the use of needles or the Transcutaneous Electrical Nerve Simulation (TENS) device.

Podiatry

The PPO pays for *medically necessary* podiatry services. Routine foot care (except as required for *medically necessary* diabetic foot care) is not covered. Podiatry services include office visits, surgery, x rays, laboratory tests, castings or molds for special supports and orthotics.

TMJ Treatment and Treatment of the Teeth, Gums, or Jaw Joints and Jaw Bones

The PPO pays for *medically necessary* treatment of temporomandibular joint (TMJ) conditions and *medically necessary* treatment of the teeth, gums, or jaw joints and jaw bones. Hospital and professional services provided for conditions of the teeth, gums, or jaw joints and jawbones, including adjacent tissues, are covered only to the extent that they are:

- Provided for the treatment of tumors
- Provided for the treatment of damage to the natural teeth caused solely by an accidental injury sustained while covered by the Blue Shield PPO option. Prosthodontics, orthodontia and cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental (e.g., resulting from chewing or biting)
- Non-surgical treatment (e.g., splint and physical therapy) of TMJ
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed
- Orthognathic surgery (surgery to reposition the upper and/or lower jaw) to correct a skeletal deformity

The benefit for treatment of the teeth, gums, jaw joints or jawbones does not include:

- Other services customarily provided by dentists and oral surgeons, including hospitalization incident thereto
- Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate TMJ
- Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures
- Dental implants (including endosteal, subperiosteal or transosteal implants)
- Crowns, inlays and bridgework

Infertility Treatment

The PPO pays for infertility services, including professional, hospital, ambulatory surgery center, ancillary services and injectable drugs administered to diagnose and treat the cause of infertility. Precertification is required. In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), artificial insemination and other forms of induced fertilization are covered upon review and approval by the PPO. Covered services include correction of physical obstruction or other physical problems. Advanced infertility procedures, (IVF, GIFT or ZIFT) will only be covered in the event all other applicable infertility treatments have been exhausted.

Coverage for advanced infertility services (IVF, GIFT and ZIFT) is limited during your lifetime to three cycles, including dropped cycles, of any form of advanced infertility services, including sperm micromanipulation or any combination of these procedures. A cycle is defined as a drug-induced ovulation and monitoring of hormonal levels, with ova retrieval, regardless of the implantation outcome. A dropped cycle is an attempted drug-induced ovulation and monitoring of hormonal levels, without the ova retrieval. Precertification is required.

PPO Lifetime Maximum Benefits

There is no lifetime maximum benefit under the PPO options. Some PPO benefits have their own annual and/or lifetime maximums.

What the PPO Does Not Cover

While the PPO options normally cover most medical treatments and services, there are some treatments and services that are not eligible for coverage. These are listed below.

You are advised to contact the Blue Shield of California Member Services department at the telephone number provided with this summary or on your Medical Plan identification card for specific information about whether a procedure or service is covered or not covered.

The PPO does not cover the following:

- Expenses for hospitalization, services, and supplies that are not *medically necessary,* whether ordered by your *physician* or not, for example:
    - Hospital admission when it is primarily for observation/evaluation or diagnostic studies that could have been provided safely and adequately in another setting, such as a *physician's* office or the outpatient department of a *hospital*
    - Continued inpatient hospital care when a patient's symptoms and condition no longer require a continued stay in a hospital
    - Hospitalization or admission to a skilled nursing facility, nursing home, or other facility for the primary purposes of providing *custodial care* service, convalescent care, rest cures, or domiciliary care
    - Hospitalization or admission to a skilled nursing facility for the convenience of the patient or *physician* or because care in the home is not available or is unsuitable
    - The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members
- Services or supplies not specifically mentioned as covered services or supplies in this summary
- Services or supplies that do not meet accepted standards of medical and/or dental practice
- Expenses incurred either before your or an enrolled family member's Medical Plan coverage begins or after it ends
- Charges in excess of the benefit maximum for any service
- Charges in excess of the maximum allowance
- Charges for failure to keep a scheduled visit or charges for completion of a claim form
- *Experimental* or *investigational* procedures, drugs, devices, or other services and supplies (those being provided or performed in special settings or controlled environments for research or study purposes and awaiting endorsement by the appropriate national medical specialty college or federal government agency for general use by the medical community. With regard to drugs, the exclusion applies to drugs or drug/device combinations not approved by the Food and Drug Administration or have not been approved by the Food and Drug Administration for the purposes for which they are being prescribed
- Over-the-counter medications not requiring a prescription
- Blood derivatives that are not classified as drugs in the official formularies
- Personal hygiene, comfort, or convenience items that are commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones
- Naturopathy
- Custodial care service
- Routine physical examinations or check-ups solely for the purpose of travel or for examination required for licensure, employment or insurance
- Cosmetic surgery, except for correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases or breast reconstructive surgery performed following a *medically necessary* mastectomy
- Dental services, except those specifically listed as a covered service. Spot grinding, crowns, orthodontia and bridges or other restorations or mechanical devices are not covered regardless of the reason for such services
- Eyeglasses or refractive eye surgery, including any associated examinations for the fitting of eyeglasses or in preparation for refractive eye surgery
- Contact lenses, including any associated examinations for the fitting of contact lenses, unless *medically necessary* to treat eye conditions such as keratoconus and keratitis sicca or when required as a result of cataract surgery when no intraocular lens has been implanted
- Low vision aids and devices
- Optometrics and orthoptics
- Procurement or use of prosthetic devices, special appliances, and surgical implants that are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury

- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this summary
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot
- Routine foot care including callus, corn paring or excision, toenail trimming, except as required for *medically necessary* diabetic foot care
- Speech therapy for treatment of psychosocial speech delay, behavioral problems, attention disorder, conceptual handicap, or mental retardation
- Occupational, physical, or speech therapy administered to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur
- Services or supplies during an inpatient stay primarily for behavioral, social maladjustment, lack of discipline, or other antisocial actions that are not specifically the result of mental illness
- Reversal of vasectomy or tubal ligation, repeat vasectomy or tubal ligation
- Under the hospice care program: *durable medical equipment*; home-delivered meals; homemaker services; respite care; traditional medical services provided for the direct care of the terminal illness, disease, or condition; or transportation
- Under transplant services: cardiac rehabilitation service when not provided within three days after discharge from a hospital for transplant surgery, transportation by air ambulance for the donor or the recipient, travel time and related expenses required by a provider, *investigational* drugs, or any other services and supplies not specifically named in this summary
- Sex change procedures or treatment, except as provided under **What the PPO Options Cover**
- Penile implant devices and surgery, and any related services except for any resulting complications
- Services or treatments for, or incident to, non-physically related sexual dysfunction
- Services or supplies for which you are not required to pay or would have no legal obligation to pay if you did not have this or similar coverage
- Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union, or other similar person or group
- Services and supplies for any illness or injury occurring on or after your coverage date as a result of war or an act of war
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are payable under any Workers' Compensation law or similar laws, whether you claim such benefits or not
- Services or supplies provided or paid for by (or for which benefits are available from) a local, state, or federal government agency. This limitation does not apply to medical assistance under Public Aid law or benefits provided for compliance with certain laws
- Professional medical services provided by a family member who either lives in your home or is related to you by blood or marriage
- Services incident to or resulting from procedures for a surrogate mother or in connection with a surrogate parenting agreement
- Services by interns, residents, or others involved in medical training programs
- Drugs determined by Express Scripts as being duplicative or ineffective
- Treatment or procedures that are not FDA-approved, but which require that approval

Medical Necessity (*medically necessary*)

Services which are *medically necessary* include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield are:

- consistent with Blue Shield's medical policy
- consistent with the symptoms or diagnosis
- not furnished primarily for the convenience of the patient, the attending *physician*, or other provider
- furnished at the most appropriate level which can be provided safely and effectively to the patient

If there are two or more *medically necessary* services that may be provided for the illness, injury, or medical condition, Blue Shield will provide benefits based on the most cost effective service.

Hospital inpatient services which are *medically necessary* include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the

physician's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

Blue Shield reserves the right to review all claims to determine whether services are *medically necessary*, and may use the services of *physician* consultants, peer review committees of professional societies or hospitals, and other consultants.

How To File a PPO Claim

You or your provider must file a claim for *covered expenses*. If you have coverage through another group medical plan, your *company* plan may coordinate benefits with that plan. If your benefit claim is denied, you may appeal that decision. See **Claims and Appeals** in the Other Important Information section for details.

This chart describes when you must file a claim under the PPO plan option:

If the provider is:	Claims are usually filed by:
A hospital or *physician*	The hospital or *physician* Usually, you need do nothing but present your Medical Plan identification card. However, it is your responsibility to make sure the necessary claim information has been provided to Blue Shield
Other than a hospital or *physician* (for example, an ambulance service)	You may be required to file a claim when you have *covered expenses.* Claim forms are available from Blue Shield's customer services department or via the website. Send the completed claim form, along with copies of the bills showing the provider's name and address, the patient's name, the diagnosis, the date of service, a description of the service, and the billed charges to the address shown on the claim form. You must: • Submit the claim form no later than the end of the calendar year following the year you received the treatment or service • Include all the information requested on the claim form • Attach the explanation of Medicare benefits if: The patient is age 65 or older, or You are an employee and have Medicare as the result of a disability

PPO Coordination of Benefits

When you or your eligible dependents are covered under a *company*-sponsored Medical Plan and another medical plan, the plans may work together to pay benefits. The rules vary depending on the types of plans by which you are covered. See **Coordination of Benefits** in the Health Care Overview section for more details.

Medicare Eligibility While You Are Still Employed

If you are still working, and you or your dependents are covered by Medicare, your *company* Medical Plan is the primary plan except for patients with End Stage Renal Disease. Medicare is secondary until you retire.

If you or your dependents are eligible for Medicare as a result of End Stage Renal Disease, after completion of the Medicare coordination period, *company* plan coverage will be coordinated with Medicare in accordance with Federal law.

If you are a disabled employee who has been approved for Social Security disability benefits and, subsequently you become eligible for Medicare, Medicare is the primary plan and the *company's* plan is secondary. If any of your dependents are, or become, eligible for Medicare, the *company's* Medical Plan continues to be their primary plan and Medicare is their secondary coverage, except in the case of End Stage Renal Disease.

Health Maintenance Organization (HMO) Medical Plan Options

If you choose an HMO Medical Plan option other than Kaiser Permanente, you must choose a primary care *physician* (PCP) or primary care medical group to coordinate your medical care. Generally, you must use the HMO's *physicians* and hospitals. Exceptions are noted below. Each HMO has a specific service area in which services are offered. To be eligible for enrollment in a specific HMO, your residence ZIP code **must** be in the HMO's service area.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

This is a description of how the HMOs work. Each HMO is the final authority on its plan provisions, covered services and exclusions.

Note that some HMO benefits may vary according to which state members live in. Therefore, you should review the information available from the HMOs, or contact the HMOs directly, for specific information.

How HMOs Work

Depending on where you live and the *company* you work for, you may select:

- Health Net of California HMO
- Kaiser Permanente
- UnitedHealthcare HMO

An HMO is a group of doctors, specialists, and a hospital (or hospitals) that agree to take care of most of your medical care needs in return for a monthly fee and relatively small copayments at the time you receive treatment.

In rare cases, your primary care *physician* (PCP) may obtain preauthorization from the HMO option to refer you to a provider outside of the network. Otherwise, HMOs require you to use their facilities and *physicians* except in an *emergency* situation. Generally, there are two types of HMOs:

- **Open Panel, Individual Practice Association.** An association of *physicians* in private practice who also provide HMO services. These *physician* members practice medicine in their own offices
- **Closed Panel, Group Practice.** A group of *physicians* who practice medicine as a coordinated staff in one or more medical facilities

When you first enroll in an HMO or during annual enrollment, you select a primary care *physician* (PCP) for yourself and each enrolled family member. HMOs allow each family member to choose a different PCP. If, for some reason, you wish to change your primary care *physician*, medical group or medical care center during the year, contact the HMO for more information about its procedure.

If you enroll in the Kaiser Permanente option, you do not have to select a PCP during annual enrollment. Kaiser allows you to select your PCP when you need care.

Your PCP, medical group or medical care center:

- Is responsible for your basic medical services
- Guides you to appropriate specialists (specialty care usually requires a written referral or prior authorization in order for benefits to be paid)
- Assures continuity of care
- Provides preventive care and treatment when you are ill
- Orders necessary laboratory, x ray and other routine diagnostic tests and studies
- Arranges any required stays in a hospital

HMOs require a small copayment for *physician* visits and some other services. HMOs do not have *deductibles*.

HMO *Emergency Care*

In a true medical *emergency*, use your best judgment - call 911 or go immediately to the nearest emergency room. Generally, you pay a copayment for the emergency room whether you receive care in a contracted hospital or non-contracted hospital.

If you are admitted to the hospital, the copayment is waived.

You will be covered in a true *emergency* as long as you call your PCP's office within 24 hours after the *emergency*. If you do not call your PCP's office within 24 hours, or it is not a true *emergency*, no benefits are payable.

Each HMO option has a slightly different definition of an *emergency* and you should check with your HMO for its specific definition. The following is a general definition of *emergency* services:

- A *medically necessary* medical or hospital service required as the result of a medical condition manifesting itself by the sudden onset of symptoms of sufficient severity (including severe pain) such that a reasonable person would expect the absence of immediate medical attention would result in:

- Placing your health or, in the case of pregnancy, the health of the woman or her unborn *child*, in serious jeopardy
- Serious impairment to your bodily functions
- Serious dysfunction of any bodily organ or part

Examples of medical conditions requiring *emergency* services include, but are not limited to, heart attacks, strokes, poisonings, active labor or sudden inability to breathe.

Urgently Needed Care

Urgently needed care is *medically necessary* care required **outside the 30 mile radius service area** of your PCP's medical group to prevent serious deterioration of your health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that treatment cannot be delayed until you return to your PCP's medical group service area.

Urgent situations refer to less serious medical conditions than *emergency* situations. Examples include, but are not limited to:

- Broken bones (e.g., arm, leg)
- Non-life threatening cuts that require immediate suturing to ensure proper healing
- Acute illnesses when you are outside your PCP's medical group service area and the delay necessary to return to the service area or to contact your PCP's medical office would result in a serious deterioration in your health

What to do When You Require *Emergency* or Urgently Needed Care

Wherever you are, if you believe that you require *emergency* care or urgently needed care, you should call 911 or go directly to the nearest medical facility for treatment if the severity of the injury or illness is such that the time required to first call your PCP would reasonably result in a serious deterioration in your health or place your life in serious jeopardy. As soon as reasonably possible, and within 24 hours of your need for *emergency* or urgently needed care, however, you should:

- Call — or have someone on your behalf call — your PCP's office. The telephone number will usually be on your Medical Plan ID card. Assistance is available 24 hours a day, seven days a week
- Identify yourself and the Medical Plan option (e.g., Health Net HMO) you participate in and ask to speak to a *physician*. If you are calling during non-business hours and a *physician* is not immediately available, ask to have the *physician*-on-call paged. A *physician* should call you back shortly
- Explain your situation and follow the instructions provided

It is important that you notify your HMO option or your PCP's office within 24 hours after the initial receipt of *emergency* or urgently needed care to inform them of the location, duration and nature of the services provided and to enable them to coordinate follow-up care.

What the HMO Options Cover

The HMO options cover similar types of services covered by the PPO option. The packet of materials available from each HMO provides specific details on what is covered. Be sure to check that information or call your HMO's Member Services department for specific information about covered services. The **Medical Plan Options Comparison chart** shows the benefit levels. Here is a list of covered services when you use HMO providers:

- Allergy testing, allergy serum and allergy injection services
- Ambulance services for *emergency* transportation
- Anesthetics, including their administration
- Blood transfusions, including blood processing and the cost of unreplaced blood products. Donor fees are not covered
- Behavioral health and substance abuse treatment, including serious mental health conditions (schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive development disorder (autism), anorexia nervosa, bulimia nervosa) and severe emotional disturbances of *children*
- Chiropractic care
- Medical or surgical services of a *physician*, including office visits and consultations, hospital and skilled nursing facility visits

- Hospital services and supplies
- Hospital room and board at the most common semiprivate room rate
- Hospital services in special care units such as intensive care
- Injectable medications approved by the Food and Drug Administration (FDA) when dispensed by a *physician* or qualified home health care agency
- Pediatric and adult immunizations and the immunizing agent, as *medically necessary* and recommended by the American Academy of Pediatrics and United States Public Health Service
- X rays and laboratory tests
- X ray, radium and radioactive isotope therapy
- Radiation therapy, chemotherapy and renal dialysis treatment
- Outpatient surgery services and supplies in a freestanding ambulatory surgery facility such as a *physician's* office, a short stay surgical unit or outpatient unit of a hospital
- Physical therapy for the treatment of illness or injury, provided by a *physician*, registered physical therapist, certified occupational therapist, respiratory therapist or licensed podiatrist
- Home infusion therapy, including the cost of pharmaceuticals administered intravenously and medical supplies ordered by the attending *physician*
- Prosthetics and corrective appliances. If more than one type of prosthetic device or corrective appliance is available, benefits will be provided for the device or appliance that is consistent with professionally recognized standards of practice
- Home medical equipment and supplies needed to operate home medical equipment, oxygen and its administration
- Speech therapy for correction of speech impediments caused by illness or injury to the vocal organs, oral cavity, or auditory canal, or caused by stroke or brain injury, congenital anomalies following corrective surgery or cerebral palsy
- Pregnancy-related services such as prenatal and postnatal care, and delivery. *Covered expenses* include prenatal diagnostic procedures in the case of high-risk pregnancies
- Family planning services, including tubal ligation and vasectomy, contraceptive devices (diaphragms and intrauterine devices) and fittings, and prescription contraceptives
- Infertility services, including professional, hospital, ambulatory surgery center, ancillary services and injectable drugs administered to diagnose and treat the cause of infertility. Coverage is provided for artificial insemination and correction of physical obstruction or other physical problems (Limitations apply. See **What the HMO Options Do Not Cover** in this summary.)
- Home health care services
- Hospice care services
- Services at skilled nursing care facilities
- Breast reconstruction after a mastectomy. Coverage is available in a manner determined in consultation between the patient and her *physician* for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prosthesis and physical complications for all stages of mastectomy, including lymphedemas. Such coverage is subject to all the terms and provisions of the plan option, including any relevant copayment provisions
- Gender reassignment services when prescribed by a *physician*, subject to the following conditions (available only to employees and their dependents; retirees and dependents of retirees are not eligible).

  Coverage for gender reassignment services shall be limited to treatment plans that conform to World Professional Association for Transgender Health's standards, which may include psychotherapy, pre- and post-surgical hormone therapy, and sex reassignment surgery performed by a qualified professional. The services must be pre-certified with the Medical Plan administrator and be performed at a Center of Excellence or other designated facility approved by the Medical Plan administrator. The benefits for gender reassignment services shall be subject to the Plan's provisions and coverage levels, except that benefits for these services shall be capped at a maximum lifetime benefit of $75,000 per participant.

About Childbirth: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn *child* to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any

case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

The HMO will review your maternity stay if the length of stay will exceed 48 hours (or 96 hours in cases where a cesarean section is performed). An admission exceeding these times requires authorization and is subject to review for medical appropriateness. Your PCP is responsible for obtaining any required authorization.

Any pregnancy-related hospital stay will be treated like any other illness.

Preventive Health Services

The HMO options emphasize preventive health services and provide a wide range of services for adults and *children* covered by the HMO. These services include:

- Well-*child* care, including routine newborn care in the hospital, periodic physical examinations and laboratory services, immunizations (diphtheria, tetanus and pertussis, polio, smallpox, measles and related boosters), tuberculin tests, and eye and ear screenings (provided by your PCP)
- Screenings for blood lead levels in dependent *children* at risk for lead poisoning, as ordered by a pediatrician
- Preventive care for women
  - Mammography
  - Pelvic exam and breast exam
  - Routine cervical smear or Pap smear
  - Breast-feeding support, supplies and counseling
  - FDA-approved contraception methods and contraceptive counseling
  - Screening and counseling for interpersonal and domestic violence
  - Gestational diabetes screening
  - HIV screening and counseling
  - Human papillomavirus (HPV) testing (beginning at age 30 and every three years thereafter)
  - Sexually transmitted infections counseling
  - Well-woman visits
- Sigmoidoscopy or colonoscopy for screening and diagnostic purposes
- Health appraisal services, including periodic physical examinations and adult immunizations and vaccinations

For more details about these and other covered preventive health services, including the frequency each service is available, you may contact the HMO's Member Services department.

Organ Transplant Services

The HMO options cover certain types of organ transplants, with coordination by your PCP and upon approval of the HMO. In some cases, the HMO and your PCP may refer you to a "Center of Excellence." This is a hospital selected by the HMO to provide specific treatment for complex medical conditions or diseases. These hospitals are selected because they have among the highest success rates in the United States for a specific procedure.

The organ transplant benefits cover services in connection with the transplant of an organ, bone marrow or tissue for an enrolled person who receives the transplant and his or her donor. Benefits are reduced by any amounts paid or payable by the donor's own coverage.

If you need more information about organ transplant benefits, you may contact the HMO's Member Services department at the telephone number on your Medical Plan identification card.

Prescription Drug Benefits

Prescription drugs are covered at the benefit levels shown in the **Medical Plan Options Comparison chart** in the front of this summary, subject to the restrictions listed below.

With the HMO options, the plan pays 80% of the cost for brand name drugs and 90% of the cost for generic drugs, in and out-of-network.

If you are enrolled in Kaiser, you must use a Kaiser pharmacy and the plan will pay 80% of the contracted cost of brand name drugs and 90% of the cost for generic drugs. If you choose a non-Kaiser pharmacy, you pay the full cost for generic and brand name drugs.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Prescriptions may be filled at a frequency that is considered *medically necessary*.

Mail Order Prescriptions – Select Home Delivery

If you or a covered dependent take long-term or ongoing medication and are enrolled in any Medical Plan option except Kaiser or a Medicare Advantage plan, you will be contacted by Express Scripts to enroll in the Select Home Delivery program. The program encourages you or a covered dependent to obtain a 90-day supply through Express Scripts' mail order prescription service. You or your covered dependent have the option to opt out of the Select Home Delivery program at anytime. For additional information, please contact an Express Scripts' Select Home Delivery representative at (888) 772-5188.

Specialty Drugs - CuraScript

If you or a covered dependent are enrolled in any medical plan other than Kaiser or a Medicare Advantage plan, and take a specialty medication (oral or injectable) for conditions such as cancer, hemophilia, hepatitis C, multiple sclerosis, HIV/AIDS, rheumatoid arthritis, etc,, you will be required to use Express Scripts' specialty pharmacy, CuraScript. For additional information, please contact a CuraScript representative at (866) 848-9870.

Injectable medications (except insulin) may be available through your primary care *physician's* medical group or through the prescription drug benefit program. Check with your HMO's Member Services department to get more information.

If you are enrolled in the Health Net HMO or the UnitedHealthcare HMO, your prescription drug benefit does not use a managed formulary. However, certain medications may require prior authorization to ensure that they are medically indicated and prescribed for the specific condition for which they were originally intended to treat.

If you are enrolled in Kaiser, "restricted medications" require a prescription from a Kaiser specialty provider. Contact Kaiser for additional information.

Prior Authorization Process

Express Scripts' prior authorization program helps to ensure the appropriate use of medications. The program utilizes peer-reviewed guidelines established by Clinical Pharmacists and Physician Specialists. The guidelines are intended to promote the appropriate use of certain medications.

Medications are typically added to the Prior Authorization list due to the concern for patient safety, or limited use established by the FDA or due to the high cost of the medication.

The prior authorization program provides coverage for some drugs only if they are prescribed for certain uses. If you are prescribed medication that must be pre-authorized, your retail pharmacist or mail service representative should inform you. You will need to ask your doctor to call the **Express Scripts Prior Authorization Line** at **(800) 698-0190**. This line is available to doctors and not Express Scripts' members. The prior authorization review process can generally be completed during the phone call with your doctor. However, if additional information is needed before a decision can be reached, the process can typically take two business days. The patient and doctor will be notified when the review process is completed. If your medication is not approved for coverage, you will have to pay the full cost of the drugs.

Drugs that require prior authorization are:

- Growth hormones
- Anti fungal medications
- Injectible medication for rheumatoid arthritis
- Tretinoin agents used in the treatment of acne and/or for cosmetic purposes, e.g., Retin-A
- Agents used to suppress appetite and control fat absorption
- Other drugs as assigned

What the Pharmacy Benefit Program Does Not Cover

No benefits are provided for:

- Any drug provided or administered while you are an inpatient, or in a *physician's* office
- Take home drugs received from a hospital, convalescent home, skilled nursing facility or similar facility
- Except for insulin, drugs which can be obtained without a prescription or have a non-prescription equivalent
- Drugs for which you are not legally obligated to pay, or for which no charge is made
- Medical devices or supplies

- Blood or blood products
- Dietary or nutritional products, unless prescribed by a *physician* and not available over-the-counter
- Any injectable drug, except Insulin, Glucagon, and *medically necessary* Bee Sting Kits. Other injectable medications may be covered under the medical benefit provisions of the HMO option or under Express Scripts' Prior Authorization Program
- Appetite suppressants and other weight loss medications, unless prescribed by a *physician* and not available over-the-counter
- Smoking cessation drugs, unless prescribed by a *physician* and not available over-the-counter
- Drugs used for cosmetic indications only
- Depigmentation products used for skin conditions requiring a bleaching agent
- Implants
- IUDs
- Non-FDA approved drugs or drugs used for indications not approved by the FDA
- Prescription multi-vitamins that have over the counter equivalents
- Supplemental agents
- Prescription homeopathic drugs
- Drugs purchased outside the United States unless in an *emergency* situation

Maximum Benefits

There is no lifetime maximum under the HMO options.

What the HMO Options Do Not Cover

Each HMO has specific exclusions and limitations. More details are available in the information available from each HMO, or by calling your HMO's Member Services department. In general, here are some services the HMOs do not cover:

- Expenses for services that are not *medically necessary*
- Expenses incurred either before the person's plan option coverage begins or after his or her coverage ends
- Services for which you are not required to pay
- Cosmetic surgery, except breast reconstructive surgery performed following a *medically necessary* mastectomy
- Cosmetic procedures, or any resulting complications. However, *medically necessary* services to treat complications of cosmetic surgery (such as infections or hemorrhages) are covered
- Dental services except immediate accidental injury to natural teeth
- Eyeglasses or refractive eye surgery, including any associated examinations for the fitting of eyeglasses or in preparation for refractive eye surgery
- Contact lenses, including any associated examinations for the fitting of contact lenses, unless *medically necessary* to treat eye conditions such as keratoconus and keratitis sicca or when required as a result of cataract surgery when no intraocular lens has been implanted
- Hearing aids
- Low vision aids and devices
- Optometrics and orthoptics
- Outpatient speech therapy, except in relation to surgery, injury or non-congenital disease
- Genetic testing and diagnostic procedures for the purpose of identifying or making a diagnosis of genetic disorders, except that prenatal diagnosis of genetic disorders of the fetus in high-risk pregnancies is covered
- Routine foot care including callus, corn paring or excision, toenail trimming, shoe inserts and treatment (other than surgery) of chronic conditions of the foot, including but not limited to weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot, except as required for *medically necessary* diabetic foot care, for special footwear required for foot disfigurement (except as specifically listed as a covered service)
- Sex change procedures or treatment, except as provided under **What the HMO Options Cover**
- Services or treatments for or incident to non-physically related sexual dysfunction
- Reversal of vasectomy or tubal ligation, repeat vasectomy or tubal ligation
- Experimental or investigational services
- *Custodial care* or domiciliary care, regardless of the type of facility

- Inpatient room and board charges in connection with a hospital stay that is mainly for environmental change, physical therapy or treatment of chronic pain
- Services or supplies provided by a noneligible institution. In general, a noneligible institution under the plan option is one that is not a legally operated hospital or Medicare-approved skilled nursing facility
- Miscellaneous hospital expenses that are primarily for personal or comfort purposes
- Private room and board expenses, except when a private room is *medically necessary*
- Private duty nursing
- Treatment for autism, hyperkinetic syndrome, learning disability, mental retardation, developmental deficits or behavioral problems except as required by state or federal mandate
- Transplants other than those that are not *experimental or investigational* organ, bone marrow and tissue transplants approved by the HMO
- Over-the-counter medications not requiring a prescription
- Items for home use such as disposable sheaths and medical supplies, exercise or hygienic equipment, environmental control equipment, home monitoring and testing devices and equipment, support appliances and supplies such as stockings, orthopedic shoes, and arch supports, comfort items and food or nutritional supplements
- Any treatment of a condition that is related to an occupational illness or injury
- Professional medical services provided by a family member who either lives in your home or is related to you by blood or marriage
- Conditions caused by acts of war or by the person's commission of an illegal act
- Services provided by, or which are paid by, a local, state, or federal government agency. This limitation does not apply to MediCal, Medicaid or Medicare
- Any expenses related to the alteration of the person's home to accommodate a particular medical or physical condition, whether authorized by your *physician* or not
- Services incident to or resulting from procedures for a surrogate mother or in connection with a surrogate parenting agreement
- Penile implant devices and surgery, and any related services except for any resulting complications
- Home monitoring equipment, except for use of the peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes and the apnea monitor for management of newborns apnea when authorized as home medical equipment
- Vocational, educational, recreational, art, dance, music therapy, weight control or exercise programs
- Any services related to the harvesting or stimulation of the human ovum (including medications, laboratory and radiology service)
- Any services related to the reversal of sterilization, surrogate procedures, or for collection, purchase or storage of sperm or eggs
- Advanced infertility procedures, including In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures
- Services by interns, residents or others involved in medical training programs
- Drugs determined by the HMO's Pharmacy Benefit Manager as being duplicative or ineffective.
- Treatment or procedures that are not approved by the Food and Drug Administration which require that approval

HMO Claims and Review Procedures

If you enroll in an HMO option, you do not need to file any claim forms. Your *physician* handles it for you.

By selecting an HMO, you are agreeing to follow the procedures of that program. This typically includes arbitration as the method of resolving disputes. Each HMO has its own review procedure.

If you are denied services or if your benefit claim is denied, you may appeal that decision. For information about the appeal procedures, see the **Claims and Appeals** in the Other Important Information summary in this handbook.

Coordination of Benefits

When you or your eligible dependents are covered under a *company*-sponsored Medical Plan option and another medical plan, the plans may work together to pay benefits. The rules vary depending on the types of plans by which you are covered. See **Coordination of Benefits** in the Health Care Overview for more details.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Medicare Eligibility While You Are Still Employed

If you are still working, and you or your dependents are covered by Medicare, your *company* Medical Plan option is the primary plan except for patients with End Stage Renal Disease. Medicare is secondary until you retire.

If you or your dependents are eligible for Medicare as a result of End Stage Renal Disease, after the completion of the Medicare coordination period, Medicare becomes the primary plan and the *company's* plan option will be secondary.

If you are a disabled employee who has been approved for Social Security disability benefits and subsequently you become eligible for Medicare, Medicare will be your primary medical coverage and the *company's* plan option will be your secondary coverage. If you select a Medicare Advantage plan, you assign your Medicare benefits to that plan and they provide your Medicare benefits through the Medicare Advantage plan along with any additional benefits the plan provides in addition to Medicare's. If any of your dependents are, or become, eligible for Medicare, the *company's* plan option continues to be their primary plan and Medicare is their secondary coverage, except in the case of End Stage Renal Disease.

Blue Shield of California Exclusive Provider Organization (EPO) Medical Plan Option

The EPO option is available to employees and retirees in the United States who live outside of California.

How the EPO Option Works

Details of the EPO's benefit levels are shown in the **Medical Plan Options Comparison chart** at the front of this summary. Here is how the benefits work for this option:

- You must use a Blue Cross Blue Shield network provider (out-of-network services are not covered except for an *emergency*)
- You are not required to satisfy an annual *deductible* before the plan begins paying benefits
- The plan pays 100% of most covered services. Your Express Scripts prescription drug benefit under the EPO pays 90% of the cost for generic and 80% of the cost for brand name drugs and individual/family annual *out-of-pocket* maximums (separate from plan's annual *out-of-pocket* maximum) will apply
- The annual *out-of-pocket* maximum includes your office visit copays
- Preventive care (physicals, well-*child* care, well woman, etc.) is covered
- *Emergency* care for a true medical *emergency* (see ***Emergency* Care** in this summary) is covered. You pay a copayment for the use of the emergency room. If you are admitted to the hospital, the copayment is waived

You must also call ahead for precertification.

Precertification

Precertification/prior authorization is required for selected inpatient and outpatient services, supplies, and *durable medical equipment*; PKU related formulas and special food products; admission into an approved hospice program; and certain radiology procedures. Preadmission review is required for all inpatient hospital and skilled nursing services (except for *emergency* services).

You or your *physician* must call (800) 343-1691 for prior authorization for the services listed in this section, except for outpatient radiological services. For prior authorization of radiological services you or your *physician* must call (888) 642-2583 for services received in California:

- admission into an approved hospice program
- clinical trial for cancer benefits
- select injectable drugs administered in the *physician* office setting
- home health care benefits from a non-preferred provider
- home infusion/home injectable therapy from non-preferred providers
- *durable medical equipment*, including, but not limited to, motorized wheelchairs, insulin infusion pumps, and CPAP (continuous positive air pressure) machines

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- surgery services which may be considered to be cosmetic in nature, rather than constructive, e.g., eyelid surgery, rhinoplasty, abdominoplasty, or breast reduction; and those reconstructive surgeries which may result in only minimal improvement in function or appearance. Reconstructive surgery is limited to *medically necessary* surgeries.
- arthroscopic surgeries of the temporomandibular joint (TMJ)
- PKU related formulas and special food products
- special transplant benefits (see transplant section)
- all bariatric surgery
- outpatient speech therapy services
- hospital and skilled nursing facility admissions that are not the result of an *emergency*
- outpatient radiological procedures when performed in an outpatient setting on a non-*emergency* basis: CT (computerized tomography scans), MRIs (magnetic resonance imaging), MRAs (magnetic resonance angiography) PET (positron emission tomography) scans, and any cardiac diagnostic procedure utilizing nuclear medicine.

For retirees with Medicare for whom Medicare is primary, Medicare is the certifying body (since they are the first payer), so those members are not subject to these same pre-certification requirements, as long as Medicare pays first.

How to Obtain Precertification

To obtain precertification, call the telephone number for your EPO provided on your Medical Plan identification card. A nurse or *physician* reviewer in the EPO's precertification unit will then review the medical information provided. The reviewer will approve the services, deny the services, recommend a second opinion or recommend that services be performed on an outpatient basis in order to receive the maximum available benefit.

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

The EPO requires precertification of a maternity stay if the length of stay will exceed 48 hours (96 hours in cases where a cesarean section is performed). An admission exceeding these times requires authorization and is subject to review for medical appropriateness. You are responsible for obtaining any required authorization.

Any pregnancy-related hospital stay will be treated like any other illness.

What the EPO Option Covers

The EPO covers those *medically necessary* expenses for treatment or services that are shown below. All charges above the *reasonable and customary* amount are your responsibility. Some special benefits are covered at different coinsurance levels and have their own annual maximums.

The following expenses are covered by the EPO option at the benefit levels shown in the **Medical Plan Options Comparison chart**, when *medically necessary*. For more details about these and other covered services, you may contact the EPO's Member Services department at the telephone number listed in the Other Important Information section of this handbook or on your Medical Plan identification card.

- Allergy testing and treatment
- Ambulance services for *emergency* local transportation air ambulances and transportation via ambulance for long distances
- Blood and blood components
- Bariatric surgery is covered when pre-authorized by Blue Shield, meets medical necessity guidelines and is performed at a Center of Excellence
- Visits by a *physician*, including office visits and visits to your home, hospital and skilled nursing facility visits, and visits to a substance abuse treatment facility
- Clinical trials for cancer. Benefits are provided for routine patient care for members who have been accepted into an approved clinical trial for cancer when pre-authorized by Blue Shield

- Consultations requested by your attending *physician* when you are an inpatient in a hospital or skilled nursing facility and another *physician's* advice is needed for diagnosis or treatment of a condition that requires special skill or knowledge (not covered if done solely because of hospital regulations or by a *physician* who renders surgery or maternity service during the same admission)
- Hospital room and board and general nursing care in a semi-private room, in a private room or in an intensive care unit
- Ancillary hospital services (such as operating rooms, drugs and lab work)
- Preadmission testing for scheduled inpatient surgery
- Partial hospitalization treatment programs approved by Blue Shield of California
- Hospital services for outpatient surgery (outpatient surgery is also covered if performed at an ambulatory surgical facility)
- *Physician* (or dentist or podiatrist) services for surgery, including abortion, sterilization, (even if elective) and oral surgery. Benefits for oral surgery are limited to the following services:
  - Accidental injury to natural teeth
  - Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth
  - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth
  - Excision of exotoses of the jaws and hard palate (provided this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints

    The plan also pays benefits for an assistant surgeon (*physician*, dentist, or podiatrist) if a hospital intern or resident is not available for such assistance
- Anesthesia services if administered at the same time as a covered surgical procedure in a hospital or ambulatory surgical facility or by a *physician* other than the operating surgeon or by a Certified Registered Nurse Anesthetist (benefits will, however, be provided for anesthesia services administered by oral and maxillofacial surgeons in the surgeon's office or ambulatory surgical facility)
- Additional surgical opinion: one consultation and related diagnostic service by a *physician* (you may request an additional consultation if you believe the need for surgery is not resolved by the first arranged consultation)
- Medical and surgical dressings, supplies, casts and splints
- Radiation therapy treatments and chemotherapy
- Renal dialysis treatments in a hospital, dialysis facility, or in your home under the supervision of a hospital or dialysis facility
- Shock therapy treatments
- Diagnostic service related to surgery or medical care for an illness or injury
- Physical therapy to restore a useful physical function when provided by a registered professional physical therapist under the supervision of a *physician* and furnished under a written plan established by the *physician* before treatment begins (does not include educational training or services designed and adapted to develop a physical function)
- Occupational therapy to restore a useful physical function when rendered by a registered occupational therapist under the supervision of a *physician* and furnished under a written plan established by the *physician* before treatment begins (does not include educational training or services designed and adapted to develop a physical function)
- Speech therapy when rendered by a licensed speech therapist for the correction of a speech impairment resulting from disease, trauma, corrective surgery, congenital anomalies, or previous therapeutic processes and designed and adapted to restore a useful physical function (does not include educational training or services designed and adapted to develop a physical function). Not covered on an inpatient basis if speech therapy is the sole reason for admission
- Cardiac rehabilitation services within six months after hospital admission for myocardial infarction, coronary artery bypass surgery or percutaneous transluminal coronary angioplasty when provided through a program approved by Blue Shield of California
- Diabetes self-management training and education and one visit for medical nutrition therapy rendered by a *physician* or duly certified, registered or licensed nutritionist, dietician or nurse. Benefits are also available for regular foot care examinations of diabetes patients by a *physician* or podiatrist

- Maternity services incurred by an employee or the *spouse* or *domestic partner* of an employee, including covered services for normal pregnancies and complications of pregnancy as well as routine hospital nursery charges and a routine examination of the newborn by a *physician* other than the *physician* who delivered the baby or administered the anesthesia. Benefits will also be provided for covered services rendered by a certified nurse-midwife.
- Coordinated home health care services, subject to Blue Shield of California's criteria for a coordinated home care program. To be eligible, you must be homebound and require skilled nursing service on an intermittent basis under the direction of your *physician*. Home health care can include the following:
  - Skilled nursing service by or under the direction of a registered professional nurse
  - The services of physical therapists and hospital laboratories
  - Necessary medical supplies

  Benefits for coordinated home health care services are limited to 100 visits per calendar year.
- Private duty nursing when Blue Shield of California determines that the services provided are of such a nature or degree of complexity or quantity that they cannot be provided by the regular nursing staff of the facility where you are an inpatient or — in your home — by non-professional personnel. *Custodial care* is not covered
- Skilled nursing facility care (bed, board, general nursing care, and ancillary services such as drugs and surgical dressings or supplies); facility must be certified
- Hospice care services and supplies (in the home, a skilled nursing facility, or a special hospice care unit) in cases of terminal illness for a member who is experiencing the last phases of life, as certified by the attending *physician*, and the patient will no longer benefit from standard medical care or has chosen to receive hospice care rather than standard care. The following services are covered:

  Coordinated home care
  Medical supplies and dressings
  Medication
  Nursing services (skilled and non-skilled)
  Occupational therapy
  Pain management
  Physical therapy
  Physician visits
  Social and spiritual services
  Respite care services (short term)

  A family member or friend should be available to provide *custodial*-type *care* between visits from hospice care program providers if hospice is being provided in the home.

  In addition, benefits for bereavement counseling will be provided to family members if a member is in the Hospice Care Program at the time of death.
- *Medically necessary durable medical equipment* (DME) for activities of daily living, supplies needed to operate DME oxygen and its administration and ostomy and medical supplies. Other covered items include: peak flow monitor, glucose monitor, and apnea monitor. Benefits will also be provided for the rental (not to exceed the total cost of equipment) or purchase of *durable medical equipment* required for temporary therapeutic use, provided this equipment is primarily and customarily used to serve a medical purpose
- Prosthetic devices, special appliances, and surgical implants required to replace all or part of an organ or tissue of the human body or all or part of the function of a nonfunctioning or malfunctioning organ or tissue. Benefits also include adjustments, repair and replacements when required because of wear or change in a patient's condition (except for dental appliances other than intra-oral devices used to treat TMJ or related disorders and cataract lenses when a prescription change is not required)
- Dental accident care (dental services from a dentist or *physician* required as the result of an accidental injury)
- Leg, back, arm, and neck braces
- Breast reconstruction after a mastectomy. Coverage is available in a manner determined in consultation between the patient and the *physician* for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and physical complications for all stages of mastectomy, including lymphedemas. Such

coverage is subject to all the terms and provisions of the plan, including any relevant *deductibles* and copayment or coinsurance provisions

- Gender reassignment services when prescribed by a *physician*, subject to the following conditions (available only to employees and their dependents; retirees and dependents of retirees are not eligible). Coverage for gender reassignment services shall be limited to treatment plans that conform to World Professional Association for Transgender Health's standards, which may include psychotherapy, pre- and post-surgical hormone therapy, and sex reassignment surgery performed by a qualified professional. The services must be pre-certified with the Medical Plan administrator and be performed at a Center of Excellence or other designated facility approved by the Medical Plan administrator. The benefits for gender reassignment services shall be subject to the Plan's provisions and coverage levels, except that benefits for these services shall be capped at a maximum lifetime benefit of $75,000 per participant.

Emergency Care

In a true medical *emergency*, use your best judgment – call 911 (if available in your area) or go immediately to the nearest emergency room. True medical *emergencies* are covered at 100% after a copayment. If you are admitted to the hospital, the copayment is waived. Follow-up care is subject to the annual *deductible*.

The EPO's definition of a true *emergency* is an unexpected medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Examples of medical conditions requiring *emergency* services include, but are not limited to, heart attacks, strokes, poisonings, active labor or sudden inability to breathe.

Preventive Care

The EPO option pays benefits for wellness care. Wellness care is defined as – services based on the Guide to Preventive Services of the U.S. Preventive Services Task Force:

- Well *child* care up to age three
  - Immunizations
  - Routine physical examinations
  - Routine diagnostic tests
- Wellness care for persons age three and over:
  - Immunizations
  - Routine physical examinations
  - Routine diagnostic tests
- Preventive care for women
  - Routine mammograms
  - Routine cervical smear or Pap smear
  - Breast-feeding support, supplies and counseling
  - FDA-approved contraception methods and contraceptive counseling
  - Screening and counseling for interpersonal and domestic violence
  - Gestational diabetes screening
  - HIV screening and counseling
  - Human papillomavirus (HPV) testing (beginning at age 30 and every three years thereafter)
  - Sexually transmitted infections counseling
  - Well-woman visits
- Routine prostate-specific antigen test and digital rectal examinations for males
- Colorectal cancer screening with sigmoidoscopy/colonoscopy or fecal occult blood tests

Organ Transplant Services

Hospital and professional services provided in connection with human organ transplants to the extent that they are both:

- Provided in connection with the transplant of a cornea, kidney or skin, and
- You or your eligible dependent is the recipient of such transplant

Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank will be covered. Precertification is required under the EPO.

Special Transplant Services

Benefits are provided for certain procedures listed below, only if

- Performed at a Special Transplant Facility that has an agreement with the EPO to provide the procedure
- Prior authorization is obtained, in writing, from the EPO
- You or your eligible dependent is the recipient of the transplant, and
- The procedure is not *experimental* or *investigational* in nature as determined by the EPO

The EPO reserves the right to review all requests for prior authorization for these Special Transplant Services and to make a decision regarding coverage based on the medical circumstances of each patient, and consistency between the treatment proposed and the medical policy of the EPO.

If you do not obtain prior written authorization from the EPO and/or do not have the procedure performed at a facility and by a *physician* meeting the EPO's medical policy for special transplants, these services are not eligible for coverage.

The following procedures are eligible for coverage under this provision:

- Human heart transplants
- Human lung transplants
- Human heart and lung transplants in combination
- Human liver transplants
- Human kidney and pancreas transplants in combination (pancreas only transplants are not covered)
- Human bone marrow transplants; however, autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high dose chemotherapy is covered only for neuroblastoma in first and second remission without evidence of marrow involvement, glioblastoma when neurologically intact, multiple myeloma, testicular germ cell carcinoma that has progressed after conventional salvage chemotherapy, and for leukemia, lymphoma and Hodgkin's Disease in first or second remission
- Pediatric human small bowel transplants
- Pediatric and adult human small bowel and liver transplants in combination
- Autologous Chondrocyte Implantation/Transplantation

Services incident to obtaining the transplant material from a living donor or an organ transplant bank will be covered.

In connection with transplant procedures for which prior authorization has been obtained from the EPO and which are to be performed at a facility meeting the qualifications of the EPO's medical policy, as described above, travel and lodging expenses will be covered for:

- You or your eligible dependent
- A *spouse* or one other adult, when the transplant procedure is for an adult patient, or two parents, when the transplant procedure is for a dependent *child*
- The organ donor

Organ transplant benefits cover services in connection with the transplant of an organ, bone marrow or tissue for the enrolled person who receives the transplant and his or her donor. Benefits are reduced by any amounts paid or payable by the donor's own coverage.

If you need more information about organ transplant benefits, you may contact the EPO's Member Services department at the telephone number on your Medical Plan identification card.

Prescription Drug Benefits

Prescription drugs are covered at the benefit levels shown in the **Medical Plan Options Comparison chart** at the front of this summary, subject to the restrictions listed below.

The EPO pays 90% of the cost for generic and 80% of the cost for brand name drugs. Prescriptions may be filled at a frequency that is considered *medically necessary*.

Mail Order Prescriptions – Select Home Delivery

If you or a covered dependent take long-term or ongoing medication, you will be contacted by Express Scripts to enroll in the Select Home Delivery program. The program encourages you or a covered dependent to obtain a 90-day supply through Express Scripts' mail order prescription service. You or your covered dependent have the option to opt out of the Select Home Delivery program at anytime. For additional information, please contact an Express Scripts' Select Home Delivery representative at (888) 772-5188.

Specialty Drugs - CuraScript

If you or a covered dependent take a specialty medication (oral or injectable) for conditions such as cancer, hemophilia, hepatitis C, multiple sclerosis, HIV/AIDS, rheumatoid arthritis, etc., you will be required to use Express Scripts' specialty pharmacy, CuraScript. For additional information, please contact a CuraScript representative at (866) 848-9870.

Injectable medications (except insulin) may be available through your *physician* or through Express Scripts' prescription drug benefit program. Check with your Medical plan's Member Services department to get more information.

Your prescription drug benefit does not use a managed formulary. However, certain medications may require prior authorization to ensure that they are medically indicated and prescribed for the specific condition for which they were originally intended to treat.

Prior Authorization Process

The prior authorization program helps to ensure the appropriate use of medications. The program utilizes peer-reviewed guidelines established by Clinical Pharmacists and Physician Specialists. The guidelines are intended to promote the appropriate use of certain medications.

Medications are typically added to the Prior Authorization list due to the concern for patient safety, limited use established by the FDA, or due to the high cost of the medication.

The prior authorization program provides coverage for some drugs only if they are prescribed for certain uses. If you are prescribed medication that must be pre-authorized, your retail pharmacist or mail service representative should inform you. You will need to ask your doctor to call the **Express Scripts Prior Authorization Line** at **(800) 698-0190**. This line is available to doctors and not Express Scripts' members. The prior authorization review process can generally be completed during the phone call with your doctor. However, if additional information is needed before a decision can be reached, the process can typically take two business days. The patient and doctor will be notified when the review process is completed. If your medication is not approved for coverage, you will have to pay the full cost of the drugs.

Drugs that require prior authorization are:

- Growth hormones
- Anti fungal medications
- Injectible medication for rheumatoid arthritis
- Tretinoin agents used in the treatment of acne and/or for cosmetic purposes, e.g., Retin-A
- Agents used to suppress appetite and control fat absorption
- Other drugs as assigned

What the Pharmacy Benefit Program Does Not Cover

No benefits are provided for:

- Any drug provided or administered while you are an inpatient, or in a *physician's* office
- Take home drugs received from a hospital, convalescent home, skilled nursing facility or similar facility
- Except for insulin, drugs which can be obtained without a prescription or have a non-prescription equivalent
- Drugs for which you are not legally obligated to pay, or for which no charge is made
- Medical devices or supplies
- Blood or blood products
- Dietary or nutritional products, unless prescribed by a *physician* and not available over-the-counter

- Any injectable drug, except Insulin, Glucagon, and *medically necessary* Bee Sting Kits. Other injectable medications may be covered under the medical benefit provisions of the EPO or under Express Scripts' Prior Authorization Program
- Appetite suppressants and other weight loss medications, unless prescribed by a *physician* and not available over-the-counter
- Smoking cessation drugs, unless prescribed by a *physician* and not available over-the-counter
- Drugs used for cosmetic indications only
- Depigmentation products used for skin conditions requiring a bleaching age
- Implants
- IUDs
- Non-FDA approved drugs or drugs used for indications not approved by the FDA
- Prescription multi-vitamins that have over the counter equivalents
- Supplemental agents
- Prescription homeopathic drugs
- Drugs purchased outside the United States unless in an *emergency* situation

Chiropractic Services

The EPO pays for *medically necessary* chiropractic services at the benefit levels shown in the **Medical Plan Options Comparison chart**. Chiropractic services include visits to a *physician* or chiropractor (D.C.) for chiropractic services in connection with the detection or correction by manual or mechanical means of

- Structural imbalance
- Distortion
- Subluxation

where such care is for the purpose of removing nerve interference and its effects and where interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column.

Acupuncture Services

The EPO pays for *medically necessary* acupuncture services by a licensed acupuncturist. Acupuncture services include any expense related to the puncture of the skin for diagnostic or therapeutic purposes either manually through the use of needles or electrically through the use of needles or the Transcutaneous Electrical Nerve Simulation (TENS) device.

Podiatry Services

The EPO pays for *medically necessary* podiatry services. Routine foot care (except as required for *medically necessary* diabetic foot care) is not covered. Podiatry services include office visits, surgery, x rays, laboratory tests, castings or molds for special supports and orthotics.

Maximum Benefits

There is no lifetime maximum under the EPO option.

What the EPO Option Does Not Cover

While the EPO normally covers the treatments and services described under What the EPO Option Covers, there are circumstances in which those treatments and services will not be eligible for coverage. There are also some medical treatments and services the EPO does not cover.

The EPO covers the treatments and services described above. Treatments and services listed below are not covered. For specific information about whether a procedure or service is covered, contact the EPO administrator's Member Services department at the telephone number provided on your EPO administrator's identification card.

The EPO does not cover:

- Expenses for services that are not *medically necessary*
- Expenses for services that are not specifically listed as a covered service
- Expenses incurred either before the person's plan option coverage begins or after his or her coverage ends
- Cosmetic surgery, except breast reconstructive surgery performed following a *medically necessary* mastectomy

- Cosmetic procedures, or any resulting complications. However, *medically necessary* services to treat complications of cosmetic surgery (such as infections or hemorrhages) are covered
- Services for which you are not required to pay
- Dental services, except those specifically listed as a covered service. Spot grinding, crowns, orthodontia and bridges or other restorations or mechanical devices are not covered regardless of the reason for such services
- Eyeglasses or refractive eye surgery, including any associated examinations for the fitting of eyeglasses or in preparation for refractive eye surgery
- Contact lenses, including any associated examinations for the fitting of contact lenses, unless *medically necessary* to treat eye conditions such as keratoconus and keratitis sicca or when required as a result of cataract surgery when no intraocular lens has been implanted
- Low vision aids and devices
- Optometrics and orthoptics
- Routine foot care including callus, corn paring or excision, toenail trimming, shoe inserts and treatment (other than surgery) of chronic conditions of the foot, including but not limited to, weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot, except as required for *medically necessary* diabetic foot care, for special footwear required for foot disfigurement (except as specifically listed as a covered service)
- Outpatient speech therapy, except in relation to surgery, injury or non-congenital disease, when those services have been precertified through the precertification program
- Sex change procedures or treatment, except as provided under **What the EPO Option Covers**
- Penile implant devices and surgery, and any related services except for any resulting complications
- Services or treatments for, or incident to, non-physically related sexual dysfunction
- Any services related to the reversal of sterilization, surrogate procedures, or for collection, purchase or storage of sperm or eggs.
- Advanced infertility services (IVF, GIFT or ZIFT).
- Reversal of vasectomy or tubal ligation, repeat vasectomy or tubal ligation
- Experimental or investigational services
- *Custodial care* or domiciliary care, regardless of the type of facility
- Inpatient room and board charges in connection with a hospital stay that is mainly for environmental change, physical therapy or treatment of chronic pain
- Services or supplies provided by a noneligible institution. In general, a noneligible institution under the plan option is one that is not a legally operated hospital or Medicare-approved skilled nursing facility
- Miscellaneous hospital expenses that are primarily for personal or comfort purposes
- Private room and board expenses, except when a private room is *medically necessary*
- Private duty nursing
- Treatment for autism, hyperkinetic syndrome, learning disability, mental retardation, developmental deficits, or behavioral problems except as required by state or federal mandate
- Transplants other than those specifically listed as a covered service for organ, bone marrow and tissue transplants unless authorized in writing by the EPO administrator's precertification unit
- Over-the-counter medications not requiring a prescription
- Items for home use such as disposable sheaths and medical supplies, exercise or hygienic equipment, environmental control equipment, home monitoring and testing devices and equipment, support appliances and supplies such as support stockings, orthopedic shoes and arch supports, comfort items and food or nutritional supplements
- Any treatment of a condition that is related to an occupational illness or injury
- Professional medical services provided by a family member who either lives in your home or is related to you by blood or marriage
- Conditions caused by acts of war
- Services provided by, or which are paid by, a local, state, or federal government agency. This limitation does not apply to MediCal, Medicaid or Medicare
- Any expenses related to the alteration of the person's home to accommodate a particular medical or physical condition, whether authorized by your *physician* or not
- Rehabilitative care, except services under the National option that are precertified under the precertification program
- Charges in excess of the annual benefit maximums for podiatry, chiropractic, and acupuncture, and the lifetime maximums for hearing aids and non-surgical treatment of TMJ

- Transportation services other than for *emergency* transportation by a professional ambulance service
- Vocational, educational, recreational, art, dance, music therapy, weight control or exercise programs
- Services by interns, residents or others involved in medical training programs
- Drugs determined by the EPO administrator's Pharmacy and Therapeutics Committee as being duplicative or ineffective, or as having preferred formulary alternatives available
- Treatment or procedures that are not FDA-approved, but which require that approval

Medical Necessity (*medically necessary*)

Services which are *medically necessary* include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by the claims administrator are:

consistent with the claims administrator's medical policy
consistent with the symptoms or diagnosis
not furnished primarily for the convenience of the patient, the attending *physician*, or other provider
furnished at the most appropriate level which can be provided safely and effectively to the patient

If there are two or more *medically necessary* services that may be provided for the illness, injury, or medical condition, the claims administrator will provide benefits based on the most cost effective service.

Hospital inpatient services which are *medically necessary* include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the *physician's* office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

The claims administrator reserves the right to review all claims to determine whether services are *medically necessary*, and may use the services of *physician* consultants, peer review committees of professional societies or hospitals, and other consultants.

Coordination of Benefits

When you or your eligible dependents are covered under a *company*-sponsored Medical Plan option and another medical plan, the plans will work together to pay benefits. See **Coordination of Benefits** in the Health Care Overview for an explanation of which plan is primary and which plan is secondary.

Medicare Eligibility While You Are Still Employed

If you are still working, and you or your dependents are covered by Medicare, your *company* Medical Plan is the primary plan except for patients with End Stage Renal Disease. Medicare is secondary until you retire.

If you or your dependents are eligible for Medicare as a result of End Stage Renal Disease, after the completion of the Medicare coordination period, Medicare becomes the primary plan and the *company's* plan will be secondary.

If you are a disabled employee who has been approved for Social Security disability benefits and, subsequently you become eligible for Medicare, Medicare will be your primary medical coverage and the *company's* plan will be your secondary coverage. If any of your dependents are, or become, eligible for Medicare, the *company's* plan continues to be their primary plan and Medicare is their secondary coverage, except in the case of End Stage Renal Disease.

Preventive Health Account

Each year the *company* allocates $400 in credits to each eligible participant's Preventive Health Account. The account will reimburse your expenses for any organized exercise programs designed to improve your health or programs that are not covered services under the Medical Plan or any other benefit plan.

Who Is Eligible

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

You are eligible for the Preventive Health Account if you are:

- A *full-time* employee,
- A part-time plus employee,
- The *spouse* (or *domestic partner*) of an eligible employee, or
- The *child* of an eligible employee

This benefit is not available to retirees or *part-time* employees.

How the Preventive Health Account Works

Your PHA account will be credited effective the date you become an eligible employee and on each subsequent January 1.

If two *full-time* or *part-time plus* employees (or a *full-time* and a *part-time plus* employee) are married or have a *domestic partner* relationship, work for the *company*, and are eligible for the Preventive Health Account, each is eligible for $400 as an employee.

To be eligible for the PHA reimbursement as an employee, you must complete an online health risk assessment available through myHealthOnline. To gain access to myHealthOnline you must be a registered member. Log on to myHealthOnline at www.webmdhealth.com/edison or register as a new user. If you are a first time user, click on "Register Now" located just below the login boxes for returning users. You must complete your online assessment before submitting claims each year.

Services That Qualify for Reimbursement

The Preventive Health Account may be used for any organized exercise programs designed to improve your health or programs that are not covered services under the Medical Plan or any other benefit plan. Services that qualify for reimbursement through the Preventive Health Account include:

- Organized exercise programs
  - Entry fees for 5k, 10k marathons or other organized runs
  - Fees to participate in organized leagues, such as for T-ball, swimming, soccer, basketball, softball and bowling
  - Fees for martial arts, for example, tai chi, jujitsu, taekwondo, judo
  - Fitness memberships
- Health promotion classes
  - Personal trainers
- Smoking cessation programs
- Weight management programs (the PHA covers only program fees and membership fees; the PHA does not cover food or dietary supplements that may be available under the program)
- Yoga

The Preventive Health Account also covers nutritional counseling by a Registered Dietitian, with or without a diagnosis, where the patient requests Preventive Health Account payment.

The Preventive Health Account provides coverage for risk reduction and health education programs and services. Clinical preventive services (e.g., physical exams, immunizations, etc.) are covered under the Medical Plan options.

To be eligible for the PHA reimbursement, you must complete an online health risk assessment available through myHealthOnline before submitting your claim for reimbursement.

Claims and Reimbursement

When you have an eligible expense, submit a Preventive Health Account Claim form and an itemized invoice that includes a description of the services provided, the date provided, and your receipt or canceled check. You will also need to certify that you have completed the health risk assessment when completing the claim form, otherwise the claim will be denied. Claim forms are available by logging on to www.eixbenefits.com or by calling the *EIX Benefits Connection* at (866) 693-4947.

Do not include a cover letter if you submit your claim by fax. Sign the claim form and be sure to place it before your receipt/supporting documentation. Fax your claim and documentation to (866) 918-9713.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Reimbursements are included in your paycheck and are subject to applicable income taxes. Reimbursement may take up to two or three payroll cycles.

Your Preventive Health Account credits must be used for expenses incurred and paid for in the year the credits are allocated to your account. For multi-year contracts, you must submit a claim form for the first year and, subsequently, submit a claim form along with a copy of the same information, for each of the following years. Eligible expenses incurred and paid for within a calendar year must be submitted for reimbursement no later than March 31 of the following year. If you lose eligibility for PHA (e.g., termination from the *company*) you can continue to submit claims through March 31 of the following year. However, the expense must have been incurred prior to the end of the month you became ineligible.

Medical Benefits When You Retire

If you retire from the *company*, you may be eligible to participate in one of the Medical Plan options available to retirees and their covered dependents. See the **Continued Health Care Coverage** summary in this handbook for specific eligibility requirements for retirees and dependents and for information on how Medical Plan contributions are determined.

If you are a retiree who is eligible for Medical coverage, each year during annual enrollment you may choose from the available PPO, HMO, or EPO options until you become eligible for Medicare. Once you and/or your *spouse* become eligible for Medicare coverage, you may choose from the available:

- PPO 90/70 option with Medicare coordination of benefits (COB)
- EPO option with a Medicare coordination of benefits (COB) feature
- Medicare Advantage options
- Senior Supplement option
- Senior Security Supplement 3500 option

If you and your *spouse* are Medicare-eligible, you each **must** be enrolled in Part A (Hospital insurance) and Part B (Supplementary Medical insurance) of Medicare in order to have coverage under any Edison sponsored Medical plan options. If you or your Medicare-eligible *spouse* fail to enroll in Medicare Parts A and B upon initial eligibility, or if you fail to maintain your Medicare coverage under Parts A and B, you may be subject to Medicare Part B surcharges/penalties by Social Security and you may be terminated from the *company's* Medical plan. (Exception: Generally, if you are actively employed and are enrolled in group health insurance through your employer, you do not need to enroll in Medicare Parts A and B until you cease to be actively employed.)

As a retiree, when you attain age 65, your *company* Medical coverage becomes secondary to your Medicare coverage even if you have not enrolled in Medicare. Here are some other important points regarding retiree Medical coverage:

- Depending on where you live and the *company* you worked for, not all of the options listed above may be available to you
- *Children* are not eligible for enrollment in options with Medicare Coordination of Benefits features or in Medicare Advantage options even if they have Medicare coverage. Your *children* will be eligible for enrollment in a plan option offered to participants that are not eligible for Medicare coverage, provided that option is offered by the same Medical Plan option administrator that the Medicare eligible adult participants are enrolled in
- The PPO 90/70 and EPO (outside of California) options coordinate coverage with Medicare
- The Medicare Advantage option is an HMO that provides Medicare benefits, plus some benefits Medicare does not offer. When you choose this option, your Medicare benefits are provided through the HMO
- The Senior Supplement 3500 plan helps pay for *deductibles* and coinsurance not covered by Medicare
- Under the Senior Supplement option, you pay for the portion of health care costs not paid by Medicare until you meet your annual *deductible*. After you meet your annual *deductible*, the plan pays 100% of your medical expenses up to the lifetime maximum
  No individual may be enrolled for retiree coverage as both a retiree and a dependent of a retiree or an employee, or as a dependent of more than one retiree or employee
  Domestic partners are not eligible dependents for retiree Medical coverage. (*Same-sex spouses* and same-sex *registered domestic partners* are eligible for retiree Medical coverage.) After you retire, your *domestic partner* may be eligible for continued health care through the plan's **Continued Coverage for *Domestic Partners* and *Same-Sex Spouses***

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The Preventive Health Account does not apply to retirees
Behavioral health benefits are provided by the Medical Plan option in which you enroll

Note: Medicare coverage is primary for employees who become disabled and are Medicare-eligible; the *company* plan becomes secondary. If you are disabled and eligible for Medicare, you must enroll in Medicare Parts A and B upon initial eligibility. The *company* will provide a subsidy equal to the cost of the Medicare Part B premium, (this subsidy discontinues upon retirement from the *company*). If you fail to enroll in Medicare Part B, you will be subject to disenrollment from the *company's* Medical Plan. If this situation applies to you, you will receive additional information about the Medicare plan options available to you.

The following chart provides an overview of benefits coverage available to retirees eligible for Medical coverage. More specific information is provided following the chart.

Medical Plan Options Comparison for Medicare-Eligible Participants – Effective January 1, 2013						
Benefit Description	**Blue Shield PPO 90/70** **Medicare Coordinated**		**UHC Senior Supplement Plan** (not available outside of the United States)	**UHC Senior Supplement 3500 (all benefits paid after $3,500 *deductible* is met)** (not available outside of the United States)	**Health Net Seniority Plus Medicare Advantage HMO – California** **Kaiser Senior Advantage Medicare Advantage HMO – California** **UnitedHealthcare Medicare Advantage HMO – California**	**Blue Shield EPO – Outside California** (not available outside of the United States)
	In-Network	Out-of-Network	You can see any provider that accepts Medicare	You can see any provider that accepts Medicare	Primary care *physician* coordinated. You must use a network provider.	You must use a network provider.
Calendar Year *Deductible*						
Individual	Member pays $300		Member pays 100% of Medicare Part B *deductible* Member pays 50% of the Medicare Part A *deductible*	$3,500	None	None
Family	Member pays $600		Not applicable	Not applicable	None	None
Maximum Calendar Year Copay (excluding pharmacy) (includes *deductible*)						
Individual	$3,995		$4,620	Not applicable	$1,995	$1,995
Family	$7,990		Not applicable	Not applicable	$3,990	$3,990
Lifetime Maximum Benefit	None		None	None	None	None
Hospital Admission *Deductible* (per admission)	Member pays $250 *deductible*		50% of Medicare Part A *deductible*	Medicare Part A *deductible* until the $3,500 calendar year *deductible* is	None	None

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

				met		
Hospital						
Inpatient Care	Plan pays 90%	Plan pays 70%	After hospital admission *deductible* is met, plan pays 100% for first 150 days of a benefit period (includes 60 lifetime days) and 100% for additional 365 lifetime days; no benefit after 365 additional days	After calendar year *deductible* is met, plan pays 100% for first 150 days of a benefit period (includes 60 lifetime days) and 100% for additional 365 lifetime days ; no benefit after 365 additional days	No copay	No copay
Outpatient Facility Services	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	No copay	No copay
Outpatient Surgery	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	Health Net; UnitedHealthcare; - No copay Kaiser - $20 copay	No copay
Emergency Room Copay	Member pays $130 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient or for observation as an outpatient)		After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	Member pays $65 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient or for observation as an outpatient)	Member pays $65 copay (applies to hospital emergency room charges only; copay waived if admitted as an inpatient or for observation as an outpatient)
Ambulance Services	Plan pays 90%	Plan pays 90%	After member pays Medicare Part B *deductible*,	After calendar year *deductible* is met, Medicare and plan	No copay	No copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

			Medicare and plan pay 90% of Medicare allowable charge	pay 100% of Medicare allowable charge		
***Physician* Services**						
Office Visits	$25 copay	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	$20 copay	$20 copay
Inpatient Hospital Visits	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	No copay	No copay
Outpatient Hospital Visits	$25 copay	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	Health Net - No copay Kaiser; UnitedHealthcare; - $20 copay	$20 copay
Urgent Care Visits	$20 copay	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	$20 copay	$20 copay
Periodic Health Exam/Preventive Care	No charge (*deductible* waived)	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	No copay	No copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Gynecological Exam (for well woman)	No charge (*deductible* waived)	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	No copay	No copay
Immunization/Inoculation	No charge (*deductible* waived)	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	Health Net; Kaiser; – No copay UnitedHealthcare – No copay limited to Medicare covered immunizations	No copay
Allergy Testing	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	No copay	No copay
Allergy Treatment	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	No copay	No copay
Vision Exam/Screening (preventive or refractive)	Not Covered	Not Covered	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	Kaiser - No copay Health Net; UnitedHealthcare - $20 copy	Not covered
Hearing Exam/Screening (preventive care – not associated with a condition)	No charge (*deductible* waived)	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable	Health Net - $20 copay Kaiser; UnitedHealthcare – No copay	No copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

			charge	charge		
Surgery/Anesthesia	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	No copay	No copay
Diagnostic x ray/Lab	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	No copay	No copay
Prescription Drugs (provided through Express Scripts under Blue Shield PPO and Senior Supplement plans)						
Retail Pharmacy (34-day supply for Blue Shield PPO and Senior Supplement plans; 31-day supply for Medicare Advantage and Blue Shield EPO plans)	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs		Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs
Mail Order Pharmacy (90-day supply) (Contracted provider only)	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs		Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs	Plan pays 90% for generic prescription drugs; Plan pays 80% for brand name prescription drugs
Maximum co-payment/coinsurance per calendar year	$1,160 individual/ $2,320 family		$1,160 individual/ $2,320 family	$1,160 individual/ $2,320 family	$1,160 individual/ $2,320 family	$1,160 individual/ $2,320 family
Durable Medical Equipment	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B	After calendar year *deductible* is met,	No copay	No copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

			deductible, Medicare and plan pay 90% of Medicare allowable charge	Medicare and plan pay 100% of Medicare allowable charge		
Substance Abuse Treatment						
Inpatient	Plan pays 90%	Plan pays 70%	Plan pays the same as any other inpatient hospital stay	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	Health Net; Kaiser - No copay UnitedHealthcare – No copay limited to a 190 day lifetime limit	No copay
Outpatient	$25 copay	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	$20 copay	$20 copay
Behavioral Health						
Inpatient	Plan pays 90%	Plan pays 70%	Plan pays the same as any other inpatient hospital stay; 190 day maximum	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	Health Net; Kaiser - No copay UnitedHealthcare - No copay limited to a 190 day lifetime limit	No copay
Outpatient	$25 copay	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 77.5% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable charge	$20 copay	$20 copay
Home Health Services (prior authorization required; custodial care not covered)	Plan pays 90%	Plan pays 70%	Plan pays 100% of Medicare allowable charges after Medicare payment	After calendar year *deductible* is met, Medicare and plan pay 100% of Medicare allowable	No copay	No copay

	(up to 100 visits per calendar year)			charge	(Health Net – unlimited visits Kaiser – up to 100 visits per calendar year)	(up to 100 visits per calendar year)
Skilled Nursing						
Inpatient (hospital or skilled nursing facility)	Plan pays 90% (up to 100 visits per calendar year)	Plan pays 70%	Medicare pays days 1-20 in full; days 21-100 Plan pays 50% Part A skilled nursing facility per day copay; no benefit after day 100 in a benefit period = $66.75 per day; no benefit after day 100 in the same benefit period	Medicare pays days 1-20 in full; after calendar year *deductible* is met, Plan pays for days 21-100 in full; no benefit after day 100 in a benefit period	Health Net - No copay Kaiser; UnitedHealthcare - Medicare pays days 1-20 in full; Plan pays for days 21-100 in full; no benefit after day 100 in a benefit period	Medicare pays days 1-20 in full; Plan pays for days 21-100 in full; no benefit after day 100 in a benefit period
Outpatient	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Occupational Therapy						
Inpatient (hospital or skilled nursing facility)	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	No copay	No copay
Outpatient (office or home visits)6	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B deductible, Medicare and plan pay 90% of Medicare allowable charge	After calendar year deductible is met, Medicare and plan pays 100% of Medicare allowable charge	Health Net; UnitedHealthcare - No copay Kaiser - $20 copay	No copay
Physical Therapy						

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Inpatient (hospital or skilled nursing facility)	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	No copay	No copay
Outpatient (office or home visits)	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	Health Net; UnitedHealthcare - No copay Kaiser - $20 copay	No copay
Speech Therapy						
Inpatient (hospital or skilled nursing facility)	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	No copay	No copay
Outpatient (office or home visits)	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	Health Net; UnitedHealthcare - No copay Kaiser - $20 copay	No copay
Hospice	Plan pays 90%	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	No copay (covered by Medicare)	No copay (covered by Medicare)
Acupuncture	$25 copay	Plan pays 70%	Not Covered	Not Covered	Health Net - $15 copay Kaiser – Not covered	$20 copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	(30 visit maximum per calendar year)				UnitedHealthcare - $20 copay (30 visit maximum per calendar year)	(30 visit maximum per calendar year)
Chiropractic (30 visit maximum per calendar year)	$25 copay (30 visit maximum per calendar year)	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	Health Net; Kaiser - $15 copay UnitedHealthcare - $20 copay (30 visit maximum per calendar year)	$20 copay (30 visit maximum per calendar year)
Podiatry	$25 copay	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable charge	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	$20 copay UnitedHealthcare – limit of six visits per year	$20 copay
Orthotics (braces and supports)	$25 copay	Plan pays 70%	After member pays Medicare Part B deductible, Medicare and plan pay 90% of Medicare allowable charge	After calendar year deductible is met, Medicare and plan pays 100% of Medicare allowable charge	No copay	No copay
Blood and Blood Products	Plan pays 90%	Plan pays 90%	After member pays Medicare Part B deductible, Medicare and plan pay 90% of Medicare allowable charge	After calendar year deductible is met, Medicare and plan pays 100% of Medicare allowable charge	No copay	No copay
Hearing Aid Services						
Audiological Exam	$25 copay	Plan pays 70%	After member pays Medicare Part B *deductible*, Medicare and plan pay 90% of Medicare allowable	After calendar year *deductible* is met, Medicare and plan pays 100% of Medicare allowable charge	Health Net; UnitedHealthcare - $20 copay Kaiser – No copay	$20 copay

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

			charge			
Hearing Aids	Plan pays 90% ($1,500 maximum in a 36-month period)	Plan pays 90%	Not Covered	Not Covered	Benefit limited to $500 every 36 months	Benefit limited to $500 every 36 months
Foreign Travel (*medically necessary emergency* services only)	Covered in accordance with the benefits shown above for the services provided (translation of bills and monetary conversion is required)	Covered in accordance with the benefits shown above for the services provided (translation of bills and monetary conversion is required)	$250 *deductible* per calendar year. Plan pays 80% of Medicare allowable charges up to a maximum benefit of $50,000 per lifetime	$250 *deductible* per calendar year. Plan pays 80% of Medicare allowable charges up to a maximum benefit of $50,000 per lifetime	Not applicable	Not applicable

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Blue Shield PPO 90/70 and Blue Shield EPO Options

The Blue Shield PPO 90/70 and Blue Shield EPO options provide the same benefit coverage and features as described in the respective PPO and EPO sections for employees. Refer to these sections for coverage details.

Medicare Advantage Options

You can choose a Medicare Advantage option if you are enrolled in both Medicare Parts A and B and you are:

- An employee who is disabled, and is Medicare-eligible
- A retiree or a retiree's *spouse* who is:
  - Under age 65 but Medicare-eligible
  - Age 65 or older

The Medicare Advantage option is an integrated health care system that provides a broad range of medical services on a prepaid basis. For the most part, you do not need to handle the administrative details or submit claims for benefits. The Medicare Advantage option covers the same services that Medicare covers and provides coverage for some services that Medicare does not offer. You select a primary care *physician* (PCP) and your PCP coordinates all of your care. Except in case of *emergency*, you must go through your PCP and use doctors, hospitals, and other health care providers that participate in your Medicare Advantage option. If you do not, non-*emergency* services and supplies are not covered.

If you choose a Medicare Advantage option, you assign your Medicare benefits to the Medicare Advantage option and then receive prepaid services through the Medicare Advantage option, instead of from Medicare. It is important for you to assign your Medicare benefits only to a *company*-sponsored Medicare Advantage option if you want to retain the level of benefits arranged by the *company* for employees and retirees.

Each Medicare Advantage option offers a directory of participating PCPs. You may obtain directories and more information about the Medicare Advantage options from each plan's Member Services department.

UHC Senior Supplement

With the UHC Senior Supplement option, you have the freedom to use any provider in the United States who accepts Medicare. Medicare is the primary payer and the UHC Senior Supplement option is secondary payer.

UHC Senior Supplement is similar to a traditional Medicare Supplement or Medigap plan. The UHC Senior Supplement option helps cover the costs not covered by Medicare Parts A & B. In addition, the option provides an additional 365 days of hospital care beyond what Medicare covers.

With the UHC Senior Supplement option, no prior authorization is required for any services covered by Medicare. For services covered by Medicare Part B (office visits/lab, x ray specialist fees, including surgeons, etc.), you must pay the Medicare Part B *deductible*. After paying the Medicare Part B *deductible*, the plan pays 50% of the remaining Medicare approved amount after Medicare's payment for the Medicare Part B services. Any balance over the Medicare approved amount will be your responsibility. To reduce your costs, it is important to use a provider that accepts Medicare assignment. Typically the maximum that a provider that accepts Medicare assignment can charge is 15% above the Medicare allowable charge.

For inpatient hospital charges, the UHC Senior Supplement pays 50% of the Medicare Part A *deductible*, and the member pays the remaining 50%. For the first 150 hospital days (inclusive of the 60 lifetime reserve days), the plan will pay 100% of the balance after Medicare's payment for Medicare Part A services. The plan will continue to pay 100% of the Medicare approved charges for the next 365 additional lifetime days. Once these days are used, the member will be responsible for 100% of the charges. The plan also includes an annual out of pocket maximum. Once this out of pocket maximum is reached, the plan covers the remaining balance of the cost of services up to the Medicare allowable amount.

For a detailed list of covered services, please refer to **What the UHC Senior Supplement and Senior Supplement 3500 Options Cover**.

UHC Senior Supplement 3500

As with the UHC Senior Supplement option, the UHC Senior Supplement 3500 option enables you to use any provider in the United States who accepts Medicare. Medicare is the primary payer and the UHC Senior Supplement 3500 option is secondary.

UHC Senior Supplement 3500 is similar to a traditional Medicare Supplement or Medigap plan. The UHC Senior Supplement 3500 option helps cover the costs not covered by Medicare Parts A & B. In addition, the option provides an additional 365 days of hospital care beyond what Medicare covers. This option has an annual *deductible* (which includes the Medicare Parts A and B *deductibles*). You must pay your annual *deductible* before the UHC Senior Supplement 3500 option will begin paying benefits.

With the UHC Senior Supplement 3500 option, no prior authorization is required for any services covered by Medicare. Once the *deductible* is met, the UHC Senior Supplement 3500 plan will pay 100% of the remaining Medicare covered charges after Medicare's payment. This includes both inpatient and outpatient care. Any balance over the Medicare approved amount will be your responsibility. To reduce your costs, it is important to use a provider that accepts Medicare assignment. Typically the maximum that a provider that accepts Medicare assignment can charge is 15% above the Medicare allowable charge.

For a detailed list of covered services, please refer to **What the UHC Senior Supplement 3500 and Senior Supplement Options Cover**.

What the UHC Senior Supplement and Senior Supplement 3500 Options Cover

Covered services will be the same as those covered under Medicare Parts A and B and must be deemed *medically necessary* by UHC. Contact UHC at (800) 851-3802 for further details on any limitations or restrictions

Inpatient Benefits

Alcohol, drug or other substance abuse treatment and detoxification

Blood and blood products

Clinical trials. Clinical trials, subject to the *company's* review and approval based on the criteria below, are covered. An approved clinical trial shall either involve a drug that is exempt under federal regulations from a new drug application or is approved by one of the following:

One of the National Institutes of Health

The federal Food and Drug Administration, in the form of an Investigational new drug application

The United States Department of Defense

The United States Veterans' Administration

Hospice services

Hospital/acute care services, including, but not limited to: semiprivate room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the hospital-based pathologist, radiologist, or anesthesiologist, emergency room *physician*, emergency room and other miscellaneous hospital charges for care and treatment.

Mastectomy, breast reconstruction after mastectomy and complications from mastectomy. *Medically necessary* mastectomy and lymph node dissection are covered, including prosthetic devices and/ or reconstructive surgery to restore and achieve symmetry for the covered person incident to the mastectomy. The length of a hospital stay is determined by the attending *physician* and surgeon in consultation with the covered person, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

Mental health care

Organ transplant and transplant services. Non-*experimental* and non-*Investigational* organ transplants and transplant services are covered when the recipient is a covered person and the transplant is performed at a Medicare participating facility. Food and housing is not covered. Autologous and allogeneic bone marrow and stem cell transplants are covered. The testing of blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the covered person is the intended recipient.

Physician services

Rehabilitation services. Rehabilitation services are the individual or combined and coordinated use of medical, physical, occupational and speech-language pathology services for training and retraining individuals disabled by sickness or Injury. A rehabilitation facility provides comprehensive rehabilitation services under the supervision of a *physician* to Inpatients with physical disabilities.

Reconstructive surgery. To correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or sickness is covered. The primary purposes of reconstructive surgery are to correct abnormal structures of the body to either (a) improve function, or (b) create a normal appearance, to the extent possible.

Skilled nursing services/subacute and transitional care. *Medically necessary* inpatient skilled nursing services in a Medicare-certified skilled nursing facility are covered. Skilled nursing services are covered if the insured requires skilled nursing services or skilled rehabilitation services on a daily basis and these skilled services can be provided only on an inpatient basis in a skilled nursing facility. Inpatient stays solely to provide *custodial care* are not covered. Covered services include, but are not limited to, the following: semi-private room (private room if *medically necessary*); meals, including special diets; regular nursing services; physical therapy, occupational therapy, and speech language pathology services; drugs (this includes substances that are naturally present in the body, such as blood clotting factors); blood; medical and surgical supplies; laboratory tests; x rays and other radiology services; use of appliances such as wheelchairs; and *physician* services.

Outpatient Benefits

Alcohol, drug or other substance abuse treatments

Allergy serum

Ambulance. The use of an ambulance (land or air) is covered when the covered person, as a prudent layperson, reasonably believes that the medical or psychiatric condition requires services, and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the “911” *emergency* response system. Ambulance transportation is limited to the nearest available emergency facility having the expertise to stabilize the covered - person’s *emergency* medical condition. Use of an ambulance for non- *emergency* services is limited to inter-facility transfers between two hospitals, between a hospital and a non-custodial skilled nursing facility, or between a non-custodial skilled nursing facility and dialysis or radiation therapy facility are covered when medical necessity criteria for an ambulance is met.

Blood and blood products

Clinical trials. If you join a clinical trial, the *company* will only pay the coinsurance or *deductible* as outlined for Outpatient Benefits in the Schedule of Benefits.

Dental treatment anesthesia. See “Oral Surgery and Dental Services” and “Oral Surgery and Dental Services: Dental Treatment Anesthesia” provisions below.

Diabetic management and treatment

Dialysis

Infusion therapy

Durable medical equipment (rental, purchase or repair)

Emergency services outside of the U.S. are covered after a $250 per incident *deductible*

Eye exams. Some preventive eye tests and screenings are covered by Medicare.

Eyewear. Eyewear and corrective lenses are covered following cataract surgery with an intraocular lens (IOL) and when the covered person is missing an intraocular lens without a replacement either after cataract surgery or naturally.

Hearing exams. Diagnostic hearing exams are covered.

Home health care. Home health services for a homebound covered person include: part-time or intermittent skilled nursing and home health aide services; physical and occupational therapy and speech pathology services; medical social services; medical supplies and *durable medical equipment* (such as wheelchairs, hospital beds, oxygen, walkers). The plan covers either part-time or intermittent skilled nursing and home health aide services in accordance with Medicare guidelines.

Hospice services

Laboratory and diagnostic services

Maternity care, tests and procedures

Medical supplies and materials

Mental health care

Neuromuscular skeletal disorder services. Treatment by means of manual manipulation of the spine to correct a subluxation, provided by a licensed chiropractor (DC), doctor of medicine (MD) or doctor of osteopathy (DO) are covered.

Oral surgery and dental services. *Emergency* services for stabilization of an acute Injury to sound natural teeth, the jawbone or surrounding structures are covered. Other covered oral surgery and dental services include:

biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease and treatment of temporomandibular joint (“TMJ”) syndrome;

preventive fluoride treatment prior to a chemotherapeutic or radiation therapy protocol; and
tooth extraction prior to a major organ transplant or radiation therapy to the head or neck.

Oral surgery and dental services

Dental treatment anesthesia. Anesthesia and associated facility charges for dental procedures provided in a hospital or outpatient surgery center are covered when the covered person's clinical status or underlying medical condition requires use of an outpatient surgery center or Inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting. Charges are also covered for: (a) a covered person who is under seven (7) years of age; and (b) a covered person who is developmentally disabled, regardless of age.

Outpatient surgery

Periodic health screenings. Refer to the plan Certificate of Coverage and Schedule of Benefits for further details. This benefit includes the following health screenings:

Diagnostic hearing screening

Immunizations for adults are covered consistent with the most current recommendations of the Centers for Disease Control and Prevention (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices. Covered immunizations include vaccines for acquired immune deficiency syndrome (AIDS) that are approved for marketing by the federal Food and Drug Administration (FDA) and recommended by the Unites States Public Health Service. Immunizations for dependent *children* through age 18 are covered consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

Diagnostic laboratory

Preventive care for women

Routine mammograms

Routine cervical smear or Pap smear

Breast-feeding support, supplies and counseling

FDA-approved contraception methods and contraceptive counseling

Screening and counseling for interpersonal and domestic violence

Gestational diabetes screening

HIV screening and counseling

Human papillomavirus (HPV) testing (beginning at age 30 and every three years thereafter)

Sexually transmitted infections counseling

Well-woman visits

Breast and pelvic cancer screening and diagnosis. An annual cervical cancer screening test will include; conventional pap test; mammogram for women age 40 and over every twelve (12) months; and one baseline mammogram between the ages of 35 and 39.

Colorectal cancer. This screening may include the following:

A fecal occult blood test performed once every twelve (12) months;

A flexible sigmoidoscopy performed every five (5) years or a colonoscopy for initial screening only and performed every ten (10) years. (If additional therapeutic or surgical services are required during the screening as a result of screening findings, the outpatient surgery coinsurance and the *deductible* will apply);

A colonoscopy performed once every twenty-four (24) months, if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every ten (10) years, but not within forty-eight (48) months of a screening sigmoidoscopy; and

A barium enema can be performed instead of a flexible sigmoidoscopy or colonoscopy.

Osteoporosis screening

Diagnostic laboratory. Services are limited to the following tests (as defined in Current Procedural Terminology (CPT) from the American Medical Association): complete blood count (CBC), urinalysis, thyroid stimulating hormone (TSH), prothrombin time/international normalized ratio (PT/INR), partial thromboplastin time (PTT), or panels for the diagnosis or treatment of disease or organ abnormalities.

Prostate screening

Glaucoma screening once every twelve (12) months for people at high risk for glaucoma

Flu shot once a year in the fall or winter

Pneumococcal pneumonia shot (vaccine)

Hepatitis B shot (vaccine) if there is medium to high risk for Hepatitis B

Foot exam for individuals with diabetic peripheral neuropathy and loss of protective sensations

Phenylketonuria (“PKU”) testing and treatment. Testing for phenylketonuria (“PKU”) is covered to prevent the development of serious physical or mental disabilities

Physician office visits

Podiatry services. Services of a podiatrist for *medically necessary* treatment of injuries or diseases of the foot.

Prosthetics and corrective appliances

Radiation therapy

Reconstructive surgery

Rehabilitation services and therapy. Covered outpatient services include physical therapy, speech therapy and occupational therapy for the treatment of a sickness or injury, provided by a licensed health care

Specialized footwear. Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes, is covered for a covered person with diabetic foot disease, disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability.

Specialized scanning and imaging procedures. Examples of specialized scanning and imaging procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET, SPECT, MRI, MRA, EKG, EEG, EMG and nuclear scans, angiograms (includes heart catheterization), arthrograms, and myelograms.

Sterilization. Benefits include sterilization procedures including, but not limited to, tubal ligations and vasectomies.

Urgent care services

Exclusions and Limitations of Benefits

The following treatments, services or supplies are either limited or not covered.

General:

Non-Medicare eligible expenses or services are not covered

Non-*medically necessary* services are not covered

Services rendered prior to the covered person’s effective date of enrollment or after the effective date of disenrollment

Experimental and *investigational* procedures

Complications or services associated with non-covered services

Services incurred as a result of active military duty

Specific:

Acupuncture and acupressure

Air conditioners, air purifiers and other environmental equipment

Ambulance services are not covered if they are not *medically necessary*

Bariatric surgical procedures

Behavior modification and non-crisis mental health counseling and treatment

Blood and blood products. The costs of transportation and processing for autologous, donor-directed or donor designated blood.

Bone marrow and stem cell transplants. Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are *experimental* or *investigational* unless required by an external, independent review panel. Unrelated donor computer searches for covered persons who require a bone marrow or stem cell transplant are limited to the donor maximum for the covered person’s transplant benefit.

Complementary and alternative medicine

Cosmetic services and surgery

Custodial care

Dental care, dental services, dental appliances and orthodontics except as otherwise provided under the Outpatient Benefit captioned “Oral Surgery and Dental Services”

Diagnostic admissions. Services in connection with a hospital stay primarily for diagnostic tests which could have been performed on an outpatient.

Disabilities connected to military services

Durable medical equipment. Replacement of lost or stolen *durable medical equipment* is not covered. The following equipment and accessories are not covered: non-*medically necessary* optional attachments and modifications to *durable medical equipment* for the comfort or convenience of the covered person; accessories for portability or travel; a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment; home and/or vehicle modifications to accommodate the covered person’s physical condition.

Educational services for developmental delays and learning disabilities

Elective enhancements. Elective or voluntary enhancement services, procedures, treatments, supplies and medications, including but not limited to, services related to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.

Exercise equipment and services

Experimental and/or *investigational* procedures, items and treatments.

Eyewear and corrective refractive procedures

Family planning

Foot care. Routine foot care, including, but not limited to, removal or reduction of corns and calluses, and clipping of toenails.

Foreign country travel. Any charges for services incurred while in a foreign country are not covered (except *emergency* services)**.**

Genetic testing and counseling

Government services and treatment

Hearing aids and hearing devices

Hearing examinations. Audiology services performed to determine the need for, or the appropriate type of, hearing aid.

Immunizations. Travel and/or required work related immunizations.

Implants. The following implants and services are not covered:

- Removal and/or replacement of breast implants for non-medical reasons
- Replacement of breast prosthesis and the prosthesis itself following cosmetic breast augmentation mammoplasty

Infertility services

Institutional services and supplies (except for skilled nursing services)

Maternity services and education. Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.

Neuromuscular skeletal disorder services. Services are limited to neuromuscular skeletal disorder services as described under Outpatient Benefits

Nurse midwife services. Elective home deliveries are not covered.

Nursing, private duty

Nutritional supplements or formulas

Organ donor evaluation and services. Medical and hospital services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a covered person. Covered services for living donors are limited to transplant-related clinical services once a donor is identified. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children.

Physical or psychological examinations. Physical or psychological examinations for court hearings, travel, premarital, pre-adoption, employment or other non-preventive health reasons.

Private rooms and comfort items

Reconstructive surgery. Reconstructive surgeries are not covered when another more appropriate surgical procedure will be approved for the covered person, or if, in accordance with the standard of care as practiced by *physicians* specializing in reconstructive surgery, the surgery offers only a minimal improvement in the appearance of the covered person. Please refer to the Reconstructive Surgery benefit.

Recreational, lifestyle, educational or hypnotic therapy

Rehabilitation services and therapy. Rehabilitation services and therapy are either limited or not covered, as follows:

- Speech, occupational or physical therapy are not covered when medical documentation does not support the medical necessity because of the covered person’s inability to progress toward the treatment plan goals or when a covered person has already met the treatment goals.
- Speech therapy is limited to *medically necessary* therapy to treat speech disorders caused by a defined sickness, injury or surgery (for example, cleft palate repair). Speech therapy for stuttering, lisping or delayed speech is not covered.
- Cognitive rehabilitation therapy is limited to initial neuropsychological testing by a treating *physician* or licensed provider and the *medically necessary* treatment of functional deficits as a result of traumatic brain injury or cerebral vascular insult. This benefit is subject to the maximum benefit for outpatient rehabilitation and applicable coinsurance and *deductibles* apply.
- Exercise programs are only covered when they require the direct supervision of a licensed physical therapist and are part of a *physician’s* treatment plan.

Aquatic/pool therapy is not covered unless conducted by a licensed physical therapist and part of a *physician's* treatment plan.
Massage therapy is not covered.
Activities that are motivational in nature or that are primarily recreational, social or for general fitness are not covered.
Developmental and neuroeducational testing beyond initial diagnosis is not covered.
Developmental and neuroeducational treatment is not covered.
Hypnotherapy is not covered.
Psychological testing is not covered.
Vocational rehabilitation is not covered.
Rehabilitation Services and therapies for the following conditions are not covered:
Learning Disability.
Mental Retardation
Respite care. Respite care is not covered, unless part of an authorized hospice plan and is necessary to relieve the primary caregiver in a covered person's residence. Respite care is covered only on an occasional basis, not to exceed five (5) consecutive days at a time.
Reversal of sterilization procedures
Services provided at no charge to the covered person
Services while incarcerated or confined
Sex transformations
Sexual dysfunction or inadequacy medications
Skin reduction surgery
Surrogacy
Telehealth
Transplant services. Transplant services are not covered when the transplant is not performed at a Medicare-certified Transplant Center. Non-human organs and artificial hearts are not covered.
Transportation
Veterans' Administration services
Vision training
Weight alteration programs
Workers' Compensation. Services payable under Workers' Compensation are not covered.
War. Services incurred as a result of declared or undeclared war are not covered.

Coordination of Benefits with Medicare

Medicare Advantage Members

If you are covered by a Medicare Advantage option, the Medicare Advantage option actually provides your Medicare benefits. That means there is no need for Coordination of Benefits.

Blue Shield PPO 90/70 Medicare Coordinated Plan

For covered Medicare services Blue Shield will waive the calendar year *deductible*, the office visit copay, the per admission copay, 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 Blue Shield have paid.

Exceptions to this include the emergency room copay and services rendered by providers who will not bill Medicare. In the case where the *physician* is unwilling to bill Medicare, Blue Shield becomes the primary payer and pays according to the 90/70 schedule of benefits. You are responsible for all expenses not paid by Blue Shield.

Blue Shield EPO Medicare Coordinated Plan

For covered Medicare services Blue Shield will waive the office visit copay, 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 Blue Shield have paid.

Exceptions to this include the emergency room copay and services rendered by providers who will not bill Medicare. In the case where the physician is unwilling to bill Medicare, Blue Shield becomes the primary payer and would pay according to the EPO schedule of benefits. This means you must pay the balance for these services.

UHC Senior Supplement Plan

Medicare is the primary payer and the UHC Senior Supplement Plan is the secondary payer.

UHC Senior Supplement 3500 Plan

Medicare is the primary payer and the UHC Senior Supplement 3500 Plan is the secondary payer.

Situations Affecting Your Coverage

Making Changes During the Year

Qualified Life Event

Within 30 days of a *qualified life event*, you may change your coverage—for example, if your marital status changes or if you leave the *company*.

See the **Events Affecting Your Benefits** section in this handbook for more information on *qualified life events*.

How You Use Your Medical Benefits

How you use your benefits can affect your Medical coverage. For example:

- If you use a provider who doesn't participate in the network of your Medical Plan option, and you don't apply for benefits or provide the necessary claim information, benefit payments may be delayed or forfeited. (If your Medical Plan option requires that you use participating providers, you may receive no benefit payments at all)
- If you abuse your Medical benefits or deliberately and persistently violate provisions of the Plan, the Medical Plan options may refuse to pay benefits or provide services
- If you enroll in an HMO option and receive medical treatment or services at other than the HMO facility you selected, you may be ineligible for reimbursement from the HMO
- If you receive behavioral health treatments or services from other than your selected carrier, you may be ineligible for reimbursement from the plan
- If you provide material information that is false or misrepresented to a Medical Plan administrator or if you attempt to obtain service or benefits under the Medical Plan by means of false, materially misleading, or fraudulent information, acts or omissions, you may be disenrolled from participation in the Medical Plan retroactively to the date of your misrepresentation or fraudulent act, and the payment of all benefits provided for a period not to exceed one year prior to the date of disenrollment may be voided. Your failure to provide timely notice of a dependent's loss of eligibility under the Medical Plan is an intentional misrepresentation of a material fact.

For other situations that could affect your and your dependents' coverage, see the **Health Care Overview**.

Dual Coverage

For coverage rules that apply when you have an eligible dependent who also works for the *company* or is a retiree of the *company* (dual coverage), see the **Health Care Overview**.

When Participation Ends

You and your covered dependents may be able to extend your coverage after your participation ends. The *company* offers you the opportunity to extend your coverage after it would normally end if your coverage is lost due to a qualifying event. This provision is in accord with the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. See **COBRA Extended Coverage** in the Continued Health Care Coverage summary in this handbook.

Other Situations Affecting Medical Coverage

There are a number of other situations that could affect your and your dependents' coverage. See **Situations Affecting Health Care Coverage** in the Health Care Overview summary for more information.

Amendment or Termination of the Medical Plan

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The Benefits Committee has power to amend or terminate the Medical Plan, including the retiree medical provisions, at any time, at its discretion.

If this Plan is terminated for any reason, you will be notified. Claims for *covered expenses* incurred before the termination date would be payable in accord with the terms of this Plan.

Right to Reimbursement (Subrogation)

If any payment is made under the Medical Plan as a result of any loss or injury caused by the negligence or wrongful act of any third party, the plan shall be subrogated to all rights of recovery that you or your eligible dependents may have against the third party to the extent of payments made under the plan. By accepting benefits (directly or indirectly) under the Medical Plan, you indicate agreement to comply with the terms of this provision, including agreement to execute such forms as are requested by the plan to receive reimbursement.

The Medical Plan may take such actions as the Medical Plan administrator, in its discretion, feels would best serve the plan. Such actions include, but are not limited to, any or all of the following actions:

- The Medical Plan administrator may require, prior to providing benefits, that you and your eligible dependents agree in writing to waive the statute of limitations in any claim for reimbursement brought by the plan against you, your dependent, your respective beneficiaries, assigns, or representatives.
- The Medical Plan administrator may seek to have any payment by a third party made payable to the plan in lieu of or in addition to you, your dependent, your respective beneficiaries, assigns, or representatives.
- The Medical Plan administrator shall refuse to provide you or your eligible dependents any benefits under the plan if you or your eligible dependents (i) refuse to execute an agreement agreeing to reimburse the plan; (ii) refuse to waive the statute of limitations, as described above; (iii) fail to reimburse the plan; or (iv) fail to cooperate in helping the plan collect reimbursement from you, your eligible dependents, or a third party.

If there is any recovery, by way of judgment, settlement or otherwise from another person or business entity, the Medical Plan shall be reimbursed by you, your dependent, your respective beneficiaries, assigns, or representatives, to the extent of benefits provided by the plan, in first priority, as soon as payment is received from the third party or an insurance company (whether or not attorneys fees have been paid from the recovery) and whether or not you or your dependent have been made whole. Such first priority shall be over any and all funds paid by a third party, including but not limited to payment made for medical expenses and claims for non-medical charges, attorneys' fees and any other costs or settlement.

If you or your eligible dependent commence a legal action against a third party as a result of an illness or injury for which benefits have been paid under the plan, you shall (i) notify the Medical Plan administrator of the details of the action and (ii) provide the plan with an assignment of your claim against the third party to the extent of benefits provided by the plan.

To the extent you or your eligible dependent receive reimbursement from a third party and fail to reimburse the Medical Plan for the appropriate amount, any benefits paid by the plan for the services or supplies for which you or your dependent are reimbursed shall be considered an overpayment by the plan and thus recoverable.

To the extent provided by law, the Medical Plan shall be subrogated and shall succeed to all rights of recovery which you or your dependent, or any beneficiary thereof, may have against a third party.

Appeals

If your claim or service is denied, in whole or in part, you or your beneficiary has a legal right to request a review of that denial. Generally, if you disagree with the outcome, you may appeal it. Refer to the **Other Important Information** section in this handbook for details about documentation and the appeals process.

For More Information

To contact your Medical Plan option directly, use the number on your Medical Plan identification card or refer to the **Other Important Information** section of this handbook.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Dental Plan

Dental Plan revised December 19, 2012.

Dental Plan Overview and Important Features

Eligible employees may choose from various Dental Plan options based on the geographic area where they live and the *company* for which they work. Employees generally pay for Dental coverage with pre-tax dollars.

This summary describes the main features of dental benefits available through Anthem Blue Cross of California Dental Net, Delta Dental PPO and SafeGuard Dental.

Delta Dental PPO pays a percentage of *covered expenses*, up to an annual limit.

Anthem Blue Cross of California Dental Net and SafeGuard Dental, which require you to use a specific dental office, pay 100 percent for some covered services and require a copayment for other covered services.

Who Is Eligible

As a general rule, you are eligible to participate in the Dental Plan option if you are a *full-time*, *part-time* or *part-time plus* employee, or an eligible dependent. Most *full-time* and *part-time* employees are eligible for Dental coverage on their date of hire.

Temporary and *leased* employees and *contingent workers* are not eligible to participate.

Dependents serving in the military are not eligible to participate.

See the **Eligibility** section at the beginning of this handbook for the specific Edison *companies* and employee groups eligible to participate in the Dental Plan options. The specific eligibility requirements for dependents and details about when your coverage begins and ends are described in the Health Care Overview.

Enrolling For Coverage

If you are a *full-time*, *part-time* or *part-time plus* employee, you may enroll in any one of the Dental Plan options offered in your geographic area and in the coverage category of your choice.

Non-represented employees of Southern California Edison Company are eligible for the following Dental Plan options (provided you reside in the respective plan's service area):

- Anthem Blue Cross of California Dental Net
- Delta Dental PPO
- SafeGuard Dental

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

You can waive coverage in this plan – there is no requirement to enroll in a Dental Plan option. If you waive Dental coverage, Dental *company* contributions will not be available for you to use toward the cost of other *Flex* benefits.

When You Retire

You may enroll for any Dental Plan option available to you and for the coverage category of your choice (see **Coverage Categories**). Under certain circumstances, you can change your coverage category before the end of the year. If you do not enroll for Dental coverage when first eligible as a retiree, or if you retired after 1990 and drop coverage as a retiree, you will not be eligible to re-enroll in the future. However, if you drop your Dental coverage because you have coverage under another group plan and, subsequently, lose that coverage, you can re-enroll in the Dental Plan within 30 days of losing coverage under the other group plan if you provide notice of the other coverage to the *EIX Benefits Connection* before you drop your Edison coverage. You must call the *EIX Benefits Connection* and speak with a representative to report this change. See **Reporting a *Qualified Life Event*** for information on how to re-enroll. To determine your eligibility for Dental coverage as a retiree, see **Continued Health Care Coverage** at the end of this section of your handbook.

Enrollment Deadlines

In the year you become eligible, you enroll for the remainder of the calendar year and your coverage begins on the date you are first eligible. You must enroll or waive coverage within 30 days from the date you first become eligible by contacting the *EIX Benefits Connection* via phone or online at:

- (866) 693-4947
  - http://www.eixbenefits.com

Default Dental Elections for Newly Eligible Employees

If you are a *full-time* employee and you do not actively enroll or waive coverage within 30 days of your eligibility date, your default Dental election will be the lowest cost plan available to you.

If you are a *part-time* employee and you do not actively enroll or waive coverage within 30 days of your eligibility date, your default Dental election will be **no coverage**.

If you become a *part-time plus* employee, the dental coverage you had in your previous classification will continue until the end of the plan year.

Annual Enrollment Period

At the end of the year in which you become eligible and each year thereafter, you may choose a Dental Plan option or waive coverage during the annual enrollment period. As long as you remain eligible, the Dental coverage you elect during annual enrollment will begin on the following January 1.

The following chart indicates your default coverage if you do not choose a Dental Plan option (or waive coverage) during annual enrollment.

Default Annual Enrollment Dental Elections	
If you are a…	**And if you don't actively enroll or waive coverage during annual enrollment, your default Dental election will be…**
Full-time employee *Part-time Plus* employee *Part-time* employee eligible for *company* contributions	• Same plan option (if available) and coverage category you had at the end of the prior calendar year; if prior option not available, the same coverage category for the lowest cost option in your home ZIP code • No coverage if you waived coverage in the prior calendar year
Part-time employee not eligible for *company* contributions	No coverage

See the ***Flex*** section in this handbook for more information on default coverage.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Coverage Categories

You have a choice of four coverage categories:

- You only
- You and *child(ren)*
- You and *spouse* (or *domestic partner*)
- You and family

During each annual enrollment period, you choose the coverage category that will best meet your needs in the coming year. See **Coverage Categories** in the Health Care Overview for more information.

Unlike the Medical Plan options, the Dental Plan options allow you to be covered both as an employee/retiree and as a dependent. Dependent *children* may be enrolled by both parents.

See **Special Rules for Dual Coverage** in the Health Care Overview for more about enrollment options when your eligible dependent(s) also works for the *company.*

Cost of Coverage

Your price tag and *company* contributions for Dental coverage depend on the *company* you work for, your respective employee group, and the plan option and coverage category you choose. *Company* contributions and price tags are divided among the *deduction periods* throughout the year. See the ***Flex*** section in this handbook for more details on price tags and *company* contributions.

Price Tags

The annual price tag of each available option is based on the plan option you choose and your coverage category and is shown in the personalized information you receive when first eligible and during the annual enrollment period. Each year the price tags of the plan options may be adjusted up or down to reflect actual cost experience or changes in Dental Plan premiums.

Company Contributions

The *company* provides contributions that may be used to help pay the cost of your Dental coverage if you are:

- A *full-time* employee
- A *part-time plus* employee
- A *part-time* employee regularly scheduled to work 16 or more hours per week on an ongoing basis

Your *company* contributions are based on the *company* you work for and your employee group and are shown in the personalized information you receive when first eligible and during the annual enrollment period.

The *company* provides a lump-sum *company* contribution allocation to help pay for the cost of all your *Flex* coverage, including Dental, if you are a part-time employee receiving *company* contributions. *Part-time* employees who are not regularly scheduled to work 16 or more hours per week on an ongoing basis do not receive *company* contributions.

The *company* contributions allotment is added to your pay for each *deduction period* in equal installments throughout the plan year. The price tag for the Dental Plan in which you enroll is deducted from your pay on a pre-tax basis in equal installments during each *deduction period* throughout the plan year.

You will not receive Dental *company* contributions if you waive Dental coverage.

Employee Contributions

If the annual price tag of the Dental Plan option you have elected is more than the allotted Dental *company* contributions, you make up the difference through pre-tax payroll deductions. If the annual price tag is less than the allotted Dental *company* contributions, you may use those remaining *company* contributions towards other *Flex* choices or receive them as taxable income in your paycheck.

Part-time employees who receive a lump-sum amount of *company* contributions can use their *company* contributions toward any of the *Flex* options for which they are eligible. Any *company* contributions they don't use are forfeited.

If you are covering a *domestic partner*, you pay for your *domestic partner's* coverage with post-tax dollars (for employees at California work locations, the cost of coverage for a *same-sex spouse* or a *domestic partner* who is registered with the Secretary of the State of California is paid with post-tax deductions for federal tax purposes, and with pre-tax deductions for California state tax purposes).

If you don't receive enough pay during a pay period to cover your price tags, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. If you are in arrears after four consecutive pay periods, you will receive a written notice that you are being changed from payroll deduction to direct billing and you will be billed for future contributions you owe. If you fail to pay your contributions, your coverage will be terminated. Any amount that you have in arrears for payroll deductions during *deduction periods* prior to your change to direct billing that could not be collected at the end of the calendar year will be added to your W-2 statement as taxable income. If you leave the *company* or cease to be eligible for benefits, you will be billed for any outstanding deduction amounts.

If you're not receiving income directly from the *company* and payroll deductions are not possible (for example, you're on an unpaid leave of absence or are receiving Workers' Compensation benefits), you will be billed and expected to pay for your Dental coverage by submitting monthly checks to an outside biller.

Anthem Blue Cross Of California Dental Net

When you enroll in Anthem Blue Cross of California Dental Net (Blue Cross Dental Net), you and your dependents may select different Blue Cross Dental Net offices to provide your dental services. Blue Cross Dental Net pays 100 percent of the cost of some covered services and requires you to make a copayment for other covered services. While Blue Cross Dental Net covers most routine dental services, there are some dental services that are not covered.

Providers

Before your Blue Cross Dental Net coverage can begin, you must enroll for coverage in a particular Blue Cross Dental Net dental office. You and your dependents may select different Blue Cross Dental Net offices to provide your dental services. If you do not select a dental office, Blue Cross Dental Net will assign one to you. Except for *emergency* services or when referred elsewhere by your Blue Cross Dental Net dentist, you must use your Blue Cross Dental Net office in order to receive plan benefits.

You receive an identification card showing your dental office number and a code identifying your benefits.

If you move or would prefer another participating dental office, you can change to another office by calling Blue Cross Dental Net Member Services at (800) 627-0004. Dental provider changes made by the 15th of the month are limited to once per month and are effective the first of the following month.

What Blue Cross Dental Net Covers

Blue Cross Dental Net pays the full cost of some covered services and establishes a copayment amount for other covered dental services. The wide range of covered services available to you under Blue Cross Dental Net are listed in detail in the Schedule of Copayments following the Summary of Blue Cross Dental Net Benefits.

Summary of Anthem Blue Cross Dental Net Benefits - Effective January 1, 2013	
Covered Services	**What Anthem Blue Cross Dental Net Pays**
Diagnostic and Preventive Services	
Oral Exams	100%
Teeth Cleaning	100%
Fluoride Treatment (to age 19)	100%
Bitewing x rays	100%
Full mouth x rays	100%
Space Maintainers	All but a $45 copayment
Study Models	Orthodontics study models are included in the initial records fee which is $300.00. That fee also includes all necessary diagnostic x rays, records, analysis and photos for orthodontic treatment.
Biopsy/tissue exam	100% after your $10 copayment
Consultation by a specialist	100%

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Oral Hygiene	*Usual, Customary and Reasonable*
Dietary Instructions	*Usual, Customary and Reasonable*
Emergency Treatment	100%
Basic, Major and Restorative Services	
Molar Sealants to age 14 (one per tooth on occlusal surface free of decay and restoration)	*Usual, Customary and Reasonable*
Basic fillings (amalgams and composites)	100%
Resin fillings (anterior only)	100%
Stainless steel crown	100%
Crowns, jackets and gold or cast restorations	100% after your $120 copayment
Oral Surgery Services	
Simple tooth extraction	100%
Impactions - soft tissue, partial bony and full bony	100% after your $50 copayment
Alveoplasty (per quadrant)	*Usual, Customary and Reasonable*
Anesthesia for dental	Not Covered
Endodontic Services	
Pulp Cap	100%
Root canal treatment	100% after your $60 to $100 copayment
Periodontic Services	
Gingivectomy-per tooth	100% after your $60 copayment
Gingivectomy-per quadrant	100% after your $60 copayment
Scaling/root planing-per quadrant	All but an $18 copayment
Osseous surgery-per quadrant	All but a $120 copayment
Frenectomy	*Usual, Customary and Reasonable*
Prosthodontic Services	
Inlay/Onlay restorations	100% after your $10 to $100 copayment
Bridges – removable or fixed	100% after your $120 copayment
Dentures - partial	All but a $160 copayment
Dentures - complete	All but a $140 copayment
Denture - repair	100% after your $20 to $50 copayment; limited to one per denture per 12 month period
Orthodontic Services (36 months of standard Phase 2 orthodontic care, exclusive of records/retention fees)	
Braces for *children*	All but a $650 copayment for Phase 2*; limited to one full case during lifetime; retreatment of orthodontic case is not covered
Braces for adults	All but a $650 copayment for Phase 2*; limited to one full case during lifetime; retreatment of orthodontic case is not covered
Calendar Year *Deductible*	None
Maximum Annual Benefit	None for adults. Pediatric dental services are limited to $500 per year. This limitation does not apply to Orthodontic services.

* Phase 1 is not covered. Phase 1 is treatment that often involves the use of partial braces, plates or retainers to expand space for developing adult teeth, correct crossbites, overbites, underbites or harmful habits. The copayment is for Phase 2 only. Phase 2 is done when all the permanent teeth are in place and involves full braces, which give maximum control over the movement of teeth, whereas plates or "retainers" can only tip teeth in certain directions. The correction of rotated teeth and any movement of teeth that involves more than simple tipping movements are usually achieved with braces.

Schedule of Copayments - Effective January 1, 2013

ADA Code	Procedure Description	Co-Payment
Preventive & Diagnostic		
0120	Periodic Oral Evaluation	No Charge
0140	Limited Oral Evaluation - Problem Focused	No Charge
0150	Comprehensive Oral Evaluation	No Charge
0160	Detailed and Extensive Oral Evaluation	No Charge
0170	Re-evaluation -- Limited Problem Focused (not post-operative visit)	No Charge
0210	Intraoral - Complete Series (including bitewings)	No Charge

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

0220	Intraoral - Periapical - First Film	No Charge
0230	Intraoral - Periapical - Each Additional Film	No Charge
0240	Intraoral - Occlusal Film	No Charge
0270	Bitewing - Single Film	No Charge
0272	Bitewings - Two Films	No Charge
0274	Bitewings - Four Films	No Charge
0277	Vertical Bitewings	No Charge
0330	Panoramic Film	No Charge
0460	Pulp Vitality Tests	No Charge
0470	Diagnostic Casts	*Usual, Customary & Reasonable*
	Office visit -- Per patient per office visit in addition to patient copays	No Charge
1110	Prophylaxis - Adult[1]	No Charge
1120	Prophylaxis - *Child*[1]	No Charge
1201	Topical Application of Fluoride (including prophylaxis) - *Child*	No Charge
1203	Topical Application of Fluoride (prophylaxis not included) - *Child*	No Charge
1204	Topical Application of Fluoride (prophylaxis not included) - Adult	*Usual, Customary & Reasonable*
1205	Topical Application of Fluoride (including prophylaxis) - Adult	*Usual, Customary & Reasonable*
1330	Oral Hygiene Instructions	*Usual, Customary & Reasonable*
1351	Sealant - Per Tooth	*Usual, Customary & Reasonable*
1510	Space Maintainer - Fixed - Unilateral	$45
1515	Space Maintainer - Fixed - Bilateral	$45
1520	Space Maintainer - Removable - Unilateral	$45
1525	Space Maintainer - Removable - Bilateral	$45
1550	Recementation of Space Maintainer	$5
[1] 3rd cleaning in 12 months, 20% of dentist's *Usual, Customary & Reasonable*		
Restorative		
2110	Amalgam - One Surface, Primary	No Charge
2120	Amalgam - Two Surfaces, Primary	No Charge
2130	Amalgam - Three Surfaces, Primary	No Charge
2131	Amalgam - Four or more Surfaces, Primary	No Charge
2140	Amalgam - One Surface, Permanent	No Charge
2150	Amalgam - Two Surfaces, Permanent	No Charge
2160	Amalgam - Three Surfaces, Permanent	No Charge
2161	Amalgam - Four or more Surfaces, Permanent	No Charge
2330	Resin - One Surface, Anterior	No Charge
2331	Resin - Two Surfaces, Anterior	No Charge
2332	Resin - Three Surfaces, Anterior	No Charge
2335	Resin - Four or more Surfaces or involving incisal angle (anterior)	No Charge
2336	Resin-Based Composite, Anterior-Primary	*Usual, Customary & Reasonable*
2337	Resin-Based Composite, Anterior-Permanent	*Usual, Customary & Reasonable*
2380	Resin - One Surface, Posterior-Primary	*Usual, Customary & Reasonable*
2381	Resin - Two Surfaces, Posterior-Primary	*Usual, Customary & Reasonable*
2382	Resin - Three or more Surfaces, Posterior-Primary	*Usual, Customary & Reasonable*
2385	Resin - One Surface, Posterior-Permanent	*Usual, Customary & Reasonable*
2386	Resin - Two Surfaces, Posterior-Permanent	*Usual, Customary & Reasonable*

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

2387	Resin - Three or more Surfaces, Posterior-Permanent	*Usual, Customary & Reasonable*
2388	Resin - Based Composite - Four or more Surfaces, Posterior Permanent	*Usual, Customary & Reasonable*
Crowns & Fixed Bridges[2]		
2510	Inlay - Metallic - One Surface	*Usual, Customary & Reasonable*
2520	Inlay - Metallic - Two Surfaces	$90
2530	Inlay - Metallic - Three or more Surfaces	$100
2542	Onlay - Metallic - Two Surfaces	$10
2543	Onlay - Metallic-Three Surfaces	$10
2544	Onlay - Metallic-Four or more Surfaces	$10
2740	Crown - Porcelain/Ceramic Substrate	$120
2750	Crown - Porcelain Fused to High Noble Metal	$120
2751	Crown - Porcelain Fused to Predominantly Base Metal	$120
2752	Crown - Porcelain Fused to Noble Metal	$120
2780	Crown - 3/4 Cast High Noble Metal	$120
2781	Crown - 3/4 Cast High Predominantly Base Metal	$120
2782	Crown - 3/4 Cast Noble Metal	$120
2783	Crown - 3/4 Porcelain/Ceramic	$120
2790	Crown - Full Cast High Noble Metal	$120
2791	Crown - Full Cast Predominantly Base Metal	$120
2792	Crown - Full Cast Noble Metal	$120
2910	Recement Inlay	$10
2920	Recement Crown	$10
2930	Prefabricated Stainless Steel Crown - Primary Tooth	No Charge
2931	Prefabricated Stainless Steel Crown - Permanent Tooth	No Charge
2932	Prefabricated Resin Crown	No Charge
2940	Sedative Filling	No Charge
2950	Core Buildup, including any pins	No Charge
2951	Pin Retention - Per Tooth, in addition to restoration	No Charge
2952	Cast Post and Core in addition to crown	$60
2953	Each additional Cast Post (same tooth)	$60
2954	Prefabricated Post and Core in addition to crown	$20
2955	Post Removal (not in conjunction with endodontic therapy)	*Usual, Customary & Reasonable*
2957	Each additional Prefab Post (same tooth)	$20
2970	Temporary Crown (fractured tooth)	$20
6210	Pontic - Cast High Noble Metal	$120
6211	Pontic - Cast Predominantly Base Metal	$120
6212	Pontic - Cast Noble Metal	$120
6240	Pontic - Porcelain Fused to High Noble Metal	$120
6241	Pontic - Porcelain Fused to Predominantly Base Metal	$120
6242	Pontic - Porcelain Fused to Noble Metal	$120
6245	Pontic - Porcelain/Ceramic	$120
6520	Inlay - Metallic - Two Surfaces	$90
6530	Inlay - Metallic - Three or more Surfaces	$100
6543	Onlay - Metallic - Three Surfaces	$10
6544	Onlay - Metallic - Four or more Surfaces	$10
6740	Crown - Porcelain/Ceramic	$120
6750	Crown - Porcelain Fused to High Noble Metal	$120
6751	Crown - Porcelain Fused to Predominantly	$120

	Base Metal	
6752	Crown - Porcelain Fused to Noble Metal	$120
6780	Crown - 3/4 Cast High Noble Metal	$120
6781	Crown - 3/4 Cast Predominately Based Metal	$120
6782	Crown - 3/4 Cast Noble Metal	$120
6783	Crown - 3/4 Porcelain/Ceramic	$120
6790	Crown - Full Cast High Noble Metal	$120
6791	Crown - Full Cast Predominantly Base Metal	$120
6792	Crown - Full Cast Noble Metal	$120
6930	Recement Fixed Partial Denture	$15
6970	Cast Post and Core in addition to fixed Partial Denture Retainer	$60
6971	Cast Post as part of fixed Partial Denture Retainer	*Usual, Customary & Reasonable*
6972	Prefabricated Post and Core in addition to fixed Partial Denture Retainer	$20
6973	Core Build Up for Retainer, including any pins	No Charge
6976	Each additional Cast Post - same tooth	$60
6977	Each additional Prefab Post - same tooth	$20
[2] Maximum additional charge for noble/high noble metal is $100. Maximum additional charge for porcelain on posterior teeth is $75.		
Endodontics		
3110	Pulp Cap - Direct (excluding final restoration)	No Charge
3120	Pulp Cap - Indirect (excluding final restoration)	No Charge
3220	Therapeutic Pulpotomy (excluding final restoration)	No Charge
3221	Gross Pulp Debridement, Prim. and Perm Teeth	No Charge
3310	Anterior (excluding final restoration)	$60
3320	Bicuspid (excluding final restoration)	$80
3330	Molar (excluding final restoration)	$100
3332	Incomplete Endodontic Therapy (inoperable or fractured tooth)	*Usual, Customary & Reasonable*
3346	Retreatment of Previous Root Canal Therapy - Anterior	$60
3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$80
3348	Retreatment of Previous Root Canal Therapy - Molar	$100
3410	Apicoectomy/Periradicular Surgery - Anterior	$90
3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	$90
3425	Apicoectomy/Periradicular Surgery - Molar (first root)	$90
3426	Apicoectomy/Periradicular Surgery (each additional root)	$20
3430	Retrograde Filling - Per Root	$100
3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	*Usual, Customary & Reasonable*
3950	Canal Preparation and Fitting of Preformed Dowel or Post	*Usual, Customary & Reasonable*
Periodontics		
4210	Gingivectomy or Gingivoplasty - Per Quadrant	$60
4211	Gingivectomy or Gingivoplasty - Per Tooth	$60
4220	Gingival Curettage, Surgical - Per Quadrant	$18
4260	Osseous Surgery (including flap entry and closure) - Per Quadrant	$120

4341	Periodontal Scaling and Root Planing - Per Quadrant	$18
4355	Full Mouth Debridgement to Enable Comprehensive Periodontal Evaluation and Diagnostic	*Usual, Customary & Reasonable*
4910	Periodontal Maintenance Procedures (following active therapy)	*Usual, Customary & Reasonable*
Removable Prosthodontics		
5110	Complete Denture - Maxillary	$140
5120	Complete Denture - Mandibular	$140
5130	Immediate Denture - Maxillary	$140
5140	Immediate Denture - Mandibular	$140
5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests)	*Usual, Customary & Reasonable*
5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests)	*Usual, Customary & Reasonable*
5213	Maxillary Partial Denture - Cast Metal Framework w/Resin Denture Bases	$160
5214	Mandibular Partial Denture - Cast Metal Framework w/Resin Denture Bases	$160
5410	Adjust Complete Denture - Maxillary	No Charge
5411	Adjust Complete Denture - Mandibular	No Charge
5421	Adjust Partial Denture - Maxillary	No Charge
5422	Adjust Partial Denture - Mandibular	No Charge
5510	Repair Broken Complete Denture Base	$15
5520	Replace Missing Or Broken Teeth - Complete Denture (each tooth)	$10
5610	Repair Resin Denture Base	$15
5620	Repair Cast Framework	$30
5630	Repair or Replace Broken Clasp	$20
5640	Replace Broken Teeth - Per Tooth	$10
5650	Add Tooth to Existing Partial Denture	$30
5660	Add Clasp to Existing Partial Denture	$40
5710	Rebase Complete Maxillary Denture	$80
5711	Rebase Complete Mandibular Denture	$80
5720	Rebase Maxillary Partial Denture	$80
5721	Rebase Mandibular Partial Denture	$80
5730	Reline Complete Maxillary Denture (chairside)	$20
5731	Reline Complete Mandibular Denture (chairside)	$20
5740	Reline Maxillary Partial Denture (chairside)	$20
5741	Reline Mandibular Partial Denture (chairside)	$20
5750	Reline Complete Maxillary Denture (laboratory)	$50
5751	Reline Complete Mandibular Denture (laboratory)	$50
5760	Reline Maxillary Partial Denture (laboratory)	$50
5761	Reline Mandibular Partial Denture (laboratory)	$50
5820	Interim Partial Denture (maxillary)	$75
5821	Interim Partial Denture (mandibular)	$75
5850	Tissue Conditioning, Per Denture	$25
5851	Tissue Conditioning, Lower, Per Denture	$25
Oral Surgery		
7110	Single Tooth	No Charge
7120	Each Additional Tooth	No Charge
7130	Root Removal - Exposed Roots	No Charge
7210	Surgical Removal of Erupted Tooth	$25
7220	Removal of Impacted Tooth - Soft Tissue	$50
7230	Removal of Impacted Tooth - Partially Bony	$50

7240	Removal of Impacted Tooth - Completely Bony	$50
7241	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical	$50
7250	Surgical Removal of Residual Tooth Roots (cutting procedure)	$30
7285	Biopsy of Oral Tissue - Hard (bone, tooth)	$10
7286	Biopsy of Oral Tissue - Soft (all others)	$10
7310	Alveoloplasty in Preparation for Dentures, In Conjunction w with Extractions - Per Quadrant	*Usual, Customary & Reasonable*
7320	Alveoloplasty in Preparation for Dentures, not in Conjunction with Extractions - Per Quadrant	*Usual, Customary & Reasonable*
7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$10
7910	Suture of Recent Small Wounds	$20
Orthodontics		
8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (including fixed removable appliance up to 36 months)	$650
8090	Comprehensive Orthodontic Treatment of the Adult Dentition (including fixed removable appliance up to 36 months)	$650
8660	Pre-Orthodontic Visit & Treatment Plan (including x ray, study models, records and photos)	*Usual, Customary & Reasonable*
8680	Orthodontic Retention (removal of appliances, construction and placement of retainers)	*Usual, Customary & Reasonable*
Miscellaneous Services		
9110	Palliative (emergency) Treatment of dental pain - Minor Procedure	No Charge
9211	Regional Block Anesthesia	*Usual, Customary & Reasonable*
9215	Local Anesthesia	No Charge
9310	Consultation	No Charge
9430	Office Visit for Observation (during regularly scheduled hours) - no other service performed	*Usual, Customary & Reasonable*
9440	Office Visit - after regularly scheduled hours	$45
9630	Other Drugs and/or Medicaments	*Usual, Customary & Reasonable*
9920	Behavior Management, by Report	$25
	Broken Appointments, Less than 24 hours[3]	*Usual, Customary & Reasonable*

[3] You pay the participating dental office and submit proof of payment to Benefits Administration. Your proof of payment will be forwarded to Blue Cross Dental Net. Blue Cross Dental Net will reimburse you.

Orthodontia

Blue Cross Dental Net covers Phase 2 orthodontia for *children* and adults. Phase 2 is done when all the permanent teeth are in place and involves full braces. These services must be received from a participating orthodontic office and be referred in writing. This coverage includes a consultation, 36 months of active treatment, and all retainers and retainer-adjustments. Your copayment is $650 for full-banded braces. However, if treatment lasts more than 36 months, you will be required to pay the participating orthodontist up to $35 per month for each additional month of standard active orthodontic treatment provided beyond the 36-month period, but before the retention phase of treatment begins.

Emergency Benefits

Special plan provisions apply if you need *emergency* dental treatment.

- If you are within 35 miles of your dental office when the *emergency* occurs, contact that office to arrange for your care. The answering service will assist you outside of regular office hours
- If you are more than 35 miles from your Blue Cross Dental Net office, you may receive treatment from another dentist. You are responsible for paying for the dentist's services. Send an itemized paid receipt of your *emergency* expense to your Blue Cross Dental Net office and they will reimburse your expenses up to $50, less any applicable co-payments for the procedures performed. You are responsible for all expenses that exceed $50.

What Blue Cross Dental Net Does Not Cover

Blue Cross Dental Net covers most dental services, but there are some exceptions and limits to your coverage. Blue Cross Dental Net limits or does not cover the following:

Limited Services

Denture Relines. Complete and/or partial denture relines or rebases are limited to one per denture during any 12-month period.

Impactions. Removal of impacted teeth is limited to impactions which show radiographic evidence of a pathologic condition or for which the member experiences symptoms of infection, swelling or chronic pain.

Pediatric Annual Maximum. Pediatric dental services performed by a pedodontist are limited to **$500** for each *child* during any 12-month period. Referral to a pedodontist will be considered ONLY for *children* to the age of 5. Pedodontist services are payable for *children* under the age of five ONLY. Charges in excess of **$500** will be your financial responsibility. *Children* age five and over would be entitled to the standard dental benefits under the Blue Cross Dental Net Plan.

Periodontal Procedures. Periodontal scaling and root planing and/or gingival curettage are limited to one course of therapy per quadrant during any 12-month period.

Precious Metals. The use of alloys with 25 percent or more noble metal content for any restorative procedure is considered optional and, if used, the additional cost for such alloy will be your responsibility.

Professionally Acceptable Treatment. In cases where multiple acceptable methods of treatment exist, the least expensive professionally acceptable treatment is considered the covered benefit.

Prophylaxis. Prophylaxis procedures are limited to two treatments during any 12-month period.

Prosthodontic Replacements:

1. Partial dentures are not eligible for replacement within five years of original placement unless required as a result of additional tooth loss that cannot be restored by modification of the existing partial denture.
2. Crowns, bridges, inlays and/or complete dentures are not eligible for replacement within five years of original placement.

Unauthorized Services. Dental services must be received from your participating dental office unless an exception is specifically authorized in writing by your participating dental office or by Blue Cross Dental Net.

Services Not Covered

Acts of Third Parties. Any illness, injury, or condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party is not covered. However, Blue Cross Dental Net will provide the benefits of this plan option subject to the following:

- Blue Cross Dental Net and your participating dental office will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in an amount equal to the reasonable cash value of the benefits provided by your participating dental office and Blue Cross Dental

Net under this plan option for the treatment of the illness, disease, injury or condition for which the third party is liable.

- You must advise your participating dental office and Blue Cross Dental Net in writing within 60 days of filing a claim against the third party, and take necessary action, furnish such information and assistance, and execute such papers as your participating dental office and Blue Cross Dental Net may be required to facilitate enforcement of their rights. You must not take action which may prejudice the rights or interest of your participating dental office and Blue Cross Dental Net under this plan option. Failure to give such notice to, or cooperate with, your participating dental office and Blue Cross Dental Net, or actions that prejudice the rights or interests of your participating dental office and Blue Cross Dental Net will be a material breach of this plan option and will result in your being personally responsible for reimbursing your participating dental office and Blue Cross Dental Net.
- Blue Cross Dental Net or your participating dental office will be entitled to collect on their lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

Composite Resin and Porcelain Restorations. Porcelain or composite labial veneers for fixed prosthodontics, posterior to the second bicuspid and composite fillings posterior to the cuspid. Any material other than base metal is optional and will be an additional cost to the member.

Congenital (Hereditary) or Developmental Malformations. Dental treatment or expenses incurred in connection with the correction of congenital or developmental malformations including but not limited to enamel hypoplasia, fluorosis, endodontia, supernumerary or impacted teeth other than third molars.

Cosmetic Services. Dental services necessary solely for cosmetic reasons including, but not limited to, bleaching of non-vital discolored teeth and bonding procedures (unless specifically shown as a covered benefit).

Cysts and Neoplasms. Histopathological exams, and/or the removal of tumors, cysts, neoplasms, and foreign bodies.

***Experimental* or *Investigative* Procedures.** Procedures which are considered *experimental* or *investigative* or which are not widely accepted as proven and effective procedures within the organized dental community.

Extensive Oral Rehabilitation. Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive oral rehabilitation or reconstruction. (Other than for replacement of structure lost due to dental decay). Five (5) or more crowns subject to the plan's approval.

Fractures or Dislocations. Treatment of fractures or dislocations.

General Anesthesia. General anesthesia, inhalation sedation, intra-venous sedation or intramuscular sedation.

Government Programs. Care or treatment which is obtained from, or for which payment is made by, any Federal, State, County, Municipal, or other government agency, including any foreign government.

Hospital Charges. Hospital and associated *physician* charges of any kind or charges for any dental treatment which cannot be performed in the participating dental office.

Implants. Dental procedures and charges incurred as part of implants or the removal of the same. Fixed or removable prosthetics in conjunction with implants. Prophylaxis on implants.

Lost or Stolen Dentures or Appliances. Replacement of lost crowns, lost or stolen dentures, bridgework, or other dental appliances.

Member Health Limitations. Charges for any dental treatment, which because of your general health, or mental, emotional, behavioral, or physical limitations, cannot be performed in the participating dental office.

Not *Medically Necessary*. A dental treatment plan which in Blue Cross Dental Net's opinion, or the opinion of the participating dentist, is not *medically necessary* or will not produce beneficial results.

Periodontal Splinting. Dental treatment or expenses incurred in connection with periodontal splinting.

Procedures Not Specified as Covered. Any procedure not specifically listed as a covered service.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Prosthetic Services Age Limitations. Inlays, onlays, crowns, fixed bridges or removable cast partials for members under 16 years of age. Space maintainers for members over 16 years of age.

Result of Nuclear Energy. Conditions that result from any release of nuclear energy, whether or not a result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Services Provided Before or After the Term of Your Coverage. Dental treatment or expenses incurred in connection with any dental procedure started prior to your effective date or after termination of your coverage, except as specifically stated under Extension of Benefits in the Blue Cross of California Dental Net Combined Evidence of Coverage and Disclosure Form.

Surgical Services. Tooth implantation or transplantation, orthognathic surgery, soft tissue or osseous grafts, hemisection, or root amputation, apexification, alveoloplasty, vestibuloplasty or ostectomy procedures.

Treatment by a Non-Participating Dentist. Any corrective treatment required as a result of dental services performed by a non-participating dentist while this coverage is in effect, with the exception of *emergency* services and any dental services started by a non-participating dentist, will not be Blue Cross Dental Net's responsibility, nor the responsibility of the participating dental office, for completion.

Treatment of the Joint of the Jaw. Diagnosis or treatment by any method of any condition related to the jaw joint (temporomandibular joint) or associated musculature, nerves and other tissues.

Vertical Dimension and Attrition. Dental treatment or procedures (other than those for replacement of structure lost due to dental decay) required in conjunction with altering vertical dimension or replacing tooth structure lost by attrition, erosion or abrasion or due to bruxism.

Workers' Compensation. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any workers' compensation or occupational disease law, even if you did not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to Blue Cross Dental Net's right of recovery and reimbursement under California Labor Code Section 4903, and as described in the "Acts of Third Parties" provision set forth above.

Drugs or Dispensing of Drugs. Blue Cross Dental Net does not cover prescription drugs as a dental benefit.

Questionable, Guarded or Poor Prognosis. Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Blue Cross Dental Net will allow for observation or extraction and prosthetic replacement.

Personalization, Characterization or Precision Attachments. Precision attachments, characterization or personalization of dentures is excluded.

Crown Lengthening. Crown exposure, ligation and crown lengthening are not covered.

Removal of Third Molars. Immature erupting third molars are not covered for extraction, i.e., tooth proceeding through a normal eruption process.

Primary Restorations. Gold, porcelain or resin fillings on primary teeth are excluded.

Build Ups. Amalgam, composite or cement build-ups are not a separate benefit, but are considered part of the completed restoration.

Denture Replacement. Dentures, full or partial-replacements will be made only if existing denture is at least five (5) years old, is unsatisfactory and cannot be made serviceable.

Services for injuries or conditions resulting from occupational causes.

Services for illness or injury sustained as the result of war, declared or undeclared.

Orthodontic Services Subject to Limitations and Exclusions

Orthodontic Limitations

Authorized Orthodontic Services. Orthodontic services must be received from a participating orthodontic office as specifically authorized and referred by Blue Cross Dental Net in writing.

Lifetime Maximum. Orthodontic treatment is limited to one full case (up to 36 months of standard orthodontic care) during your lifetime.

Loss of Coverage During Orthodontic Treatment. If your coverage under Blue Cross Dental Net ends, for any reason, while you are still receiving orthodontic treatment during the 36 month treatment period, you and NOT Blue Cross will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's *customary and reasonable* fee, prorated for the number of months of treatment remaining.

Orthodontic Consultation/Observation Fees. If treatment is not required or you choose not to start treatment after a diagnosis and consultation have been completed by the provider, you may be charged a consultation fee of **$30** in addition to diagnostic record fees.

Orthodontic Retention Phase of Care. Retention services include initial fabrication, placement, observation, and adjustments of passive retention appliances for a 12-month period. The retention services fee of **$250** is your responsibility and is payable at the beginning of the retention phase of treatment. Retention services fees are subject to review and modification on an annual basis.

Orthodontic Services in Excess of 36 Months of Active Care. You are required to pay the participating orthodontist up to **$35** per month for each additional month of standard active orthodontic treatment provided beyond the 36-month period, but before the retention phase of treatment begins.

Orthodontic Exclusions

Phase 1 Orthodontic Services are not covered. Phase 1 is treatment that involves the use of partial braces, plates or retainers to expand space for developing adult teeth, correct crossbites, overbites, underbites or harmful habits.

Changes in Treatment. Changes in treatment necessitated by an accident of any kind.

Myofunctional Therapy. Myofunctional therapy and related services. (Myofunctional therapy involves the use of muscle exercises as an adjunct to orthodontic mechanical correction of malocclusion.)

Orthodontic Records. Orthodontic records including, but not limited to, cephalometric tracings, photographs, study models and diagnostic radiographs.

Orthodontic Retreatment. The retreatment of a previously treated orthodontic case (whether treated under this coverage, at fee-for-service, or under another benefit plan) is not covered.

Orthodontic Services Provided Before or After the Term of Your Coverage. Treatment of orthodontic cases begun prior to your effective date or after termination of your coverage.

Orthodontic Treatment Incidental to Surgical Procedures. Orthodontic treatment in conjunction with oral surgical procedures including, but not limited to, orthognathic surgery.

Orthopaedic/Orthodontic Treatment. Any orthopaedic/orthodontic treatment which may be deemed advantageous or necessary by the participating orthodontist prior to the 36 months of standard active treatment. Orthodontic treatment for malocclusions which, in the opinion of the participating orthodontist will not produce beneficial results.

Other Orthodontic Services. Services for braces, other orthodontic appliances, or orthodontic services, except as specifically stated in this document and the Blue Cross of California Dental Net Evidence of Coverage Form.

Replacement of Orthodontic Appliances. Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances broken due to your negligence.

Special Orthodontic Appliances. Special types of orthodontic appliances which are considered cosmetic including, but not limited to, lingual or "invisible" braces, sapphire or clear braces, or ceramic braces.

Surgical Procedures Incidental to Orthodontic Treatment. Surgical procedures incidental to orthodontic treatment including, but not limited to, extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate.

T.M.J. or Hormonal Imbalance Orthodontic Services. Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance.

How To File A Blue Cross Dental Net Claim

You do not need to file claims if you enroll in Blue Cross Dental Net — Blue Cross Dental Net dentists charge you only your share of the cost of services. Your primary dentist will file any necessary claims for you.

If you have a Blue Cross Dental Net claim (for example, when you receive *emergency* treatment from a provider outside of your dental office), you must send proof of your itemized paid receipt to your dental office, but you do not need to fill out a special claim form.

If your claim is denied, in whole or in part, you may request a review of that denial. See **Claims and Appeals** in the Other Important Information section in this handbook for details.

Coordination of Benefits - Effect on Benefits

If you are covered by more than one group dental plan, your benefits under Blue Cross Dental Net will be coordinated with the benefits of those other plans, as shown below. These coordination provisions apply separately to each member, per year, and are largely determined by California law.

1. If Blue Cross Dental Net is the principal plan, then its benefits will be determined first without taking into account the benefits or services of any other plan.

2. If Blue Cross Dental Net is not the principal plan, then its benefits may be reduced so that the benefits and services of all of the plans do not exceed the allowable expense.

3. The benefits of Blue Cross Dental Net will never be greater than the sum of the benefits that would have been paid if you were covered under Blue Cross Dental Net only.

If Blue Cross Dental Net is not the principal plan, you may be billed by a dentist or other provider of dental care.

Your copayments through the Blue Cross Dental Net plan option may be reduced if a member and spouse both employed by the company enroll for Blue Cross Dental Net and use the same participating dental office. Copayments will be waived for all coverages, except orthodontia.

If you are covered by more than one dental plan, see **Coordination of Benefits** in the Health Care Overview to see how they may work together to provide benefits.

Delta Dental PPO

Delta Dental PPO (Delta) is a preferred provider organization plan. The Delta plan gives you the freedom to visit any licensed dentist. However, to minimize your *out-of-pocket* costs, you are encouraged to seek care from a Delta Dental PPO dentist.

With Delta, you have three options for choosing a dentist:

- For the lowest *out-of-pocket* solution, you can visit a Delta Dental PPO dentist. There is no *deductible* required and because PPO dentists are Delta dentists who have agreed to charge discounted fees to PPO enrollees, the payment will be made based on a negotiated rate
- You can visit a non-PPO Delta dentist. You will pay the first $50, with a $150 family limit per calendar year, before Delta begins to pay benefits for covered procedures[1]. Payments will be made based on a negotiated rate
- You can select any licensed dentist, even one who is not a PPO or Delta dentist. Again, you will pay the first $50, with a $150 family limit per calendar year, before Delta begins to pay benefits for covered procedures[1]. With this option, you will likely have higher *out-of-pocket* costs since those dentists' fees are not pre-negotiated by Delta

[1] The *deductible* is not required for Diagnostic and Preventive Services.

When you visit a PPO or Delta dentist, you do not pay the entire bill in advance and wait for reimbursement from Delta. Instead, Delta pays its portion directly to your dentist. You are responsible for your portion of the bill (any applicable copayment, *deductible* and/or amount over your annual maximum). The PPO or Delta dentist also handles claim forms and other paperwork for you.

While Delta covers most regular dental services, there are some dental services that are not covered.

Providers

PPO dentists are a select group of Delta dentists who have an agreement with Delta to provide services to you at moderate fees. If you don't visit a PPO dentist, it's still to your advantage to seek treatment from a Delta dentist, whose fees are pre-approved by Delta, to reduce your *out-of-pocket* expense.

For the most current list of PPO dentists, visit Delta's Web site at www.deltadentalca.org. Click on "Finding a Dentist" in the Enrollees section to search for a PPO dentist. You can specify:

- California or another state
- The dentist's network (PPO)
- The dentist's specialty
- The dentist's city and/or zip code
- The dentist's name to find out if a specific dentist participates

The online directory for California provides address and phone numbers and additional office information when available (such as office hours, languages spoken, etc.). By clicking on the street address, you can view a map and directions to the dental office.

You may also call Delta's toll-free directory service at (800) 427-3237. This automated service is available 24 hours a day. You will be asked to provide:

- Your program type (PPO)
- Your name and complete address, and
- The city or cities (up to three) and state for which you are requesting a listing

If your dentist is not a Delta dentist, Delta may consider him or her for participation in the PPO network.

To nominate your dentist for PPO membership, use the "Nominate Your Dentist" page at the Delta Web site (www.deltadentalca.org). Click on Online help in the Enrollees section. Or, you can send Delta a note and provide the dentist's name, address, phone number and your name, address and company name. Mail the information to Delta Dental of California, Professional Relations – 5Z, 100 First Street, San Francisco, CA 94105, or fax it to (415) 543-6326.

What Delta Dental PPO Covers

Delta Dental PPO pays a percentage of the PPO dentist's allowed fee or the Delta dentist's allowed fee. You pay the remaining percentage plus the amount, if any, in excess of the allowed fees. If you choose a more expensive plan of treatment than is customarily provided - for example, you choose a gold crown where a silver filling would suffice—the plan pays a percentage of the lesser fee, and you are responsible for the remainder.

Until you reach the plan maximum, Delta pays a percentage of *covered expenses* for services listed in the following chart.

Delta Dental PPO Benefits – Effective January 1, 2013		
When treatment is provided by…	**A PPO in-network dentist**	**An out-of-network dentist**
Deductible	None	$50 per person, $150 per family
Diagnostic and Preventive Services		
Oral Exams	100% of PPO dentist's allowed fee; limited to two examinations per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee; limited to two examinations per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)
Teeth Cleaning	100% of PPO dentist's allowed fee; limited to three cleanings per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee; limited to three cleanings per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)
Fluoride Treatment	100% of PPO dentist's allowed fee; limited to three fluoride treatments per calendar year	100% of PPO dentist's allowed fee; limited to three fluoride treatments per calendar year

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	(no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)	(no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)
Bitewing x rays	100% of PPO dentist's allowed fee; full mouth x rays every three years; supplemental x rays when needed, up to once every six months (*deductible* applies and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee; full mouth x rays every three years; supplemental x rays when needed, up to once every six months (*deductible* applies and does not count toward the plan's Maximum Annual Benefit)
Full mouth x rays	100% of PPO dentist's allowed fee; full mouth x rays every three years; supplemental x rays when needed, up to once every six months (*deductible* applies and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee; full mouth x rays every three years; supplemental x rays when needed, up to once every six months (*deductible* applies and does not count toward the plan's Maximum Annual Benefit)
Space Maintainers	100% of PPO dentist's allowed fee (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)
Study Models	100% of PPO dentist's allowed fee (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)
Biopsy/tissue exam	100% of PPO dentist's allowed fee; limited to two exams per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee; limited to two exams per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)
Consultation by a specialist	100% of PPO dentist's allowed fee; limited to two consultations per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee; limited to two consultations per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)
Oral hygiene	Not Applicable	Not Applicable
Dietary Instructions	Not Applicable	Not Applicable
Emergency treatment	100% of PPO dentist's allowed fee; limited to two exams per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)	100% of PPO dentist's allowed fee; limited to two exams per calendar year (no *deductible* applies for these services and does not count toward the plan's Maximum Annual Benefit)
Basic, Major and Restorative Services		
Major Sealants to age 14 (one per tooth on occlusal surface free of decay and restoration) Basic fillings (amalgams and composites) Resin fillings (anterior only) Inlays/Onlays Stainless steel crown Crowns, jackets and gold or cast	70% of PPO dentist's allowed fee	70% of Delta dentist's allowed fee

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

restorations		
Oral Surgery		
Simple tooth extraction Impactions – soft tissue, partial bony and full bony Alveoplasty (per quadrant) Anesthesia for dental care	70% of PPO dentist's allowed fee	70% of Delta dentist's allowed fee
Endodontic Services		
Root canal treatment Pulp Cap	70% of PPO dentist's allowed fee	70% of Delta dentist's allowed fee
Periodontic Services		
Gingivectomy – per tooth Gingivectomy – per quadrant Scaling/root planning – per quadrant Osseous surgery – per quadrant Frenectomy	70% of PPO dentist's allowed fee	70% of Delta dentist's allowed fee
Prosthodontic Services		
Bridges – removable or fixed Dentures – partial or complete Dental Implants	70% of PPO dentist's allowed fee	70% of Delta dentist's allowed fee
Orthodontic Services (Phase 2 only)		
Braces for *children* Braces for adults	80% of PPO dentist's allowed fee (subject to a lifetime maximum of $2,000 per person)	80% of Delta dentist's allowed fee (subject to a lifetime maximum of $2,000 per person)
Maximum Annual Benefit (excluding orthodontia, preventive and diagnostic services)	$2,000 per person	$2,000 per person

Pre-Determination of Benefits

If your dentist recommends services that are expected to cost more than $300, you can get an estimate of how much the plan will pay before you begin treatment. To do so, have your dentist submit for a pre-determination to Delta. (Forms are available from your dentist.)

Delta will notify your dentist of the maximum payment for the services described. Then you and your dentist can decide on your treatment. You are responsible for any excess charges related to services that are limited or not covered. If there is a major change in the treatment plan, a revised plan should be sent to Delta. Predetermination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time the services are completed.

Maximum Benefits

The plan will pay up to $2,000 per eligible person, per calendar year, in addition to any benefits for orthodontia.

Delta Dental PPO Maximum Benefits per Person	Employees and Dependents
Annual maximum (excluding orthodontia, preventive and diagnostic services)	$2,000 per person
Orthodontia lifetime maximum	$2,000 per person

What Delta Dental PPO Does Not Cover

Delta Dental PPO covers most dental services, but there are some exceptions and limitations to your coverage. Delta limits or does not cover the following:

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- An oral examination is a benefit only when the dentist has an accepted fee on file with Delta for this procedure. It will not be provided more than twice in a calendar year while the patient is an eligible person under any Delta program
- Delta pays for full-mouth x rays only after three years have elapsed since any prior set of full mouth x rays was provided under any Delta program. Bitewing x rays are limited to two in a calendar year while the patient is an eligible person under any Delta program
- Prophylaxis cleanings and topical application of fluoride solution is limited to three cleanings and fluoride treatments each calendar year
- Sealant benefits are limited to eligible dependent *children* under age 14. Sealant benefits include the application of sealants only to permanent posterior molars with no caries (decay), with no restorations and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three (3) years of its application
- Expenses for services that are not considered to be "dentally necessary." Dentally necessary services or supplies are those provided by a professional provider that the plan administrator determines are:
  - Appropriate for the symptoms and diagnosis or treatment of the dental condition, illness or injury
  - Provided for the diagnosis or direct care and treatment of the condition, illness or injury
  - In accordance with accepted standards of good dental practice within the organized dental community
  - Not primarily for your convenience or for the convenience of your dentist, *physician* or other provider
- Replacement in less than five years of crowns, jackets, and gold or cast restorations that you received under Delta
- Crowns, jackets, inlays, onlays, and gold or cast restorations, unless teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations
- Replacement in less than five years of prosthodontic appliances (such as bridges, implants and dentures) that you received under Delta. If a prosthodontic appliance was not received under Delta and cannot be adjusted as necessary, it can be replaced under Delta
- Surgery or services for cosmetic reasons
- Services to treat disturbances of the temporomandibular (jaw) joints
- Services required because of injury or illness resulting from occupational causes which are covered under Workers' Compensation or Employer's Liability Laws.
- Periodontal cleanings, if the eligible patient has received three cleanings covered by the program in the same calendar year
- Services related to congenital or developmental malformations
- Services to restore tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to crooked teeth or occlusion, or for stabilizing teeth, including equilibration and periodontal splinting
- Prosthodontic services and devices or any single procedure started before your coverage begins
- *Experimental* procedures
- Hospital charges and any additional fees charged by your dentist for hospital treatment
- Anesthesia charges other than general anesthesia administered by a licensed dentist in connection with covered oral surgery
- Grafting of tissues from outside the mouth to oral tissues
- Replacement and/or repair of orthodontic appliances
- Prescribed drugs
- Services provided by a federal government or another *company* benefit plan
- If an eligible person selects a more expensive plan of treatment than is customarily provided, or specialized techniques rather than standard procedures, Delta will pay the applicable percentage of the lesser fee and the patient is responsible for the remainder of the dentist's fee.

How To File A Delta Dental PPO Claim

When you visit a Delta dentist, the dentist may only charge you your share of the cost of services. If an eligible person has any questions about the charges for services received from a participating dentist, Delta recommends that he or she first discuss the matter with the dentist. If he or she continues to have concerns, the eligible person may call or write Delta.

If you enroll in Delta but use a nonparticipating dentist, you must file a claim within six months of the date services were provided in order to receive benefits. Send a copy of the dentist's bill along with an Attending Dentist Statement (Claim Form) to:

Delta Dental Plan
P. O. Box 997330
Sacramento, CA 95899-7330.

If your claim is denied, in whole or in part, you may request a review of that denial. See **Claims and Appeals** in the Other Important Information section in this handbook for details.

Coordination of Benefits

When you (or your dependents) are covered under two group dental plans, your plan and the other plan will work together to pay benefits. Your combined benefit from the two plans, depending on their type, may be as much as, but not more than 100 percent of your *covered expenses.*

If you and your *spouse*, or *domestic partner*, both work for the *company* and have enrolled each other as dependents in the *company's* Dental Plan benefits, you may receive up to, but not more than 100 percent of *covered expenses* if:

- You both enroll for Delta
- One of you enrolls in Delta and the other enrolls in another company dental plan option

If you are covered by more than one dental plan, see **Coordination of Benefits** in the Health Care Overview to see how they may work together to provide benefits.

SafeGuard Dental (SafeGuard Health Plans, Inc. of California, a MetLife company)

When you enroll in SafeGuard Dental (SafeGuard), you and your enrolled dependents may select different SafeGuard offices to provide your dental services. SafeGuard pays 100 percent of the cost of some services and requires you to make a copayment for other covered services. While SafeGuard covers most regular dental services, there are some dental services that are not covered.

Providers

Before your SafeGuard coverage can begin, you must enroll for coverage in a particular SafeGuard dental office. You and your dependents may select different SafeGuard dental offices directly through SafeGuard. If you do not select a dental office, SafeGuard will assign one to you. Except for *emergency* services or when referred elsewhere by your SafeGuard dentist, you must use your SafeGuard office in order to receive plan benefits. You receive an identification card showing your dental office number and a code identifying your benefits.

If you move or would prefer another SafeGuard office, you and/or your enrolled dependents may change to a different office by calling SafeGuard at (800) 880-1800. Dental provider changes are limited to once per month and are effective the first of the following month.

What SafeGuard Dental Covers

SafeGuard pays the full cost of some covered services and establishes a copayment amount for other covered dental services.

Summary of SafeGuard Dental Benefits - Effective January 1, 2013	
Covered Services	**SafeGuard Pays**
Calendar Year *Deductible*	None
Maximum Annual Benefit	None
Diagnostic and Preventive Services	
Oral Exams	100% after a $5 copay
Teeth Cleaning	100%
Fluoride Treatment (to age 18)	100%
Bitewing x rays	100%
Full mouth x rays	100%
Space Maintainers	100%
Study Models	100%

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Biopsy/tissue exam	100%
Consultation by a specialist	100%
Oral Hygiene	100%
Dietary Instructions	*Usual, Customary and Reasonable*
Emergency treatment	100%
Basic, Major and Restorative Services	
Molar Sealants to age 14 (one per tooth on occlusal surface free of decay and restoration)	100% after a $5 copay per sealant
Basic fillings (amalgams and composites)	100%
Resin fillings (anterior only)	100%
Stainless steel crown	100%
Crowns, jackets and gold or cast retorations	100% after an $85 copayment
Oral Surgery Services	
Simple tooth extraction	100%
Impactions - soft tissue, partial bony and full bony	100% after a $15 to $130 copayment
Alveoplasty (per quadrant)	100%
Anesthesia for dental	Not Covered
Endodontic Services	
Root canal treatment	100% after a $70 to $160 copayment
Pulp Cap	100%
Periodontic Services	
Gingivectomy – per tooth	100% after a $26 to $35 copayment
Gingivectomy – per quadrant	100% after a $26 to $35 copayment
Scaling/root planing – per quadrant	100% after an $11 to $15 copayment
Osseous surgey – per quadrant	100% after a $113 to $150 copayment
Frenectomy	100%
Prosthodontic Services	
Inlay/Onlay restorations	100% after a $85 copayment
Bridges – removable or fixed	100% after a $85 copayment per unit
Dentures – partial	100% after a $100 to $125 copayment
Dentures – complete	100% after a $100 copayment
Denture – repair	100% after a $10 to $35 copayment
Orthodontic Services (36 months of standard Phase 2 orthodontic care; exclusive of records/retention fees)	
Braces for *children*	100% for Phase 2 after a $650 copayment *
Braces for adults	100% for Phase 2 after a $650 copayment *

***** Phase 1 is not covered. Phase 1 is treatment that often involves the use of partial braces, plates or retainers to expand space for developing adult teeth, correct crossbites, overbites, underbites or harmful habits. The copayment is for Phase 2 only. Phase 2 is done when all the permanent teeth are in place and involves full braces, which give maximum control over the movement of teeth, whereas plates or "retainers" can only tip teeth in certain directions. The correction of rotated teeth and any movement of teeth that involves more than simple tipping movements are usually achieved with braces.

SafeGuard Pays the Full Cost of the Following Covered Services:

- Diagnostic and preventive services including:
  - Full-mouth x rays every 12 months, unless required more often for specific diagnostic reasons
  - Teeth cleaning every six months
  - Topical fluoride treatments once every six months up to age 18
  - Space maintainers
- Fillings, including amalgam and composite restorations (anterior-primary only)
- Periodontics, including subgingival curettage, root planing and gingivectomy
- Some endodontics, such as pulp capping, pulpotomy, recalcification, culturing canal, apicoectomy and filling canal, and apicoectomy on separate appointment
- Some prosthetics, such as simple stress breakers, stayplate, denture adjustment and repair
- Some oral surgery, such as single extractions
- Charges for failure to give 24 hours' notice when canceling an appointment. You pay the dentist and submit your proof of payment to Benefits Administration. Your proof of payment will be forwarded to SafeGuard. SafeGuard will reimburse you directly.

SafeGuard Requires a Copayment for:

- Oral exams
- Some endodontics, such as root canals
- Some prosthetics, such as a partial denture or complete upper or lower denture
- Some oral surgery, such as removal of an impacted tooth

Refer to the SafeGuard Schedule of Benefits which specifies covered services and member copayment information.

Orthodontia

SafeGuard covers Phase 2 orthodontia for *children* and adults. This coverage includes a consultation, 36 months of active treatment and all bionators, retainers, and retainer-adjustments. Your copayment is $650 for full-banded braces. Treatment that extends thirty-six (36) months beyond the point of full permanent dentition will be subject to a $25 office visit charge. Should a member be terminated for any reason, and at the time of termination be receiving orthodontic treatment, the member and not SafeGuard will be responsible for payment of the balance due for treatment performed after termination. The member's payment shall be based upon a maximum copayment of fourteen hundred dollars ($1,400) and be prorated over the number of months to completion of treatment, and be payable on such terms and conditions as are arranged between the member and the orthodontist.

***Emergency* Benefits**

Special provisions apply if you need *emergency* dental treatment for the relief of pain, bleeding, or any condition that could result in disability or death.

- If you are within 50 miles of your SafeGuard office when the *emergency* occurs, call the *emergency* number of your dental office. You will be provided *emergency* dental service subject to the usual plan provisions
- If you are more than 50 miles from your SafeGuard office, you may receive *emergency* treatment only from another dentist. You are responsible for paying for the dentist's services. Submit an itemized paid receipt of your *emergency* expense to your SafeGuard office and they will reimburse your expenses up to $50, less any applicable copayments for the procedures performed. You are responsible for all expenses that exceed $50.

Other Covered Services

If your SafeGuard dentist recommends that a *child* under age six see a specialist, SafeGuard will pay 50% of the SafeGuard specialist's fee for covered services.

For other covered services, SafeGuard charges a copayment, based on a schedule. The SafeGuard Schedule of Benefits lists those services that require copayments.

Safeguard Schedule Of Benefits - Effective January 1, 2013

Diagnostic Treatment

CODE	SERVICE	MEMBER COPAYMENT
00120	Periodic oral examination	$5
00140	Limited oral evaluation (problem focused)	No Charge
00150	Comprehensive oral evaluation (including periodontal charting)	No Charge
00180	Comprehensive periodontal evaluation – new or established patient	No Charge
09491	Office visit fee - per visit	$5
00210	Intraoral - complete series (including bitewings)	No Charge
00220	Intraoral - periapical first film	No Charge
00230	Intraoral - periapical - each additional film	No Charge
00240	Intraoral - occlusal film	No Charge
00250	Extraoral - first film	No Charge
00260	Extraoral - each additional film	No Charge

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

00270	Bitewings - single film	No Charge
00272	Bitewings - two films	No Charge
00274	Bitewings - four films	No Charge
00330	Panorex	No Charge
00460	Pulp vitality tests	No Charge
00470	Diagnostics casts	No Charge

Preventive Services

- Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.

CODE	SERVICE	MEMBER COPAYMENT
01110	Prophylaxis - adult*	No Charge
01120	Prophylaxis - *child**	No Charge
01201	Fluoride (including prophylaxis) - *child**	No Charge
01203	Fluoride (excluding prophylaxis) - *child**	No Charge
01204	Fluoride (excluding prophylaxis) - adult*	No Charge
01205	Fluoride (including prophylaxis) - adult*	No Charge
01330	Oral hygiene instruction (preventive dental education)	No Charge
01351	Sealant – per tooth	$5
01510	Space maintainer - fixed - unilateral	$20
01515	Space maintainer - fixed - bilateral	$20
01520	Space maintainer - removable - unilateral	$20
01525	Space maintainer - removable - bilateral	$20
01550	Recementation of space maintainer	$5

Restorative Treatment

CODE	SERVICE	MEMBER COPAYMENT
02140	Amalgam - one surface, permanent	No Charge
02150	Amalgam - two surfaces, permanent	No Charge
02160	Amalgam - three surfaces, permanent	No Charge
02161	Amalgam - four or more surfaces, permanent	No Charge
02210	Silicate cement - per restoration	No Charge
02330	Resin - one surface, anterior	No Charge
02331	Resin - two surfaces, anterior	No Charge
02332	Resin - three surfaces, anterior	No Charge
02335	Resin - four or more surfaces, anterior	No Charge
02390	Resin-based composite crown, anterior	$30
02391	Resin-based composite crown, one surface, posterior	$65
02392	Resin-based composite crown, two surfaces, posterior	$75
02393	Resin-based composite crown, three surfaces, posterior	$80
02394	Resin-based composite crown, four or more surfaces, posterior	$80

Crowns - Per Unit: Plus Additional Cost Of Noble/High Noble Metal (Gold)

- Replacement limit: one every five years.
- Procedures identified by two asterisks (**) involve the additional cost of noble/high noble metal.
- Cases involving seven or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- $75 fee per crown unit above co-pay for porcelain on molars.

CODE	SERVICE	MEMBER COPAYMENT
02510	Inlay – metallic – one surface**	$85
02520	Inlay – metallic – two surfaces**	$85
02530	Inlay – metallic – three or more surfaces**	$85
02543	Onlay – metallic – three surfaces**	$85
02544	Onlay – metallic – four or more surfaces**	$85
02740	Porcelain/ceramic substrate	$225
02750	Porcelain fused to high noble metal (gold)*	$85
02751	Porcelain fused to predominantly base metal*	$85
02752	Porcelain fused to noble metal*	$85
02780	Crown – ¾ cast high noble metal**	$85
02781	Crown – ¾ predominately base metal	$85
02782	Crown – ¾ cast noble metal**	$85
02790	Crown - Full cast high noble metal (gold)**	$85
02791	Crown - Full cast predominantly base metal	$85
02792	Crown - Full cast noble metal**	$85
02910	Recement inlay	No Charge
02920	Recement crown	No Charge
02930	Prefabricated Stainless Steele crown - primary tooth	No Charge
02931	Prefabricated Stainless Steele crown - permanent tooth	No Charge
02940	Sedative filling	No Charge
02950	Crown buildup, including any pins	$15
02951	Pin retention - per tooth – in addition to restoration	$10
02952	Cast post and core in addition to crown	$25
02954	Prefabricated post and core in addition to crown	$25
02955	Post Removal (not in conjunction with endodontic therapy)	$10

Endodontics

- All procedures exclude final restoration.

CODE	SERVICE	MEMBER COPAYMENT
03110	Pulp cap - direct (excluding final restoration)	No Charge
03120	Pulp cap - indirect (excluding final restoration)	No Charge
03220	Therapeutic or vital pulpotomy/pulpectomy	No Charge
03230	Pulpal therapy with restorable filing – primary anterior tooth	$5
03240	Pulpal therapy with restorable filing – primary posterior tooth	$10
03310	Root canal – Anterior, per tooth	$70
03320	Root canal – Bicuspid, per tooth	$80
03330	Root canal – Molar, per tooth	$150
03346	Retreatment of root canal – anterior, per tooth	$80
03347	Retreatment of root canal – bicuspid, per tooth	$100
03348	Retreatment of root canal – molar, per tooth	$160
03351	Apexification/recalcification – initial visit	$65
03352	Apexification/recalcification – interim visit	$65
03353	Apexification/recalcification – final visit	$65
03410	Apicoectomy/periradicualr surgery - anterior	$90
03421	Apicoectomy/periradicualr surgery – bicuspid, first tooth	$90
03425	Apicoectomy/periradicualr surgery – molar, first root)	$90
03426	Apicoectomy/periradicualr surgery – each additional root	$90

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

03430	Retrograde filling - per root	$90
03450	Root amputation – per root	$95
03920	Hemisection – including root removal (excluding root canal therapy	$90

Periodontics

CODE	SERVICE	MEMBER COPAYMENT
4210	Gingivectomy or Gingivoplasty - per quad. (4 or more teeth)	$35
4211	Gingivectomy or gingivoplasty - per quad (3 to 1 teeth)	$26
4240	Gingival flap procedure, including Root planning - (4 or more teeth) per quadrant)	$150
4241	Gingival flap procedure, including Root planning - (3 to 1 teeth) per quadrant)	$113
4249	Clinical Crown lengthening - hard tissue	$125
4260	Osseous Surgery, including Flap Entry and Closure - per quad. (3 to 1 teeth)	$150
4261	Osseous Surgery, including Flap Entry and Closure - per quad. (4 or more teeth)	$113
4270	Pedicle soft tissue graft procedure	$250
4271	Free soft tissue graft procedure, including Donor site surgery	$250
4273	Subepithelial connective tissue graft proc.	$300
4274	Distal or proximal wedge procedure-separate procedure	$50
4341	Periodontal Scaling and Root Planing - per quad. (4 or more teeth)	$15
4342	Periodontal Scaling and Root Planing - per quad. (3 to 1 teeth)	$11
4355	Full mouth debridement to enable comprehensive evaluation & diagnosis	$15
4381	Localized site - specific therapy	$60
4910	Periodontal maintenance procedures - following active surgery (2 in a 12 month period)	$25

Removable Prosthodontics

- Replacement limit: one every five year
- Procedures identified with three asterisks (***) are limited to one every 24 months.
- Includes up to three adjustments within six months of delivery.

CODE	SERVICE	MEMBER COPAYMENT
05110	Full upper denture	$100
05120	Full lower denture	$100
05130	Immediate upper denture	$100
05140	Immediate lower denture	$100
05211	Upper partial - resin base (includes any conventional clasps and rests)	$100
05212	Lower partial - resin base (includes any conventional clasps and rests)	$100
05213	Upper partial - cast metal base with resin saddles (including any conventional clasps and rests)	$125
05214	Lower partial - cast metal base with resin saddles (including any conventional clasps and rests)	$125
05410	Adjustment full denture - upper	No Charge
05411	Adjustment full denture - lower	No Charge
05421	Adjust partial denture - upper	No Charge

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

05422	Adjust partial denture - lower	No Charge
05510	Repair broken full denture base	$10
05520	Replace missing or broken teeth, full denture (each tooth)	$10
05610	Repair resin acrylic saddle or base	$10
05620	Repair cast framework	$10
05630	Repair or replace broken clasp	$10
05640	Replace broken teeth - per tooth	$10
05650	Add tooth to existing partial denture	$10
05660	Add clasp to existing partial denture	$10
05710	Rebase full upper denture	$35
05711	Rebase full lower denture	$35
05720	Rebase partial upper denture	$35
05721	Rebase partial lower denture	$35
05730	Reline full upper denture (chairside) ***	$20
05731	Reline full lower denture (chairside) ***	$20
05740	Reline upper partial denture (chairside) ***	$20
05741	Reline lower partial denture (chairside) ***	$20
05750	Reline full upper denture (lab) ***	$35
05751	Reline full lower denture (lab) ***	$35
05760	Reline upper partial denture (lab) ***	$35
05761	Reline lower partial denture (lab) ***	$35
05820	Interim partial denture (upper)	$35
05821	Interim partial denture (lower)	$35
05850	Tissue conditioning – upper	$10
05851	Tissue conditioning – lower	$10

Crowns/Fixed Bridges - Per Unit

- Replacement limit: one every five years.
- Procedures identified by two asterisks (**) involve the additional cost of noble/high noble metal.
- Cases involving seven or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.
- $75 fee per crown unit above co-pay for porcelain on molars.

CODE	SERVICE	MEMBER COPAYMENT
06210	Pontic - cast high noble metal**	$85
06211	Pontic - cast predominantly base metal	$85
06212	Pontic - cast noble metal**	$85
06240	Pontic - porcelain fused to high noble metal**	$85
06241	Pontic - porcelain fused to predominantly base metal	$85
06242	Pontic - porcelain fused to noble metal**	$85
06750	Crown - porcelain fused to high noble metal**	$85
06751	Crown - porcelain fused to predominantly base metal	$85
06752	Crown - porcelain fused to noble metal**	$85
06780	Crown - ¾ cast high noble metal**	$85
06781	Crown - ¾ cast predominantly base metal	$85
06790	Crown - full cast high noble metal**	$85
06791	Crown - full cast predominantly base metal	$85
06792	Crown - full cast noble metal**	$85
06930	Recement bridge	No Charge
06970	Cast post and core in addition to bridge retainer	$25
06971	Cast post as part of bridge retainer	$25

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

06972	Prefabricated post and core in addition to bridge retainer	$25
06973	Core build up for retainer - including any pins	$15

Oral Surgery

- Includes routine – post operative visits/treatment.
- Surgical removal of impacted teeth – (not covered unless pathology (disease) exists).
- Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.

CODE	SERVICE	MEMBER COPAYMENT
07140	Extraction - erupted tooth or exposed root (evaluation and/or forceps removal)	No Charge
07210	Surgical removal of erupted tooth	$15
07220	Extraction - Removal of impacted tooth - soft tissue	$15
07230	Extraction - Removal of impacted tooth - partial bony	$60
07240	Extraction - Removal of impacted tooth - complete bony	$90
07241	Extraction - Removal of Impacted tooth - completely bony w/ unusual surgical complications	$130
07250	Surgical removal of residual tooth roots	$50
07270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$110
07285	Biopsy of oral tissue - hard	No Charge
07286	Biopsy of oral tissue - soft	No Charge
07310	Alveolectomy/alveoplasty in conjunction with extractions (per quadrant)	No Charge
07320	Alveolectomy/alveoplasty not in conjunction with extractions (per quadrant)	No Charge
07960	Frenulectomy (frenectomy or frenotomy) separate	No Charge
07971	Excision of pericornal gingival	$40

Adjunctive General Services

CODE	SERVICE	MEMBER COPAYMENT
09110	Palliative (*emergency*) treatment of dental pain minor procedures	No Charge
09215	Local anesthesia	No Charge
09310	Consultation - (diagnostic service provided by dentist other than practitioner providing treatment)	No Charge
09430	Office visit for observation (during regularly scheduled hours) no other services performed	No Charge
09440	Office visit - after regularly scheduled hours	$20
09630	Medicinal application/irrigation per visit	$15
09951	Occlusion adjustment – limited	No Charge
09952	Occlusion adjustment - complete	No Charge
09999	Broken Appointment (Less than 24-hour notice)	No Charge

Orthodontics

CODE	SERVICE	MEMBER COPAYMENT
08020	Limited ortho treatment - *child*	Not Covered
08030	Limited ortho treatment - adolescent	Not Covered

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

08040	Limited ortho treatment – adult	Not Covered
08070	Comprehensive ortho treatment – *child* transitional dentition	$650
08080	Comprehensive ortho treatment – adolescent dentition (full band)	$650
08090	Comprehensive ortho treatment - adult dentition	$650
08660	Pre-orthodontic treatment visit	$25
08680	Retention Phase (including fee for fixed/removable retainers and monthly visits for 24 months)	No Charge
08755	Office visit after 36 months	$25
08999	Orthodontia records	No Charge

Maximum Benefits

There are no annual or lifetime maximum benefit limits under this Dental Plan option.

SafeGuard Limitations

The following limitations apply to your SafeGuard coverage:

- Dentures (full or partial): Dentures or appliances will be replaced only after five (5) years have elapsed following any prior provision of such dentures or appliances under any SafeGuard program unless the dentures become unsatisfactory due to illness or other causes not controlled by ordinary circumstances. Replacements under SafeGuard will be made only if the existing denture is unsatisfactory and cannot be made satisfactory
- Prophylaxis: Once every six (6) month
- Full mouth x rays: Once every three (3) years unless *medically necessary*
- Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption
- Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years
- Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 copayment per unit in addition to copayment for each crown/bridge unit
- There is a $75 copayment per crown/bridge unit in addition to regular copayments for porcelain on molars
- Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit
- Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service
- Surgical removal of impacted teeth is not a covered benefit unless pathology [disease] exists
- The copayments listed for endodontic procedures do not include the cost of final restoration

What SafeGuard Dental Does Not Cover

SafeGuard does not cover the following:

- Services performed by a general dentist or dentist whose practice is limited to providing Specialty Care, not contracted with SafeGuard without prior approval by SafeGuard, (except for out of area *emergency* services)
- Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard Selected General Dentist
- Any procedures not specifically listed as a covered benefit in the Schedule of Benefits
- Dental procedures or services performed solely for cosmetic purposes or solely for appearance
- Orthognathic surgery
- General anesthesia or intravenous sedation
- Any inpatient/outpatient hospital charges of any kind including dentist and/or *physician* charges, prescriptions or medications
- Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect
- Treatment of malignancies, cysts, or neoplasms
- Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits

- Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services
- Precision attachments
- Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan
- Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare
- Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war
- Services considered unnecessary or *experimental* in nature
- Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting
- Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics
- Dental services relating to injuries which are self-inflicted

Orthodontic Limitations and Exclusions

Orthodontic treatment is subject to the following:

- Orthodontic treatment must be provided by a SafeGuard Selected General Dentist or contracted dentist whose practice is limited to providing Specialty Care in order for the copayments listed in the Schedule of Benefits to apply
- Plan benefits shall cover thirty-six (36) months of *usual and customary* orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of $25
- The following are not included as orthodontic benefits:
  - Repair or replacement of lost or broken appliances
  - Retreatment of orthodontic cases
  - Treatment in progress at inception of eligibility
  - Interceptive or Phase I orthodontics
  - Changes in treatment necessitated by an accident
  - Treatment involving:
    - Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia
    - Hormonal imbalances or other factors affecting growth or developmental abnormalities
    - Treatment related to temporomandibular joint disorders
    - Lingually placed direct bonded appliances and arch wires ("invisible braces")
    - Functional appliances that are used in conjunction with fixed appliances
- The retention phase of treatment shall include the construction, placement, and adjustment of retainers

How To File A SafeGuard Dental Claim

You do not need to file claims if you enroll in SafeGuard and only seek treatment from your SafeGuard dental office. SafeGuard dentists charge you only your share of the cost of services and, if necessary, your primary dentist files your claims for you.

If you have a SafeGuard claim (for example, when you receive *emergency* treatment from a provider outside of your dental office), you must send proof of your itemized paid receipt to your dental office, but you do not need to fill out a special claim form.

If your claim is denied, in whole or in part, you may request a review of that denial. See Claims and Appeals in the Other Important Information section in this handbook for details.

Coordination of Benefits

SafeGuard does not coordinate coverage.

If you are covered by more than one dental plan, SafeGuard does not coordinate coverage and will provide its normal benefits regardless of the availability of other coverage.

Situations Affecting Dental Coverage

There are a number of situations that could affect your Dental coverage. For example, if you use a dentist who doesn't participate in your Dental Plan option, if you don't apply for benefits, or if you don't provide the necessary claim information, benefit payments may be delayed or forfeited. Also, if your Dental Plan option requires you to choose a primary dental office and you receive dental services at a different dental office, you may be ineligible for plan benefits. See **Events Affecting Your Benefits** for other situations that could affect your coverage.

Appeals

If a benefit claim is denied, in whole or in part, you or your beneficiary has a legal right to request a review of that denial. Generally, if you disagree with the outcome, you may appeal it.

Refer to the **Other Important Information** section of this handbook for details about documentation and the appeals process.

For More Information

You can get information about Dental coverage, claims inquiries, or customer service issues by calling the applicable numbers listed below:

Anthem Blue Cross of California Dental Net	(800) 627-0004
Delta Dental PPO	(800) 765-6003 or (888) 335-8227
SafeGuard Dental	(800) 880-1800

If you have called your dental plan and still have a question or concern, you may call the *EIX Benefits Connection* at (866) 693-4947.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Vision Plan

Vision Plan revised December 19, 2012.

Overview and Important Features

This plan provides vision benefits for *full-time* and *part-time plus* employees, eligible retirees, eligible dependents, and eligible survivors. Benefits are provided through VSP, an independent company offering vision services. Here are a few key features of the plan:

- You are required to pay a per-person *deductible* in each 12-month period
- If you use a VSP provider - after you meet any applicable *deductible* - your Vision coverage pays all or part of the cost of eye exams, frames, and lenses
- If you use a non-VSP provider - after you meet any applicable *deductible* - the plan pays benefits based on a schedule

Who Is Eligible

You are eligible for the Vision Plan if you are a *full-time* or *part-time plus* employee, eligible retiree, eligible dependent, or an eligible survivor. *Part-time, temporary* and *leased* employees and *contingent workers* are not eligible for Vision coverage.

Dependents serving in the military are not eligible for Vision coverage.

The specific eligibility requirements for dependents and details about when your coverage begins and ends are described in the **Health Care Overview** . Eligibility requirements for retirees are described in **Continued Health Care Coverage** at the end of this section of your handbook.

Enrolling For Coverage

Enrollment Deadlines

Full-time employees are automatically covered when hired.

If you don't enroll your eligible dependents within 30 days of first becoming eligible, you'll have to wait until annual enrollment to enroll them. If you enroll them during annual enrollment, their participation will become effective on January 1 of the following year. You cannot change your enrollment decisions during the calendar year unless you have a *qualified life event* or lose vision benefits you had through other group coverage. (See

Making Changes During the Year in the Health Care Overview at the beginning of this section of your handbook.)

If you become a *part-time plus* employee, the vision coverage you had in your previous classification will continue until the end of the plan year.

Annual Enrollment

Each year during annual enrollment, you'll have the opportunity to add or delete eligible dependents for the following year. If you don't add or delete eligible dependents during annual enrollment, you won't have another opportunity until the next year's annual enrollment period. Exceptions are made only if you have a *qualified life event* or lose vision benefits you had through other group coverage.

Making Changes During the Year

Within 30 days after the effective date of a *qualified life event*, you may change your Vision coverage. For example, within 30 days of your marriage, you may add your *spouse* to your coverage. To change your Vision coverage because you have a *qualified life event*, contact the *EIX Benefits Connection* at:

- (866) 693-4947
- www.eixbenefits.com

See **Making Changes During the Year** in the Health Care Overview at the beginning of this section of your handbook for more information. Special enrollment rights are described under **Enrolling for Coverage** in the Health Care Overview. Also see the **Events Affecting Your Benefits** section for details about *qualified life events.*

Cost of Coverage

The *company* currently pays the full cost of Vision coverage for eligible employees and employees' dependents. For information about eligibility and contributions after you retire, see **Continued Health Care Coverage** at the end of this section of your handbook.

Price Tags

You pay the cost of coverage for a *domestic partner* with post-tax payroll deductions. For employees at California work locations, the cost of coverage for your *domestic partner* or *same-sex spouse* is paid with post-tax deductions for federal tax purposes, and with pre-tax deductions for California state tax purposes.

If you're not receiving income directly from the *company* and payroll deductions are not possible (for example, you're on an unpaid leave of absence or are receiving Workers' Compensation benefits), you will be billed monthly.

If you don't receive enough pay during a pay period to cover your price tags, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. If you are in arrears after four consecutive pay periods, you will receive a written notice that you are being changed from payroll deduction to direct billing and you will be billed for future contributions you owe. If you fail to pay your contributions, your coverage will be terminated. Any amount that you have in arrears for payroll deductions during *deduction periods* prior to your change to direct billing that could not be collected at the end of the calendar year will be added to your W-2 statement as taxable income. If you leave the *company* or cease to be eligible for benefits, you will be billed for any outstanding deduction amounts.

How the Vision Plan Works

After you pay your *deductible*, the plan pays all or part of the cost of covered services if you use a VSP provider, and up to a scheduled amount if you use a non-VSP provider.

Deductible

The *deductible* must be paid to the provider on the date services are provided. If you pay the *deductible* for eligible vision services you received on February 1, you have satisfied the *deductible* requirement until February 1 of the following year.

Providers

You have the option of receiving vision services from a VSP provider or from any other licensed provider:

- When you use a VSP provider, the plan pays the full cost of covered services for standard frames and lenses, after you meet the *deductible*
- When you use any other provider, the plan pays benefits according to a schedule, after you meet the *deductible*

If you need help locating a VSP-participating doctor, call VSP at (800) 877-7195 or visit the VSP web site at www.vsp.com.

To be sure you receive full benefits, follow plan procedures shown in the chart below.

VSP Vision Plan Procedures	
If You Use a VSP Provider	**If You Use a Non-VSP Provider**

• Make an appointment with a VSP doctor
• Identify yourself as a VSP patient and indicate that your benefits are provided through the *company* and any other plan under which you may have coverage
• Give the doctor your VSP identification number (last four digits of your Social Security number) *
• The doctor's office will obtain the necessary authorization and benefit level information
  ◦ If you are not eligible for services at that time, the VSP doctor will notify you
  ◦ If you are authorized for and receive services, you will be charged only a *deductible*, if applicable, and any additional fees not covered by the plan
	• Make an appointment with a doctor of your choice
	• Pay the doctor the full cost of your visit
	• Mail an itemized statement of the charges within 180 days of your visit to the doctor to:
	VSP
	Attn: Out-of-Network Provider Claims
	P. O. Box 997105
	Sacramento, CA 95899-7105
	• Be sure the itemized statement includes:
	  ◦ Your name and address
	  ◦ Your VSP identification number (last four digits of your Social Security number) *
	  ◦ The patient's name
	  ◦ The date services were received
	  ◦ A list of the services and materials received
	  ◦ The charge for each item

* If you and/or your enrolled dependents have Vision coverage under more than one plan, you must give your provider the last four digits of your Social Security number, and the other plan's identification number and/or the last four digits of the Social Security number of the person who has the other coverage. Benefits from the plans will be coordinated. See **Coordination of Benefits** in this summary.

What the Vision Plan Covers

The plan covers the following Vision benefits for employees and their eligible dependents.

Summary of Vision Benefits for Active Employees		
Benefit Description	**VSP Provider**	**Non-VSP Provider**
12-month *deductible*	$20	$20
Eye exam - once every 12 months	100% after *deductible*	100% after *deductible*, up to a maximum benefit of $40
Standard frame - once every 24 months	100% after *deductible*, up to a maximum retail frame allowance of $115 Discount on any amount over the maximum allowance	100% after *deductible*, up to a maximum retail frame allowance of $45
Standard lenses (pair) - twice every 24 months	100% after *deductible* for single vision, lined bifocals, lined trifocals and lenticular lenses	100% after *deductible* for single vision, lined bifocals, lined trifocals and lenticular lenses, up to: $40 single vision

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

		$60 lined bifocals $80 lined trifocals $125 lenticular lenses
Elective contact lenses (in lieu of lenses and frame) - twice every 24 months	100% after *deductible*, up to $125	100% after *deductible*, up to $125
Medically necessary contact lenses (in lieu of lenses and frame) – once every 24 months Determination of medical necessity is made by VSP.	100% after *deductible*	100% after *deductible*, up to $250
Laser vision correction surgery (requires VSP approval)	$2,000 maximum lifetime benefit for one covered family member	Not covered

Contact Lenses

Contact lenses are considered *medically necessary* if prescribed for any of these conditions:

- Cataract surgery
- Extreme vision problems that cannot be corrected with glasses
- Certain conditions of anisometropia (a significant difference in vision between the two eyes) or keratoconus (a disease of the cornea)

Benefits for contact lenses include contact lens fitting and materials, and is in place of all other benefits for frames and lenses.

Laser Vision Correction Surgery

Laser vision correction surgery includes Photo Refractive Keratectomy (PRK), Laser In Situ Keratomileusis (LASIK) and Custom LASIK. This benefit is available from VSP providers for covered employees and their eligible dependents. Retirees and survivors are not eligible for this benefit.

There is a $2,000 lifetime maximum benefit for laser vision correction surgery, which is limited to one individual – either the employee or an eligible dependent age 18 or older. If an individual receives laser vision correction surgery benefits of less than $2,000, the remaining benefit cannot be used by a different individual.

If you are eligible and interested in obtaining the laser vision correction surgery benefit, you must contact VSP for a referral to a participating provider for a complete eye exam and evaluation of the patient's candidacy for surgery. If a VSP provider is not reasonably accessible, VSP may authorize use of a non-VSP provider. For this surgery to be covered, VSP must approve it in advance.

Additional Discount from VSP

You will receive a 30% discount toward the purchase of additional complete pairs of prescription glasses and sunglasses, including lens options, from the same VSP provider on the same day as your exam. Or, get 20% off from any VSP provider within 12 months of your last exam.

Low Vision Benefit

If you or your eligible dependent has severe visual problems that are not correctable with regular lenses, you may be eligible for the low vision benefit. To receive low vision benefits, VSP must approve the benefit in advance. Low vision benefits include the following:

	VSP Provider	Non-VSP Provider
Supplementary Testing Complete low vision analysis and diagnosis, including a comprehensive examination of visual functions and the prescription of corrective eyewear or vision aids where indicated	Covered in full	Up to $125
Supplemental Care Aids	75% of cost	75% of cost*

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Subsequent low vision aids if *medically necessary*		
Benefit Maximum	$1,000 every 24 months	$1,000 every 24 months

* Reimbursement for the cost for supplemental care aids provided by a non-VSP provider will be limited to the amount VSP would pay to a VSP provider in similar circumstances. If you use a non-VSP provider, your actual cost may exceed 25% of the cost of the supplemental care aid.

If You Have Dual Coverage

If two *company* employees who are married (or who are in a *domestic partner* relationship) are eligible for Vision coverage under this plan, they may cover each other as dependents.

If they do, the lifetime maximum benefit for laser vision correction surgery will be two $2,000 benefits. Each $2,000 maximum cannot be used by more than one individual. The two $2,000 maximums may be applied to either:

- One employee or one eligible dependent (if both employees cover the eligible dependent) for up to a total of $4,000
- Two individuals (either two employees, an employee and a dependent, or two dependents) up to $2,000 each

Therefore, one individual could receive benefits up to $4,000 or two individuals could each receive benefits up to $2,000.

Vision Plan Limitations

The plan is designed to cover visual needs rather than cosmetic materials. You may be required to pay a fee for the following:

- Blended lenses
- Elective contact lenses (not *medically necessary*)
- Oversize lenses
- Photochromic and tinted lenses, except Pink #l and Pink #2
- Progressive multifocal lenses
- Coating or laminating the lens or lenses
- Frames that cost more than the plan allows, for example, some designer frames (For more information, contact your VSP provider.)
- UV-protected lenses
- Cosmetic lenses
- Optional cosmetic processes

What the Vision Plan Does Not Cover

The plan does not cover all vision services. For example, the plan does not cover:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (nonprescription lenses)
- Two pairs of glasses instead of bifocals
- Replacement lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eye (except for the laser vision correction surgery benefit)
- Eye examinations or corrective eyewear required as a condition of employment
- Corrective vision treatment of an *experimental* nature
- Costs for services and/or materials above the plan allowances

Benefits That Require VSP's Prior Authorization

Plan Benefits from a VSP Provider

Your VSP Provider will be responsible for obtaining VSP's authorization to provide you Vision benefits, provided you identify yourself (or your eligible dependent) in advance as a VSP participant.

***Medically necessary* contact lenses**

If you use a VSP provider, the VSP provider will request authorization. If you use a non-VSP provider, you must obtain VSP's prior authorization to receive an allowance toward the cost of the lenses.

Laser vision correction surgery

You must obtain VSP's prior authorization for this surgery to be covered. If you use a VSP provider, the VSP provider will request authorization for the surgery. A non-VSP provider will be approved only if a VSP provider is not reasonably accessible to you (within 50 miles of your residence).

To obtain VSP's prior authorization, call VSP at (800) 877-7195. VSP will notify you within 15 days (30 days if an extension is necessary due to matters beyond VSP's control) as to whether the authorization is approved or denied. If your request for prior authorization is an urgent care claim, VSP will notify you within 72 hours after receiving your claim. An urgent care claim is a claim that (i) requires prior authorization and (ii) VSP or your doctor has determined that the regular 15 day response time will seriously jeopardize your life, health, or ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the requested care or treatment.

Situations Affecting Vision Coverage

There are a number of situations that could affect your and your dependents' coverage. For more information, see **Events Affecting Your Benefits** in this handbook.

When You Retire

You may be able to continue Vision coverage when you retire from the *company*. To determine your eligibility for Vision coverage when you retire, see the **Continued Health Care Coverage** section. If you do not enroll for Vision coverage when first eligible as a retiree, or if you retired after 1990 and drop coverage as a retiree, you will not be eligible to re-enroll in the future. However, if you drop your Vision coverage because you have coverage under another group plan and, subsequently, lose that coverage, you can re-enroll in the Vision plan within 30 days of losing coverage under the other group plan. See **Reporting a *Qualified Life Event*** for information on how to re-enroll.

How to File a Claim

You do not file a claim if you use a VSP doctor. The VSP doctor files the claim and is paid directly by the plan. You are responsible for the applicable *deductible* and payment for any services that are not covered under the plan. If you see any provider other than a VSP doctor, you must send a copy of the itemized statement to VSP within 180 days of the date of service to receive Vision benefits. Follow the process described for non-VSP providers in the **Vision Plan Procedures** chart above.

Normally, your claim will be processed within 30 days.

- If you don't provide the necessary claim information when using a non-VSP provider, benefit payments may be delayed until the required information is received
- If you don't notify VSP of your correct address, your payment may be delayed

See the **Other Important Information** section of this handbook for further information on the procedures that apply to processing claims under this plan, including the time limit for issuing a decision on any claim for benefits.

Coordination of Benefits

VSP will coordinate benefits for you and your enrolled dependents covered through two VSP participants. VSP benefits may also be coordinated with other group health plans. Sometimes Vision coverage is provided under a person's medical plan. If you or your enrolled dependents are covered under another vision or medical plan, the plans will work together to pay benefits for covered services.

See **Special Rules for Dual Coverage** and **Coordination of Benefits** in the Health Care Overview at the beginning of this section of your handbook for how health care plans work together.

If you and/or your eligible dependents have Vision coverage under more than one plan, you must give the last four digits of your Social Security number and that of the individual who has additional coverage to your provider (VSP or non-VSP, whichever you use).

Appeals

If a benefit claim is denied, in whole or in part, you or your beneficiary has a legal right to request a review of that denial. Generally, if you disagree with the outcome, you may appeal it.

Refer to the **Other Important Information** section of this handbook for details about documentation and the appeals process.

For More Information

You can get information about Vision coverage, locating a VSP provider or help with your claim, by contacting:

- VSP
  - (800) 877-7195
  - www.vsp.com
- *EIX Benefits Connection*
  - (866) 693-4947
  - www.eixbenefits.com

Employee Assistance Program

Overview

The Employee Assistance Program (EAP) is designed to help you and your family members resolve personal problems affecting life at work or at home.

Who Is Eligible

Employees, eligible retirees, and their household members can participate in the EAP. *Leased* employees and *contingent workers* are not eligible to participate. The eligibility requirements for retirees are provided in the **Continued Health Care Coverage** section of this handbook.

When Coverage Takes Effect

You and your household members are covered for the EAP immediately upon your hire date. There is no need to enroll for coverage.

Cost of Coverage

The *company* pays the entire cost of the EAP for employees, most retirees, and for their household members. See **Continued Health Care Coverage** to determine EAP contributions for retirees.

How the EAP Works

The EAP provides short-term assistance, assessment and counseling services through Resources for Living. Resources for Living is a private firm that specializes in employee assistance programs. Resources for Living's staff of licensed clinical professionals has special expertise and experience in counseling people with personal problems. All transactions between you and Resources for Living are confidential.

You and each of your household members can see a counselor for up to five separate visits per incident, per calendar year at no charge. Resources for Living's counseling services include:

- Problem assessment
- Referrals to appropriate resources
- Short-term counseling
- Treatment monitoring

When you call your EAP, a Resources for Living counselor speaks with you to determine the nature of the problem. A determination can then be made if short-term counseling or a referral is needed. Examples of personal problems Resources for Living can help with are:

- Marital or family problems
- Drug or alcohol dependence
- Emotional problems such as depression or anxiety
- Financial or legal concerns

The EAP counselor does not counsel in certain specialized services such as providing legal advice or help with serious financial problems. However, you are encouraged to use the EAP to find the most appropriate and cost-effective services and to receive as much emotional support as possible from the EAP. Resources for Living can refer you to a participating attorney or financial advisor in your area for a ½ hour consultation at no charge. A 25% discount off the standard fee is available if you use a participating attorney for additional legal services. The discount does not apply to additional financial advisor services. For a consultation appointment, call Resources for Living at (800) 443-4474.

How to Use the EAP

Resources for Living counselors are available 24 hours a day, 365 days a year. You can get more information and arrange for confidential counseling sessions by contacting Resources for Living:

- (800) 443-4474 (or (858) 571-1698 if outside the United States)
- (800) 733-0373 for hearing impaired
- www.HorizonCareLink.com Logon: edison, password: eap
- You may also call your *company* operator and ask to be connected to Resources for Living

When you speak to Resources for Living, a trained Member Advocate verifies your name, telephone number, and address.

In an *emergency*, you may speak to a licensed mental health professional anytime, 24 hours a day, 365 days a year, by calling Resources for Living directly. If the situation is urgent, but not critical, you are scheduled for an appointment within 48 hours. Routine appointments are scheduled within seven working days.

Supervisor Referral

If your supervisor refers you to the EAP because of an on-the-job issue, the decision about using the EAP is up to you.

Medical Referrals

Physical problems may have important psychological aspects. Your doctor may suggest that you contact the EAP if he or she feels that, due to a physical problem, you might benefit from counseling.

Anonymous Assistance

You and your household members can use the EAP without giving your name. Although the EAP is most effective when counselors are fully informed, you can receive counseling and referrals on an anonymous basis if you wish.

Short-Term Counseling and Referrals

The program provides up to five free visits per incident, per calendar year to you and each of your household members. Resources for Living provides referral service to your Medical Plan option if:

- Additional counseling is needed after five visits, or
- After the first visit, the counselor determines the problem needs more than five visits to resolve

If you are referred to your Medical plan option, you must pay for copayments under the Medical Plan. You must pay full charges if you:

- Are referred or self-referred to a provider who is not contracted with your Medical Plan option, and
- Do not receive prior authorization from your plan

For details about your Behavioral Health benefits and copayments, see the **Medical Program** summary. Behavioral Health benefits covered by your Medical Plan option are in addition to any benefits you receive under the EAP.

Confidentiality

Using the EAP is voluntary and confidential. Resources for Living will not release information obtained during any contact with a client — without express client permission — except where disclosure is authorized by law. The law may require the release of specific information when the life or safety of a person is seriously threatened.

If your medical doctor refers you to the EAP, your doctor and psychotherapist may discuss information related to your treatment. Because both are licensed health care professionals, this information remains confidential within the limits of the law.

What the EAP Does Not Cover

If your EAP counselor refers you to another resource for assistance (such as an attorney* for legal problems, a financial advisor* for money problems, or an external counselor or therapist for treatment), you must pay for those charges yourself.

* The EAP provides limited benefits for an attorney and financial advisor. See How the EAP Works for details.

Claims and Appeals

You do not file any claim forms to receive EAP benefits.

Quality Concerns

If you have a complaint regarding the service you have received through your EAP, please call Resources for Living directly at (800) 443-4474 so that your issues can be addressed immediately. If you still feel that your complaint has not been adequately resolved, you have the option of contacting the California Department of Managed Care directly at (800) 400-0815.

Appeal Procedures

If a benefit is denied, in whole or in part, you or your beneficiaries have a legal right to request a review of that denial. Generally, if you disagree with the outcome, you may appeal it.

Refer to the **Other Important Information** section of this handbook for details about documentation and the appeals process.

Situations Affecting EAP Coverage

There are a number of situations that could affect your EAP coverage. See the **Events Affecting Your Benefits** section for more information.

For More Information

You can get more information about EAP coverage and answers to your questions by contacting Resources for Living directly (see How to Use EAP above) or you may contact:

- The *EIX Benefits Connection:*
  - (866) 693-4947
  - www.eixbenefits.com

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Continued Health Care Coverage

Continued Health Care Coverage revised December 19, 2012.

Overview and Important Features

The *company* offers continued health care coverage to eligible employees and retirees and eligible dependent survivors of employees and retirees. It also offers COBRA Extended Coverage to *company* health care benefit plan participants who qualify. Under federal law, *domestic partners* and *same-sex spouses* are not eligible for COBRA Extended Coverage. However, the *company* offers Continued Coverage to eligible *domestic partners* and *same-sex spouses* under terms equivalent to COBRA Extended Coverage.

This section of your handbook describes eligibility, contributions and the duration of continued health care coverage for:

- Retirees
- Survivors of deceased employees and retirees
- Employees and dependents who are no longer eligible for *company*-sponsored health care coverage and qualify for COBRA Extended Coverage or Continued Coverage
- Employees on *military leave* and covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
- Employees on a family leave under the Family and Medical Leave Act of 1993 (FMLA)

Continued Health Care Coverage for Retirees

Retirees Eligible for COBRA Extended Coverage Only

When you terminate employment, the *company* will offer you and your eligible covered dependents health care coverage through COBRA Extended Coverage if you're among the employees listed below and you satisfy the COBRA eligibility requirements:

- Represented employees whose union has not bargained for retiree health care coverage
- Employees who do not meet the eligibility requirements for retiree health care coverage

See **COBRA Extended Coverage** in this section of your handbook for more information.

Retirees Eligible for Retiree Health Care Coverage

You are eligible for retiree health care coverage if you satisfy at least one of these requirements:

- You have 10 or more *years of service* and are at least age 55
- You retire under a special *company* retirement program for represented employees that provides for health care coverage and you are at least age 50 and have at least 10 *years of service*
- You retire under a special *company* retirement program for non-represented employees that provides for health care coverage and you are at least age 50 and have at least 15 *years of service*

Retiree health care coverage includes Medical, Dental, Vision and EAP benefits.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Company Contributions for Retiree Health Care Coverage

If and how much the *company* contributes toward the cost of retiree health care coverage varies depending on your retirement date, your *years of service*, and the *company(ies)* you worked for as shown in the chart that follows. You pay the difference between the cost of the coverage you elect and the *company* contributions

The actual amount of retiree and *company* contributions toward the cost of health care coverage is communicated at retirement and each year thereafter during the annual enrollment period. The *company* may adjust the cost of health care plans up or down each year to reflect the plan's cost experience or changes in plan premiums. The *company* may also stop contributing towards the cost of health care coverage, or amend or terminate retiree health care coverage, at any time, at its discretion.

***Company* Contributions for Retiree Health Care Coverage as of January 1, 2013**		
If you retire(d) from one of these *companies*...		**The *company* pays...**
• Edison International • Edison Material Supply, LLC • Southern California Edison Company		The full cost of EAP coverage and part of the cost of Dental, Vision and Medical coverage, based on your retirement date and your *years of service*, as shown below.
Retirement Date	***Years of Service***	
On or after January 1, 2009	You are age 55 or older and you retire with 10-14 *years of service*	Medical Plan Cost: 50% of an amount that is based on the 2008 cost of the lowest cost medical plan option offered in your geographic area, plus an annual escalation amount[1] Dental and Vision Plan Cost: 50% of the cost for retirees and dependents
On or after January 1, 2009	You are age 60 or older and you retire with 15 or more *years of service*	Medical Plan Cost: An amount that is based on 85% for retirees and 80% for dependents of the 2008 cost of the lowest cost medical plan option offered in your geographic area, plus an annual escalation amount[1] Dental and Vision Plan Cost: 50% of the cost for retirees and dependents
Before January 1, 2009 or were eligible to retire with retiree health care benefits before January 1, 2009 or had 25 or more *years of service* before January 1, 2009	10 or more	Medical Plan Cost: 85% of the cost for retirees and 80% for dependents of the lowest cost medical plan option offered in your geographic area Dental and Vision Plan Cost: 50% of the cost for retirees and dependents
1991 or 1992	10 or more	Medical Plan Cost: 100%* Dental and Vision Plan Cost: 50% of the cost for retirees and dependents
Before 1991	10 or more	Medical, Dental and Vision Plan Cost: 100%*

[1] The escalation amount is equal to the greater of the increase in the Consumer Price Index, All Urban Consumers, U.S. All Items, for the twelve month period ending on July 1 of each year or the lowest cost plan available in your geographic area's escalation at 50%. The maximum increase in escalation amount will be the increase in the Consumer Price Index, All Urban Consumers, U.S. All Items, for the twelve month period ending on July 1 of each year plus 2%.

* You may be eligible for a partial reimbursement of your Medicare Part B premiums. See **Medicare Reimbursements** in the Medical Plan summary for more information.

Enrolling for Retiree Health Care Coverage

If you are eligible for retiree health care coverage with a *company* subsidy when you retire, you will receive a personalized benefits worksheet showing the options available to you. If you do not elect new options within the time frame specified on your worksheet, by default you and your covered eligible *spouse* (or *same-sex spouse* or same-sex *registered domestic partner*) and dependents will be enrolled in the default coverage shown in each section of your enrollment worksheet. Your coverage as a retiree remains in effect until the next year's annual enrollment or until you make a change in coverage during the year due to a *qualified life event*.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

You will be billed monthly for your retiree health care coverage unless you select to pay for your coverage through direct debit or by having your payments deducted from your monthly retirement check (if applicable). If payment is not made when due, your coverage will be cancelled retroactive to the date through which your coverage was paid. You may elect medical coverage during a future annual enrollment.

If you are covering a *domestic partner* (other than a same sex *registered domestic partner*), you can no longer cover him or her after you retire. Your *domestic partner* may be eligible for continued health care through the plan's **Continued Coverage for *Domestic Partners* and *Same-Sex Spouses***.

If you waive Dental or Vision coverage as a retiree, you will not be eligible to re-enroll in the respective plan at a later date unless you had previously notified the *EIX Benefits Connection* that you were waiving your coverage because you had separate group coverage. If you subsequently lose that other coverage, you can re-enroll in the respective plan within 30 days of losing coverage under the other group plan. If you stop participating in Dental or Vision coverage and had not previously spoken with a representative at the *EIX Benefits Connection*, or your Dental or Vision coverage was cancelled for non-payment, you will not be allowed to re-enroll in the future. See **Reporting a *Qualified Life Event*** for information on how to re-enroll.

If you have any questions about retiree health care coverage, contact the *EIX Benefits Connection* at:

- 866) 693-4947
- www.eixbenefits.com

If You are Rehired

If you retire from the *company* and are eligible for retiree health care coverage, and are rehired as a *full-time* or *part-time* employee eligible to receive *company* contributions, any retiree health care coverage you may have had will stop on the last day of the month of your rehire date and you will be eligible for the employee health care coverage and costs available to similar employees of your rehiring *company* beginning the first day of the following month. When you subsequently retire, you will be eligible for the retiree health care coverage you had during your initial retirement (subject to the benefit plan options available upon your subsequent retirement).

If you retire from the *company* and are eligible for retiree health care coverage, and are rehired as a *part-time* employee not eligible for *company* contributions, any retiree health care coverage you may have had will continue.

If you terminate employment and are not eligible for retiree health care coverage, and are rehired as a *full-time* or *part-time* employee, you will be eligible for the employee health care coverage and costs available to similar employees of your rehiring *company*.

Your *company*-provided retiree life insurance coverage, if any, will be suspended.

Continued Health Care Coverage for Survivors

Survivors of Eligible Employees

If you die while you are an employee, the *company* may provide health care coverage for your surviving dependents that are covered by the *company* health care plans at the time of your death. Your survivor may not cover a new *spouse* or newly acquired *children*. If your surviving dependents are not eligible for survivor coverage, they may extend coverage through **COBRA Extended Coverage** as explained later in this summary.

If you are covering a *domestic partner* or *same-sex spouse* and you die, your *domestic partner* or *same-sex spouse* will not be eligible for survivor coverage. Your *domestic partner* or *same-sex spouse* may be eligible for continued health care through the plan's **Continued Coverage for *Domestic Partners* and *Same-Sex Spouses***.

Eligibility and Contributions

To continue coverage, survivors must remain eligible and pay any required contributions. For surviving dependent *children*, eligibility for survivor coverage ends when they no longer meet the definition of an eligible dependent *child*. Details on the costs of survivor coverage will be provided to all eligible surviving *spouses* and *children* when they first become eligible for coverage as survivors and, subsequently, during each annual enrollment period for as long as they remain eligible.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The following chart summarizes eligibility and contributions for survivor coverage for surviving *spouses* and *children* of deceased eligible employees.

Eligibility and Contributions for Survivor Health Care Coverage for Survivors of Employees			
Employee's Eligibility Requirements	**Health Care Plans Available to Eligible Survivors**	**Duration of Continued Coverage**	**Who Pays for Coverage**
Died prior to January 1, 1991	Medical, Dental, Vision and EAP	As long as they remain eligible	The *company* pays 100% of the cost.
Died on or after January 1, 1991 and before January 1, 1993	Medical, Dental, Vision and EAP	As long as they remain eligible and pay any required contributions	The *company* pays the full cost of Medical and EAP coverage. For Dental and Vision coverage, the *company* pays 50% of the cost.
Died on or after January 1, 1993 with **25 or more *years of service*** or was **at least age 55 at death with 10 or more *years of service***	Medical, Dental, Vision and EAP	As long as they remain eligible and pay any required contributions	The *company* pays the full cost of EAP coverage. Survivors pay the same amount that dependents of retirees pay for Medical coverage as though the employee had retired on the date of his or her death. For Dental and Vision coverage, the *company* pays 50% of the cost.
Died on or after January 1, 1993 with **20 to 24 *years of service*** and was less than age 55 at death	Medical, Dental, Vision and EAP	Up to five years — as long as they remain eligible and pay required contributions	The *company* pays the full cost of EAP coverage. Survivors pay the same amount that dependents of retirees pay for Medical coverage as though the employee had retired on the date of his or her death. For Dental and Vision coverage, the *company* pays 50% of the cost.
Died on or after January 1, 2006 as a result of a work related accident, was less than age 55 at death, and death due to the accident occurred within six months of the accident	Medical, Dental, Vision and EAP	Up to five years as long as they remain eligible and pay any required contributions	The *company* pays the full cost of EAP coverage. Survivors pay the same amount that dependents of retirees pay for Medical coverage as though the employee had retired on the date of his or her death. For Dental and Vision coverage, the *company* pays 50% of the cost.

Survivors of Eligible Retirees

If you die while participating in *company*-sponsored health care plans (Medical, Dental, Vision and EAP) as a retiree, this coverage may continue for your enrolled and eligible dependents:

- For your *spouse* throughout his or her lifetime
- For your dependent *children* as long as they meet the definition of an eligible dependent

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Eligibility for retiree health care coverage is explained above under **Continued Health Care Coverage for Retirees**.

Contributions

To continue their coverage, survivors of retirees must remain eligible and pay any required contributions.

Generally, eligible survivors of retirees contribute the same amount as the retiree paid for the same coverage. The actual amount of survivors' contributions may vary from year to year, based on plan experience, the levels of coverage selected, and other factors.

Details on the costs of survivor health care coverage will be provided to all eligible surviving *spouses* and *children* when they first become eligible for coverage as survivors and, subsequently, during each annual enrollment period for as long as they remain eligible.

Enrolling for Survivors' Continued Health Care Coverage

If you die and your survivors are eligible for survivor health care coverage, your survivors will receive an information package after the *company* has been notified of your death. The information advises survivors of their health care eligibility and any applicable costs. If your survivor stops participating in or otherwise waives Dental or Vision coverage, your survivor will not be eligible to re-enroll in the respective plan at a later date. However, if your survivor drops Dental or Vision coverage because they have coverage under another group plan and, subsequently, lose that coverage, they can re-enroll in the respective plan within 30 days of losing coverage under the other group plan. Your survivor must call the *EIX Benefits Connection* and speak with a representative to report this change before dropping the *company* Dental or Vision coverage. See **Reporting a *Qualified Life Event*** for information on how to re-enroll. If you have any questions about continued coverage for survivors, contact the *EIX Benefits Connection* at:

- 866) 693-4947
- www.eixbenefits.com

After Eligibility for Survivor Health Care Coverage Ends

Your surviving *spouse* and eligible *children* may be eligible for COBRA Extended Coverage after they cease to be eligible for survivor coverage. If your survivor(s) had survivor coverage for less than 36 months, COBRA Extended Coverage will be available for the length of time equal to the difference between 36 months and the time your survivor(s) had survivor coverage. If your survivor(s) had survivor coverage for 36 months or longer, COBRA Extended Coverage will not be available when survivor coverage ceases.

COBRA Extended Coverage

If you or any of your covered dependents become ineligible for *company*-sponsored health care coverage, you may be able to extend coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA provides extended coverage for the Medical (including Behavioral Health), Dental, Vision, Employee Assistance Program (EAP), and Health Care Reimbursement Account (HCRA) plans you or your covered dependents are enrolled in at the time you become ineligible. Under federal law, *domestic partners* and *same-sex spouses* are not eligible to extend coverage under COBRA. However, your *domestic partner* or *same-sex spouse* may be able to continue their health care through the plan's **Continued Coverage for *Domestic Partners* and *Same-Sex Spouses***.

Extended coverage is available on a post-tax basis, but you must request it within the **COBRA election period** explained below.

How Extended Coverage Works

You or your covered dependents may elect to extend coverage if coverage is lost due to one of the following COBRA qualifying events:

- Termination of employment
- Reduction in hours of employment
- Death
- Divorce or legal separation
- *Child's* loss of dependent eligibility
- Medicare entitlement

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Extended Coverage for Up to 18 Months

Extended coverage is available for you and your covered dependents for up to 18 months if coverage is lost due to one of the following events:

- Your *company* employment ends for any reason except gross misconduct
- You are laid off
- Your hours are reduced or you change to an ineligible employment status

Disability Extension for Up to 11 Months

If the Social Security Administration determines that you or your covered dependent is disabled (for Social Security purposes) at the time of the qualifying event or within the first 60 days of COBRA coverage, you may extend your coverage by an additional 11 months—for a total period of 29 months from the date of the qualifying event.

To apply for this extension, you must provide a copy of the Social Security Disability "Notice of Award" to the plan administrator:

- During the initial 18-month COBRA election period and
- Within 60 days of the determination by the Social Security Administration

You are required to notify the *EIX Benefits Connection* within 30 days of the date you or your dependent is no longer disabled. This 11-month extension is also available to the COBRA beneficiaries within your family who are not disabled but are receiving COBRA coverage based on the same qualifying event as the disabled COBRA beneficiary.

Extended Coverage for Dependents for Up to 36 Months

Extended coverage is available for up to 36 months to your covered dependents if coverage is lost due to one of the following events:

- You die as an active participant and your survivors are not eligible for survivor coverage as described under **Continued Health Care Coverage for Survivors** or if your survivors had survivor coverage for less than 36 months (in which case COBRA Extended Coverage would be available for the length of time equal to the difference between 36 months and the time your survivor had survivor coverage)
- You and your *spouse* legally separate or divorce
- Your dependent *child* loses eligibility
- You become entitled to Medicare

The 18-month coverage period available upon termination of employment or reduction in hours of employment may be extended to 36 months from the initial qualifying event if a death, divorce, legal separation, *child's* loss of dependent eligibility, or Medicare entitlement occur during the 18-month period or the 11-month disability extension. However, even if more than one qualifying event occurs, 36 months is the maximum coverage period available under COBRA.

When COBRA Coverage Ends

COBRA coverage will end when the applicable COBRA continuation period ends. Coverage will end earlier if:

- Payment of the required contribution is not made within the allowable grace period
- The person with extended coverage becomes entitled to Medicare, or becomes covered by another group plan which begins after the date of their COBRA election and provides health care benefits which do not contain any exclusions or limitation on preexisting conditions, or such preexisting condition exclusions or limitations are not applicable to the COBRA beneficiary under the Health Insurance Portability and Accountability Act
- The *company* terminates the plan

Once COBRA Extended Coverage ends for any reason, it will not be reinstated.

Cost of COBRA Extended Coverage

You (or your dependents) pay 102% of the full cost of extended coverage (which includes a 2% administrative fee) on a post-tax basis. The cost of coverage for an 11-month disability extension (after 18 months of coverage) is 150% of the cost of the selected option if the disabled qualified beneficiary is one of the qualified beneficiaries receiving the disability extension.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Notifying the *EIX Benefits Connection* of Qualifying Events

You or your covered dependents have the responsibility to inform the *EIX Benefits Connection* of a divorce, legal separation, or a *child* losing dependent eligibility within 60 days of the event. Failure to provide such notice within this period will result in a loss of COBRA eligibility. The *company* has the responsibility to notify the *EIX Benefits Connection* of your death, termination, reduction in hours of employment, or Medicare entitlement. When the *EIX Benefits Connection* is notified that one of these events has happened, you will be notified of the right to choose COBRA coverage.

To notify the *EIX Benefits Connection* of the qualifying event, please call (866) 693-4947.

The notification should include:

- Employee's name and Social Security number
- Names and Social Security numbers of individual(s) requesting extended coverage
- Mailing address of individual(s) requesting extended coverage
- Date and nature of qualifying event

COBRA Election Period and First Payment

Once COBRA extended coverage is offered to you, the COBRA administrator must receive your election within 60 days after the later of:

- The date you would otherwise lose coverage
- The date notice is provided to you

After your initial election, you have 45 days to make your first payment to bring the account to current status. This 45-day period is a grace period required by Federal law and no further extension will be permitted. If the COBRA administrator does not receive your first payment within this 45-day grace period, your COBRA coverage will be cancelled retroactive to the day of your qualifying event. You will be responsible for any expenses incurred during this period.

If you become eligible for trade adjustment assistance (TAA) pursuant to the Trade Act of 1974, and you did not elect COBRA Extended Coverage during the 60-day election period that was a direct consequence of the TAA-related loss of coverage, you may elect COBRA Extended Coverage during a 60-day period that begins on the first day of the month in which you are determined to be eligible for TAA. Your election, however, must be made not later than six months after the date you lost your health care coverage resulting from the TAA-related event.

Your Monthly Payments for COBRA Extended Coverage

Payments are due on the first of each month to an outside vendor, who will collect all payments. Federal law requires that you have a 30-day grace period after the first of the month for making these payments. No further extension will be permitted. If your monthly payment is not received within the 30-day grace period, your COBRA coverage will be cancelled retroactive to the due date of the missed payment (i.e., the first of the month for which the payment was due). You will be responsible for any expenses incurred during this period.

Newborns and Adopted *Children*

Any *child* who is born to, placed for adoption with, or adopted by a covered employee can be added to the employee's COBRA coverage upon proper and timely notification to the *EIX Benefits Connection* of the birth, adoption or placement for adoption of the *child*. The *child* will be a qualified beneficiary and have the same rights as a qualified beneficiary under COBRA. The qualifying event for the *child* shall be the same as the qualifying event giving rise to the employee's COBRA continuation coverage period.

Continued Coverage for *Domestic Partners* and *Same-Sex Spouses*

If your covered dependent is your *domestic partner* or *same-sex spouse*, and he or she becomes ineligible for *company*-sponsored health care coverage, your *domestic partner* or *same-sex spouse* may be eligible for Continued Coverage. Continued Coverage provides extended coverage for the Medical (including Behavioral Health), Dental, Vision, Employee Assistance Program (EAP), and Health Care Reimbursement Account (HCRA) plans your covered dependents are enrolled in at the time they become ineligible.

Eligibility for, and benefits provided through, Continued Coverage will be available on terms and conditions equivalent to those described above under **COBRA Extended Coverage**.

Continued Health Care Coverage During *Military Leave*

If you take a *military leave of absence*, you must notify the *EIX Benefits Connection*. You will continue to be covered under the health care plans in which you are enrolled.

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), coverage for you and your eligible dependents may be extended until the earlier of:

- The day after 24 months have lapsed since the date your coverage would have otherwise ended
- The day after the date you fail to apply for or return to work after your *military leave of absence* ends

If your health care coverage is extended due to a *military leave of absence*, you will be billed for each applicable plan. If you do not make your required payments on time, your health care coverage will be cancelled retroactive to the date your payment was due.

If you do not return to work for the *company* after the leave ends, you and your dependents may be eligible for COBRA Extended Coverage. If you do not make your required payments on time, your health care coverage will be cancelled retroactive to the date your payment was due.

Extended coverage under USERRA counts toward the time limits for COBRA Extended Coverage.

Continued Health Care Coverage During Family Leave

If you are granted a medical leave of absence under the Family and Medical Leave Act (FMLA) of 1993 (and state law where applicable), you will continue to be covered under the health care plans in which you are enrolled. Your coverage will continue from the first day that the approved leave begins until the leave ends. If you do not return to work for the *company* after the leave ends, you and your dependents may be eligible for COBRA Extended Coverage. If you do not make your required payments on time, your health care coverage will be cancelled retroactive to the date your payment was due. FMLA leave may be coordinated with any applicable state-mandated family leave.

Certificate of Prior Creditable Coverage

You and your covered dependents will automatically receive a certificate of coverage when you lose coverage under the Medical Plan. This certificate will document that you and your enrolled dependents, if any, had medical coverage. If you elect COBRA Extended Coverage, you and your covered dependents will also receive a certificate of coverage after COBRA coverage ends. Keep a copy of the certificate(s) of coverage you receive because you may need to prove you had prior coverage when you join a new health care plan. That way you may not be subject to a new plan's preexisting conditions limitation, if any. You or your dependents may also request a certificate of coverage within 24 months of the date coverage was lost. To make this request, contact the *EIX Benefits Connection*.

Disability Program Overview

Disability Program Overview revised December 19, 2012.

The Disability Program is designed to provide financial protection in case you are unable to work due to illness or injury, need time off to attend health care appointments, or are unable to work due to a family member's qualifying event.

In addition, the program offers assistance to disabled employees who are able to return to work.

The Disability Program is comprised of the following benefit plans and related programs:

- The **Comprehensive Disability Plan (CDP)** is the *company's* voluntary plan, offered in lieu of California's State Disability Insurance. The plan complies with all requirements of the California Unemployment Insurance Code, protecting you against a loss of income if an illness or injury prevents you from performing your regular job, you need time off to attend medical appointments or you are unable to work due to a family member's qualifying event. It includes provisions for employees working in California for paid and protected time off to attend to a family member's illness (under California's Sick Leave Statute, also referred to as Kin Care) and paid but unprotected time off when you are unable to work due to a family member's chronic serious health condition or for birth/bonding with a child (Paid Family Leave)
- The **Long Term Disability Plan (LTD)** is a *Flex* plan that provides you with a choice of three income replacement levels which become payable following a continuous six month qualifying period, if you are unable to perform your regular and customary job for the first two years of a disability period and any reasonable job for the *company* after two years of a disability period
- The **Return to Work Program** offers partial income replacement and other customized benefits if you have permanent work restrictions which, for medical reasons, prevent you from performing your regular and customary job, but allow you to perform a reasonable job for the *company*
- **Workers' Compensation** pays your medical bills and provides partial wage replacement and vocational rehabilitation should you become unable to work due to a work-related injury or illness

These benefits are designed to work together to provide a seamless approach to disability income continuation. If you are eligible, you will continue to receive income, for example, if an illness keeps you out of the office for a day or two, if you suffer a disability that prevents you from returning to work for an extended period of time, you have a family member with a chronic serious health condition, or you are bonding with a new *child*.

This overview summarizes the general eligibility requirements, enrollment processes, and coverage features of the *company's* disability benefit program. It also shows how these plans work together. Details on specific benefits under each plan are included in the individual summaries that follow this overview.

The *company* also enables you to purchase Long-Term Care Insurance through post-tax payroll deductions. Call Prudential Insurance Company of America at (800) 732-0416, 5:00 a.m. to 5:00 p.m., Pacific time, Monday through Friday, for information on Long-Term Care Insurance.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Who Is Eligible

In general, most active *full-time* employees are eligible for coverage under all of the *company's* disability plans. However, some *companies* and unions do not participate in all plans. These are specifically noted in each individual plan summary under Who Is Eligible. Most *part-time* and *temporary* employees of participating *companies* are eligible only for CDP and Workers' Compensation coverage. *Leased* employees and *contingent workers* are not covered under any of the *company's* disability plans.

If you are eligible, your disability coverage normally begins on your first day at work.

Enrolling for Coverage

Enrollment is automatic for the CDP, if you are eligible, but you may be allowed to waive CDP coverage.

When you first become eligible for LTD coverage, you have 30 days in which to select a coverage level. Eligible employees who do not enroll in the LTD plan during this time will be automatically enrolled in the 60% of *base pay* coverage level (one of three LTD options).

Coverage under the Return to Work Program and Workers' Compensation is automatic if you are eligible. There is no enrollment process for these benefits.

Making Changes During the Year

Eligible employees may make changes in their LTD and CDP coverage. If you waive CDP coverage, you may enroll at a later time. If you are enrolled in CDP, you may also choose to waive during the year. You may change your LTD coverage level for any reason during annual enrollment. Outside of annual enrollment, you may change your LTD coverage only if you have a *qualified life event*. You must be *actively at work* for any changes to become effective.

Cost of Coverage

The *company* pays the majority of the cost of the Disability Program, as shown in the following table.

Disability plan...	Who pays for coverage...
CDP	You and the *company* contribute toward the cost of CDP coverage. Your share of the cost is equal to what you would pay if you were enrolled in California's State Disability Insurance (SDI) program.
LTD	The *company* provides you with contributions equal to the cost of the 60% option. The price tag depends on your age, your *base pay* and the coverage level you select.
Return to Work Program	The *company* pays the full cost.
Workers' Compensation	The *company* pays the full cost.

Applying for Benefits

Active Employees

It's important to make your supervisor and/or the appropriate claims administrator aware of your need for time away from work. Under CDP, for example, you or your supervisor must note your absence on your regular timesheet.

Depending on the duration of your absence, you may also have to provide ongoing medical certification regarding your illness, injury or qualifying family event to the claims administrator.

You must also immediately report any job-related illness or injury to your supervisor to qualify for Workers' Compensation benefits. Your supervisor will give you proper forms to complete and return.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Once you have been off work due to disability for about four months, the LTD claims administrator will send you a claim package. You do not need to complete the claim package to receive benefits, but if you do not provide a completed package, the decision on your eligibility for LTD benefits will be based on the information available to the claims administrator.

The Return to Work Program administrator will evaluate your medical information when it is made available and notify you if you qualify for benefits under this program.

Terminated Employees

Certain disability benefits may be payable to covered employees who terminate employment with the *company*. For example, you may be eligible for CDP and/or LTD benefits if it's determined that your qualifying period of disability began prior to your last day of employment.

When Benefits Are Paid

Since disability benefits are designed to provide financial protection if you are unable to work, the *company* is committed to making sure you receive eligible payments in a timely manner, as shown below.

If you are eligible to receive benefits from this plan...	Normally your benefits will be paid...
CDP for *full-time*, *part-time*, *part-time plus* and *temporary* employees	From your first day of absence, according to your normal pay schedule
LTD	Once approved, according to your normal pay schedule
Return to Work Program	Once approved, according to your normal pay schedule
Workers' Compensation	After the first three days you are unable to work and every two weeks thereafter

Amount of Benefits

Generally disability benefits replace all or a percentage of your *base pay*, but a number of other factors are considered in determining the benefits payable under the various disability plans. See each individual summary for details.

Coordination with Other Income

While illness or injury prevents you from working, the Disability Program ensures that you receive a certain level of income — including income from other sources such as Social Security Disability Insurance benefit payments. The income you receive from such other sources is subtracted from most disability benefits you receive from the *company's* Disability Program. These sources are listed in the individual plan summaries.

Failure to notify the *company* or claims administrator of any other income you are getting while receiving disability benefits could lead to termination of employment. In addition, you will be required to reimburse the *company* for any overpayment you received.

Certifying Your Disability Status

Eligibility for benefits under CDP and LTD requires providing ongoing medical certification that you remain disabled or you have a qualifying family event.

Employees receiving CDP benefits must contact the CDP claims administrator after missing more than three full consecutive days of work due to illness or injury and provide medical certification as required. Employees must contact the CDP claims administrator for all claims for Paid Family Leave benefits.

If you are receiving LTD benefits, you are required to periodically submit medical evidence indicating your continued eligibility for benefits to the LTD claims administrator.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

You may also have to periodically certify your disability status while receiving benefits under the Return to Work Program.

When Benefits End

Disability benefits generally continue for the period of time you or your family member remain disabled or until you have received the maximum benefit payable under the plan, whichever occurs first.

If Your Benefits Are Denied or Terminated

Unless you qualify for continued unpaid leave, if your disability benefits are denied or terminated and you are determined to be able to return to your regular and customary job, your work location will be notified and you will be given a return-to-work date. If you fail to return to work on your return-to-work date, your employment may be terminated. If you are receiving Paid Family Leave benefits, you are expected to return to work upon the expiration of certification or immediately upon receipt of the maximum benefit payable, unless you remain eligible for additional unpaid leave.

For information about appealing a denied claim or terminated benefit, see the **Appeals section of the CDP** and **LTD** summaries and **How to Appeal a Denied Claim in the Workers' Compensation** summary.

What Disability Benefits Do Not Cover

The Disability Program provides benefits for most absences from work due to illness or injury. It does not, however, pay for all such absences. CDP benefits, for example, are not payable for any absences during which you receive unemployment compensation benefits. Review each plan summary for specific exclusions and limitations.

Comprehensive Disability Plan

Overview and Important Features

Most *full-time, part-time, part-time plus* and *temporary* employees are eligible for Comprehensive Disability Plan (CDP) coverage. The CDP is designed to provide income to you if you are unable to perform your regular job due to illness or injury, need to attend medical appointments, or because of a qualifying family event and you suffer a loss of income as a result.

The amount of CDP benefits *full-time* and *part-time plus* employees receive when they are ill or injured and unable to work depends on whether or not they have unused full pay sick leave and/or hospital days and what their *base pay* is. For eligible *part-time* and *temporary* employees, benefits are based on the amount they would receive if they were covered by California State Disability Insurance (SDI) — even if they don't live or work in California — and their *base pay*.

Employees working outside of California may participate in the CDP or waive coverage. In some instances, employees outside of California are subject to other state short-term disability laws that may supercede participation in the CDP.

CDP benefits include:

- A number of full pay sick leave (FPSL) days, based on length of service, for eligible *full-time* employees
- A number of full pay sick leave (FPSL) days for eligible *part-time plus* employees accrued while an eligible *full-time* employee and as a *part-time plus* employee through June 30, 2008
- Twenty hospital days (160 hours) of pay available for the duration of your career to use for hospitalization and/or outpatient procedures
- Twenty hospital days (160 hours) of pay available (if applicable) for eligible *part-time plus* employees accrued while an eligible *full-time* employee
- Extended benefits, which provide a weekly income benefit for up to 52 weeks for eligible *full-time*, *part-time*, *part-time plus* and *temporary* employees
- Limited paid time off for your health care appointments and illness in the immediate family for eligible *full-time* and *part-time plus* employees
- Limited paid time off for employees working in California who are unable to work due to a seriously ill family member or for birth/bonding with a new *child* (California's Sick Leave Statute [aka Kin Care] and Paid Family Leave)

Who Is Eligible

The following employees are eligible for CDP coverage:

- *Full-time* employees
- Part-time plus employees
- *Part-time* employees that are regularly scheduled to work 16 hours or more per week
- *Temporary* employees hired to work at least two weeks and regularly scheduled to work 16 hours or more per week

Leased employees and *contingent workers* are not eligible for CDP coverage.

Enrolling for Coverage

You are automatically enrolled in the CDP as soon as you are eligible. You will not be covered, however, if you:

- Elect SDI coverage and work in California, or
- Are covered by another state's short-term disability plan, or
- Waive CDP coverage

If you initially waive coverage under the CDP and then enroll at a later date, your coverage begins on the first day of the first pay period of the calendar quarter following your election of CDP coverage. See **Waiving Coverage** in this summary for more information.

Eligible California Employees

If you work in California, you are subject to the California Unemployment Insurance Code, as amended from time to time. This code requires you to have short-term disability coverage either through SDI or through an employer's voluntary plan that is more generous than SDI. Since CDP offers more generous benefits than SDI, you have a choice between CDP and SDI coverage. Unless you elect SDI coverage or waive CDP coverage, you are automatically enrolled in the CDP as soon as you are eligible.

Eligible Employees Outside California

If you work in a state that has state-mandated short-term disability coverage, you may be required to participate in the state's program instead of the CDP. Your Human Resources representative will give you details if you work in a state that has mandated coverage.

If you work in a state that doesn't have a short-term-disability coverage requirement, you are automatically enrolled in the CDP as soon as you are eligible-unless you waive CDP coverage.

When Coverage Takes Effect

If you're eligible, your CDP coverage normally takes effect on your first day at work. If you are covered by a state-mandated short-term disability program that does not allow you to participate in the CDP and you move to a non-mandated state or a state that does allow you to participate in the CDP, your coverage in the CDP will begin on the date you transfer to your new work location unless you waive CDP coverage. If you waive CDP coverage and then enroll at a later date, your coverage will begin on the first day of the first pay period of the calendar quarter that follows your enrollment date.

Waiving Coverage

California Employees

If you are working in California, you may waive CDP coverage **only** if one of the following two circumstances applies to you:

- You do not want any disability income protection (CDP or SDI) because you depend upon prayer for healing in accordance with the creed, tenets, or principles of the faith or teaching of a bona fide religious sect, denomination, or organization
- You choose to be covered under SDI instead of the CDP

If you waive both CDP and SDI coverage, you must file a statement with the California Employment Development Department as well as with the *company*.

Employees Outside California

Employees working outside of California can waive CDP coverage at any time.

Extent of Waiver

If you initially waive CDP coverage, you will not receive any CDP benefits (full pay sick leave, hospital days, extended benefits, paid time off for health care appointments, paid time off for family member's illness, California's Sick Leave Statute [aka Kin Care] or Paid Family Leave under the CDP) if you are absent from work. Your waiver of coverage will be effective immediately and will remain in effect for all subsequent calendar quarters until you rescind the waiver by enrolling in the CDP or in SDI. If you are a California employee and you waive SDI as well as CDP, you will not have any SDI benefits either.

Cost of Coverage

You share the cost with the *company*. Your contribution toward CDP coverage is equal to the amount you would pay if you were enrolled in California's SDI, as amended from time to time. You pay your share of the cost of coverage through post-tax payroll deductions. The benefits paid to you under CDP are subject to federal and state income taxes. A portion of the benefits is excluded from taxability based on the proportion of employee contributions to the program.

Contributions will not be deducted from your pay if you waive coverage.

How the CDP Works

If you are unable to work due to illness, injury or a qualifying family event, and meet the eligibility and certification requirements, the CDP will provide you with an income for a specified period of time or up to a maximum payment amount. If you are a *full-time* or *part-time plus* employee and are unable to work due to illness or injury, your benefits and their duration depend on your unused FPSL, applicable hospital days, the effect of other offsets, and your *base pay*. If you are an eligible *part-time* or *temporary* employee and are unable to work due to illness or injury, your benefits are based on the rate payable under California SDI and your *base pay* over the 12 weeks preceding your disability (see **Extended Benefits** for details). Your benefits will be paid while you remain unable to work or until you reach your maximum payment amount.

What the CDP Covers

The CDP provides replacement for lost income when you are disabled or unable to work due to a qualifying family event. You are "disabled" if you are unable to perform your regular and customary job due to illness or injury. This includes participation in an approved residential alcohol recovery or drug-free program when recommended by a competent medical authority. It also covers absence from work ordered by a state or local health officer because of your possible or actual infection with a communicable disease. A qualifying family event includes time off if you are unable to work due to caring for a family member or bonding with a new *child*.

Your "regular and customary job" is the occupation you are performing for the *company* on the date your disability period begins. Your regular and customary job may change if you return to a new position and become disabled again.

A "disability period" is the period of time during which you are unable to perform your regular and customary job due to illness or injury. It begins on the first day for which you file a valid claim for CDP benefits. Two

consecutive periods of disability separated by less than 15 consecutive calendar days and due to the same or a related cause are considered one disability period.

Benefits for *Full-time* and *Part-time Plus* Employees

Full Pay Sick Leave (FPSL)

You earn FPSL based on your length of service as a *full-time* employee as shown in the **chart** below. FPSL is credited to you on the monthly anniversary of your CDP in-service date. This is normally your date of hire, but your CDP in-service date can be adjusted to reflect a break in service, a leave of absence, or other absence from the *company*. (See **What Service Means** below.) Unused FPSL accumulates from year to year. The rate of pay for your FPSL is your *base pay* on your last day worked.

If you become a *part-time plus* employee, you will not earn any additional FPSL while in the *part-time plus* classification after June 30, 2008. FPSL accrued while in such classification prior to this date as well as FPSL accrued prior to your classification as a *part-time plus* employee may be used while you are a *part-time plus* employee in accordance with the provisions of the CDP.

You will forfeit any unused FPSL when you leave the *company*.

If you retire from the *company*, however, you may be eligible to receive a supplemental benefit under the Southern California Edison Company Retirement Plan based on your unused FPSL balance. (See the **Retirement Plan** summary for details.)

Your FPSL as a *full-time* employee and while in the *part-time plus* classification through June 30, 2008 is credited according to the following schedule.

Length of Service	FPSL Per Month	FPSL Per Year
4 years or less	3.33 hours	5 days
Between 4 years and 1 month, and 9 years	6.66 hours	10 days
More than 9 years and 1 month	10 hours	15 days

Prior to January 1, 1979, eligible employees were credited with 10 hours of FPSL per month (15 days per year).

Hospital Days

You are granted a one-time allocation of 20 hospital days (160 hours) to be used at any time during your tenure with the *company* for absences due to inpatient hospitalization and/or outpatient procedures performed under general anesthesia. Hospital days may be used from the first date of hospitalization or from the date of outpatient procedures performed under general anesthesia through your recovery. The rate of pay for hospital days is your *base pay* on the date your disability period begins.

What 'Service' Means

Under this plan, "service" for all *full-time* employees means your active and continuous employment from your date of hire, including:

- Absence due to military service
- Prior active and continuous service of six months or more with the *company* or its predecessors, provided you have completed at least one or more years of active and continuous service since your last hire date
- Prior service as a *temporary* employee if you became a *full-time* employee after a break in service of 30 days or less
- Service with a prior employer acquired by the *company*, if provided for under **Special Rules for Certain Transferred Employees** in the Appendix to this section of your handbook
- Service while in the *part-time plus* classification through June 30, 2008

Service does not include:

- Time spent working for the *company* as a *part-time* or *leased* employee, while in the *part-time plus* classification after June 30, 2008, as a *temporary* employee not described above, or as a *contingent worker*
- Unpaid absences of more than 30 consecutive calendar days
- Absence after all CDP benefits have been exhausted and you are receiving only Long Term Disability Plan benefits or Return to Work Program benefits

In addition, there are some historical periods of absences that are not included for CDP service calculation. These include:

- Absences caused by an industrial accident or illness that began before July 1, 1968
- Absences before August 1, 1973, that were in excess of 30 consecutive calendar days due to illness or injury following exhaustion of FPSL (over 30 days of extended benefits)

Extended Benefits

Full-time and *Part-time Plus* Employees

If you are a *full-time* or *part-time plus* employee who is unable to work due to illness or injury, and you have used up your FPSL and hospital days (if applicable), you may be eligible for extended benefits if you remain unable to perform your regular and customary job. Extended benefits may continue for up to 52 weeks if you remain disabled and are unable to perform your regular and customary job. (See **Coordination with Other Income** for a possible extension of coverage beyond 52 calendar weeks.)

Extended benefit payments are based on your *base pay* rate on the date your disability period begins, the benefit payable under California SDI, and the state and federal minimum wage.

Extended benefit payments are the greater of:

- 60% of your *base pay*
- The amount payable by SDI
- 130% of the state or federal minimum wage

In no event will your extended benefit be higher than your *base pay* rate. If you are eligible to receive CDP benefits for less than one full week, your CDP benefit will be one-fifth of the specified weekly benefit for each day of work you are disabled.

Part-time and *Temporary* Employees

Part-time and *temporary* employees are not eligible for FPSL, hospital days, paid time off for Illness in the Family, paid time off for medical appointments, or California's Sick Leave Statute (aka Kin Care). However, the extended benefit portion and the Paid family Leave portion of the CDP pay benefits to eligible disabled *part-time* and *temporary* employees who meet the certification requirements outlined in this summary under **How to Apply for CDP Benefits**. To receive extended benefits, *part-time* and *temporary* employees must be unable to perform their regular and customary jobs due to illness or injury.

Extended benefit payments are based on your *base pay* rate on the date your disability period begins, the benefit payable under California SDI, and the state and federal minimum wage. Your weekly and maximum benefit amounts are based on a comparison of the greater of what SDI would pay, 60% of your *base pay* averaged over the twelve weeks preceding your disability, and 130% of the state and federal minimum wage. SDI bases its payment on the income paid to you during SDI's specified 12-month base period. In no event will your extended benefit be higher than your *base pay* rate. Extended benefits may continue while you remain disabled for up to 52 weeks.

If you are eligible to receive CDP benefits for less than one full week, your CDP benefit will be one-seventh of the specified weekly benefit for each day of work you are disabled. (See **Coordination with Other Income** for a possible extension of coverage beyond 52 calendar weeks.)

Other Paid Time Off for *Full-time* and *Part-time Plus* Employees

If you are a *full-time* or *part-time plus* employee and have completed six months of service, the *company* provides paid time off (not paid from the CDP) with supervisor approval, up to certain limits, for health care appointments (medical, dental, and vision) and illness in your immediate family. Approved time off taken in excess of the limits is either:

- Deducted from your FPSL if available and paid at your *base pay* rate
- Paid at your applicable extended benefit rate (see **Extended Benefits** in this summary)

If you are not enrolled in the CDP, time taken in excess of the limits is not paid unless you use vacation or floating holiday time. Time off in these cases is subject to your supervisor's approval in connection with the following situations.

Medical, Dental and Vision Appointments

The *company* may provide you with full pay for up to the first hour away from work for approved medical, dental, and vision appointments. Time off in excess of the first hour counts against the CDP, if you're enrolled in the CDP. The time you can take is limited to the actual travel time to and from the appointment and the time spent at the appointment.

Illness in Your Immediate Family

With proper approval, you will receive pay for time away from work due to illness in your immediate family for up to a maximum of 24 hours per calendar year.

The *company* provides pay at your *base pay* rate for the first 16 hours approved for each calendar year. Approved time off in excess of the first 16 hours per calendar year is deducted from your FPSL, if available, or your extended benefits. Immediate family includes your:

- Spouse
- *Child*, step-child, and child of your *domestic partner*
- Parent and step-parent
- Brother and step-brother
- Sister and step-sister
- Mother-in-law and father-in-law
- Grandparent (but not your *spouse's* grandparent)
- Grandchild
- Domestic partner
- Parents of your *domestic partner*

California Statute Regarding Time Off for Family Illness

Under the provisions of California's Sick Leave Statute (aka Kin Care) set forth in Section 233 of the California Labor Code, *full-time* employees enrolled in the CDP and *part-time plus* employees who work in California are eligible to use some of their FPSL to care for a seriously ill *child* (under age 18), parent, *spouse* or *registered domestic partner*, even if they have not yet completed six months of service. If this applies to you, you may use your eligible FPSL before or after you exceed the 24-hour per calendar year limit for illness in the immediate family, if applicable. Each calendar year, an employee may use the lesser of the following:

- The FPSL you would accrue in six months at your current rate of accrual (or, for *part-time plus* employees after June 30, 2008, at the rate of one-half of the FPSL being accrued per year prior to your conversion to such classification), less any time you have used in the calendar year under California's Sick Leave Statute (aka Kin Care). FPSL accrual for *part-time plus* employees ended on June 30, 2008
- Your accrued and available FPSL

You may not be refused time off for qualifying reasons under California's Sick Leave Statute, nor can you be discharged, demoted, suspended, or discriminated against in any manner by the *company*.

Paid Family Leave

Eligible employees working in California and enrolled in CDP are eligible for partial income replacement for time off if they were unable to work due to a family member's (*child*, parent, *spouse* or *domestic partner*) chronic serious health condition or for birth/bonding, adoption or foster care placement of a *child* (including a *domestic partner's child*). Over a 12-month period, eligible employees can receive up to six weeks of pay at 55% of their *base pay* rate up to a maximum weekly benefit calculated at the State Disability Insurance rate for the year in which the claim is incurred. Paid Family Leave can be taken either continuously, on a reduced schedule or intermittently. Paid Family Leave time off must be taken within 12 months of placement for birth and bonding. Time off under Paid Family Leave is not necessarily job-protected unless the employee is also eligible for protected time off under either the California Family Rights Act (CFRA) and/or the Family and Medical Leave Act (FMLA). If your qualifying family event began before February 1, 2010 you would need to first satisfy a seven calendar day waiting period unless you are a female employee requesting Paid Family Leave for bonding within

12 months of the birth of your *child*. Effective February 1, 2010, the seven calendar day waiting period was eliminated. If you are enrolled in CDP and are an eligible employee working in California your approved PFL benefit payments will commence on the first day of absence.

Paid Leave for Organ or Bone Marrow Donors

California-based employees who have exhausted all available sick leave will be permitted to annually take a job-protected leave of absence (on a rolling 12-month basis) with pay for the purpose of bone marrow donation (not to exceed five business days) or organ donation (not to exceed 30 business days).

How to Apply for CDP Benefits

To receive CDP benefits, you (or your supervisor) must note your absence and the reason for it on your time sheet. In addition, you must follow the procedures for your employee group, shown in the following chart.

CDP Application Procedures	
If you are disabled and you are a…	**To receive CDP benefits, you must…**
Full-time, part-time, part-time plus or *temporary* employee	Provide current ongoing medical certification to your supervisor or to the *company's* CDP claims administrator, as requested, for the duration of your absence
Terminated employee whose disability started prior to the end of the day on your last day of employment	Have your doctor complete the CDP Medical Certification form and return it to the CDP claims administrator for the duration of your disability
Terminated employee whose disability started after your last day of employment	No CDP benefits are payable

During the first three consecutive work days of absence due to an employee's illness or injury, employees enrolled in CDP are required to submit certification of their absence to their work location as requested. Employees enrolled in CDP are required to contact the *company's* CDP claims administrator if they remain unable to work after three full consecutive work days of absence and provide medical certification, as required. (See **Certification for CDP Benefits**, below.) In addition, all claims for Paid Family Leave must be submitted to the *company's* CDP claims administrator before the time off is needed, or as soon as practical following an *emergency*. The *company's* CDP claims administrator can be contacted at:

Sedgwick, CMS
P.O. Box 14435
Lexington, KY 40512-4435
866-925-6789

The CDP claims administrator will make a determination on your continued eligibility for benefits based on all the medical documentation available. If you disagree with the administrator's decision you have the right to appeal the decision (see **Appeals** in this section). If the decision on your claim is based on a medical judgment, it will be referred by the CDP claims administrator to a pre-established panel of board-certified *physicians* within the appropriate specialty. Your claim will be independently reviewed by three *physicians* from this panel. If two out of three *physicians* agree you are disabled, then your CDP benefits will be approved.

On or after June 7, 2010, if your CDP benefits are discontinued or reduced, and you appeal this decision to the State of California's Employment Development Department (EDD), the *company* will pay CDP benefits to you during the EDD appeal process, but you will need to repay these benefits if the EDD upholds the discontinuation or reduction of benefits. The repayment amount is calculated based on benefits received from the date of the last scheduled and missed IME (or the last panel *physician* report, if applicable), until maximum benefits are received or the *company* is notified of the EDD decision, whichever comes first.

Employees enrolled in SDI must submit all claims to the EDD for payment. Employees enrolled in SDI receive payment directly from the State of California.

To be eligible for CDP benefits, you must apply for them no later than 41 days after the start of your disability or qualifying family event. The time limit may be extended if you can show good cause for the delay, for example, if you have been too sick to apply for benefits.

Certification for CDP Benefits

The *company* has the right to require that absences due to illness or injury be supported by certification stating all of the following:

- Diagnosis (if you prefer not to disclose your diagnosis to your supervisor you may note 'confidential' on your timesheet and provide the diagnosis to the CDP claims administrator)
- Relevant medical facts within your care provider's knowledge
- Your care provider's assessment of your disability
- The anticipated duration of your disability

The State of California requires a diagnosis for all absences for which CDP benefits are payable.

If a competent medical authority has recommended or referred you to an approved alcoholism recovery home or approved drug-free residential program, the certificate does not have to mention the actual disability.

The CDP claims administrator may determine that you or your family member needs to attend an independent medical examination (IME) to obtain additional medical information to further evaluate your claim. If you or your family member do not attend the evaluation, your claim may be denied and you may have your benefits suspended until you, or your family member, attends.

If you fail to provide medical certification of your disability or your qualifying family event to your supervisor or to the CDP claims administrator, the *company* may suspend your benefits and terminate your employment.

For employees working in California, certification for Paid Family Leave includes the following additional items:

- Providing care to a seriously ill family member

The medical eligibility of the serious health condition of your family member that warrants your care must be established by a certificate from a *physician* or practitioner. The information provided must be within the *physician's* knowledge and must be based on a physical examination and documented medical history of the family member. The claim must contain all of the following information:

- Care Provider Certification:
    - The employee's legal name, Social Security number, date of birth, gender, mailing address, last day worked, reason why the employee is no longer working at his or her last job, and occupation
    - The date upon which the employee requests benefits to begin
    - The employee's relationship to the care recipient
    - The care recipient's legal name
    - A statement attesting to whether any other family member is ready, willing, able and available to provide care for the same period of time in a day
- Care Recipient Certification:
    - The care recipient's legal name, Social Security number,* date of birth, gender and residence address
    - The care recipient's signature authorizing the treating *physician* or practitioner to release the care recipient's protected health information to the *company*, (or its authorized plan administrator), the Employment Development Department and the employee
- Medical Certification:
    - The name and date of birth of the care recipient
    - A diagnosis and diagnostic code prescribed in the International Classification of Diseases, or where no diagnosis has been obtained, a detailed statement of symptoms
    - The date, if known, on which the condition of the care recipient commenced
    - The probable duration of the care recipient's condition
    - An estimate of the amount of time that the employee is needed to care for the care recipient
    - A statement that the care recipient's serious health condition warrants the participation of the employee to provide care for the care recipient. "Warrants the participation of the employee" includes, but is not limited to, providing psychological comfort and arranging third party care for the care recipient, as well as directly providing or participating in medical care

    - A statement regarding whether disclosure of the *physician's* or practitioner's certificate would be medically or psychologically detrimental to the care recipient
    - The *physician's* or practitioner's name, address, license number and signature
- Bonding with a new minor *child*

PFL eligibility for bonding is limited to the first year after the birth, adoption or foster care placement of the *child*. The employee may be eligible for PFL benefits if the employee files a claim and supporting documentation that provides satisfactory evidence of the birth, adoption or foster care placement of the *child* and which verifies the relationship of the employee to the *child*. The supporting documentation must include the following:

- The new *child's* relationship to the employee, legal name of the *child*, date of birth, gender, residence address, and, if available, Social Security number
- The date of foster care placement or adoption placement of the new minor *child* with the employee
- The employee's signature

For maternal, paternal, or registered *domestic partners*, any of the following documents are acceptable to verify the birth of the *child*:

- A photocopy of the *child's* birth certificate
- A photocopy of the completed hospital or birthing center documents attesting to the birth of the *child*
- A letter from the birthing center's or hospital's Director of Medical Records or designee containing the *child's* full name, gender and date of birth, the full name of the mother, full name of the father, or registered *domestic partner*, and a dated signature of the treating *physician*, practitioner, midwife or Director of Medical Records

For paternal non-spouse bonding claims*, where the individual is not named on a document above, a photocopy of California Department of Child Support Services form, "Declaration of Paternity," CS-909, is required

For adoptive parent(s) bonding claims*, supporting documentation includes:

- Dept. of Social Services form, Notice of Placement, AD-907
- Dept. of Social Services form, Independent Adoption Placement Agreement, AD-924
- Photocopy of a conformed court order of placement for adoption, issued within the United States
- Photocopy of the *child's* passport clearly showing an Immigration and Naturalization Services (INS) stamp 1-551
- Photocopy of the *child's* adoption certificate from the foreign country's competent local authority, with a notarized English translation

For foster parent(s) bonding claims*, supporting documentation includes:

- Photocopy of the Dept. of Social Services form, Approval of Family Caregiver Home, SOC-815
- A statement on letterhead from the County Dept. of Social Services, or equivalent government entity, containing all the following:
    - *Child*: full name; gender; date of birth; Social Security number (if issued)*; residence address where *child* is placed; and date of foster care placement (including the duration of placement, if established)
    - Foster parent(s): full name; date of birth; residence address; and Social Security number (if issued)*
    - Social worker involved with placement: full name, typed; direct telephone number; and dated signature (in signature block area)

*The absence of a Social Security number will not disqualify the employee.

A certificate of disability may be provided by:

- A *physician*, surgeon, optometrist, dentist, chiropractor, podiatrist, or qualified licensed psychologist
- A licensed nurse-midwife or nurse practitioner (with respect to normal pregnancy and childbirth-related disabilities only)
- A duly authorized medical officer of any recognized medical facility of the United States Government in which you are hospitalized or under care
- The registrar of a county hospital in which you are confined, indicating the date that your *physician* ordered your confinement and the duration of the confinement
- A duly authorized or accredited practitioner of any bona fide church, sect, denomination, or organization that depends for healing entirely upon prayer or spiritual means, if you, in good faith, adhere to their teachings; in such case, certification should state your disability and its estimated duration

- Evidence of receipt of Temporary Disability or Vocational Rehabilitation Maintenance Allowance, or their equivalents from Workers' Compensation, will be accepted in lieu of a certificate of disability.

When CDP Payments Begin and End

***Full-time*, *Part-time*, *Part-time Plus* and *Temporary* Employees**

Employee Illness or Injury - If you meet all eligibility and certification requirements and your claim for benefits has been approved, you will be eligible for benefits from the first day you miss work (effective February 1, 2010 for *part-time* and *temporary* employees). Benefits are paid according to your normal biweekly pay schedule and continue until you recover from your disability, return to work, die or use all of your CDP benefits, whichever comes first. The maximum duration of benefits is equal to the number of your FPSL and hospital days (if available and applicable) plus up to 52 weeks of extended benefits.

Qualifying Family Event - If your Paid Family Leave claim begins on or after February 1, 2010, then once you have met all eligibility and certification requirements and your claim for benefits has been approved, you will be eligible for benefits on your first approved day. Benefits are normally paid according to your normal pay schedule and continue for the duration of the certification or until the maximum benefit allowable has been paid, whichever comes first. However, if your Paid Family Leave claim is reduced schedule or intermittent, your benefit payments may be paid with a one pay period delay to allow for payroll reconciliation.

If you meet all eligibility and certification requirements, benefits continue until you or your family member recovers or dies, your certification expires, or you use all of your CDP benefits, whichever comes first.

Disability Benefits after Termination of Employment

If your disability period or your qualifying family event period continues past the date your employment with the *company* ends, CDP benefits may still be payable after your termination date for the same length of time as they are under California's SDI. (See **How to Apply for CDP Benefits**). For all employees who are eligible to receive benefit payments after their employment ends, any prior payments made by the *company* are included in determining when your maximum benefit payment has been made.

The following chart shows how your payments are affected if your disability period starts before and continues beyond the date you terminate employment with the *company* for any reason, including retirement.

If You Terminate Employment During a Disability Period	
State in Which You Work	**Effect on CDP Benefits**
• California • A state other than California that doesn't have a mandated short-term disability plan	CDP benefits will be paid in the same amount and for the same length of time as California's SDI would pay them. Any payments made prior to your termination of employment will be included in the determination of the remaining amount and duration of your payments
A state other than California that has a mandated short-term disability plan	Any benefits payable will be determined by the short-term disability plan of the state in which you work

Coordination with Other Income

If you are approved for CDP benefits, the amount you receive from CDP will be coordinated with any income you are eligible to receive from other sources. The benefits you receive from CDP will be reduced by the income you receive from other sources while you're disabled. You must notify the *company* or the CDP claims administrator of any other income you are entitled to receive while CDP benefits are being paid to you. Failure to do so is grounds for suspension of employment without pay, which may lead to termination of employment. Any overpayment of benefits due to duplicate payments will be deducted from any future payments from the *company*. If future payments are not expected from the *company*, you must repay the *company* for the amount of overpayment you received, or legal action will be taken against you.

Other income includes:

- Earned income - Includes wages, salaries, bonuses, commissions, tips and net earnings from self-employment, excluding income from a business founded prior to the onset of disability. Earned income does not include alimony or child support.
- California SDI or other state-mandated benefits
- Benefits received from another *company* disability plan
- Benefits received due to simultaneous coverage under multiple employers
- Social Security Disability Insurance (coordinates with FPSL only)
- Social Security Retirement benefits (coordinates with FPSL only)
- Temporary Disability (TD), Vocational Rehabilitation Maintenance Allowance (VRMA), or any equivalent benefits paid under Workers' Compensation
- Other offsets as permitted by law

On or after February 1, 2010, Workers' Compensation Permanent Disability (PD) payment awards no longer offset (reduce) CDP, Long Term Disability (LTD), or Return to Work Program (RTWP) disability payments.

Other Income you receive in a lump sum will be converted to a pro-rated weekly benefit.

If you receive payments from any of the above sources while you are also receiving CDP payments, the length of time you are eligible to receive CDP benefits may be extended, possibly beyond the normal 52 week maximum extended benefit period of coverage. That's because you will not be using your CDP benefits up as quickly, so they will be available to you for a longer period of time. If your CDP benefits are reduced because of your receipt of other income, your CDP benefits will continue until you have received the dollar equivalent of 52 weeks of CDP extended benefits, provided you remain disabled through this period.

What the CDP Does Not Cover

While CDP pays benefits during most absences from work due to disability, it does not pay for all such absences. CDP does not pay for absences during which:

- You receive benefits from any unemployment compensation act
- You are incarcerated for a criminal conviction
- You are disabled as a result of a criminal act resulting in your being convicted of a felony
- You file a claim for a disability arising from your arrest, investigation, or prosecution of a felony which results in your being convicted of a felony
- Any other exclusions that are permitted under the law, including the unemployment law of California or other jurisdictions
- If the *company* provides modifications that allow you to return to your regular and customary job (must be at your normal work location and within your work restrictions) and you refuse to return to work, you will receive benefits at the greater rate payable to you under SDI or 55% of your *base pay*

On or after June 7, 2010, your CDP payment level may be reduced to the rate payable to you under SDI for:

- Failure to submit a completed, signed claim package
- Noncompliance with the treating physician's treatment plan
- Certification by an unqualified provider
- Lack of objective findings of disability
- Being suspended for disciplinary action and then filing a disability claim

If you work in California and are entitled to leave under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA), you must establish your Paid Family Leave (PFL) claim concurrent with leave taken under those laws.

No PFL benefits are payable under the following conditions:

- For any period for which you are eligible for unemployment insurance in any state or from the federal government
- For any days for which you receive wages. However, benefits may be paid in an amount which does not exceed your regular weekly *base pay* immediately prior to the leave.
- Wages includes paid time off if it is used for purposes of family care leave

- For any period for which benefits are payable under a Workers' Compensation or employer liability law of any state, or for the federal government, for temporary disability in an amount equal to or in excess of the PFL weekly benefit amount for this plan. PFL benefits are payable for any difference between the PFL weekly benefit amount and the temporary disability weekly benefit amount

You may supplement vocational rehabilitation maintenance allowance with permanent disability advances to receive benefits equal to your temporary disability amount. In such cases, PFL benefits are payable for any difference between the combined total Workers' Compensation benefit and the PFL weekly benefit amount.

If you choose not to draw available permanent disability advances to supplement vocational maintenance rehabilitation allowance up to the temporary disability rate you are not eligible for PFL benefits.

If permanent disability advances are not available, PFL benefits may be paid for the difference between the maintenance allowance and the PFL weekly benefit amount.

Permanent disability advances, alone, are not in conflict with PFL benefits:

- For any period for which benefits are payable under a disability insurance act of any state, or any *company* plan established in lieu of a state plan
- For the same period of time in a day for which another family member is ready, willing, able and available to provide the required care

Situations Affecting CDP Benefits

There are a number of situations that may affect your CDP benefits. Some of these situations are described in this chart. See **Events Affecting Your Benefits** for other situations that may affect your benefits.

If you…	This will happen…
Request in writing to waive or cancel CDP coverage	• Coverage will not begin, or it will end on the first day of the first pay period of the calendar quarter following your request • If you work in California, you will be enrolled in SDI unless you also provide a statement to the Employment Development Department and to the *company* that you are waiving participation in SDI for religious reasons
Are receiving CDP benefits and a holiday occurs during your disability period	• You receive holiday pay for all *company* holidays instead of your FPSL and extended benefits under the CDP • *Part-time plus* employees receive holiday pay instead of your FPSL and extended benefits under the CDP if they were scheduled to work on the holiday • *Part-time* and *temporary* employees are not paid for holidays while receiving CDP benefits
Are receiving CDP benefits and request floating holiday or vacation time	You may not use floating holiday or vacation time while you are disabled. You must reschedule the floating holiday or vacation time. Once your full pay sick leave benefits and/or hospital days have been exhausted, you may request cash in lieu of vacation
Are receiving CDP benefits and will return to work prior to December 31, but will not be in imminent danger of forfeiting vacation hours	• You continue to accrue vacation, but you may not use vacation while you are disabled • Your unused accrued vacation will be deferred until you return to work
Are receiving CDP benefits, and will not return to work prior to December 31	You continue to accrue vacation, but you may not use vacation while you are disabled. You should contact your payroll location and request that they contact HR EDIT at the beginning of December to arrange for a cash-out of vacation days you would otherwise forfeit (see the **Vacation and Holiday** summary for details)

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Are receiving CDP benefits, and will return to work before December 31, but not in time to use all your vacation by December 31	You continue to accrue vacation, but you may not use vacation while you are disabled. You must contact the Employee Information Center at the beginning of December to arrange for a cash-out of vacation days you would otherwise forfeit (see the **Vacation and Holiday** summary for details)
Return to work on a reduced work schedule because of your own illness or injury	You may be eligible for continued benefits under the CDP up to a maximum of your lost income while you are working the reduced schedule. Please contact Disability Management if you feel you qualify
Are a *full-time* or *part-time plus* employee using disability on a partial day and working partial days	If you are on approved Family Leave, you will be eligible for disability pay for the number of hours you were disabled from your FPSL, if available. Otherwise, any lost income will be paid from your extended benefits. If you are an exempt employee not on approved Family Leave, you will receive full pay for each day worked
Are a *part-time* or *temporary* employee using disability on a partial day and working partial days	You are not entitled to any disability pay for a partial disability day
Are a *full-time* employee reclassified to a lower-paying job due to medical reasons and are receiving Supplemental Pay under the Return to Work Program (RTWP) and you become disabled again	• Your FPSL payments will be supplemented • Extended benefits will not be supplemented
Become disabled while on a scheduled vacation, jury duty, or on a holiday	• Your disability period will begin on the date your disability occurred. You may be required to submit medical certification of your disability and the date it began • If properly certified, your vacation, holiday, or jury duty time (if applicable) will be credited back to you
Become disabled, have exhausted your FPSL, and begin receiving reduced pay (CDP extended benefits) for your disability	• You continue to accrue vacation, but you may not use vacation while you are disabled • You may request pay in lieu of unused floating holidays and earned, unused vacation. You may not request pay in lieu of bought vacation
Exhaust the CDP benefits available to you	You may be eligible for benefits from another *company* disability plan or program

Exhaust all of your CDP benefits and are receiving:
• Long Term Disability Plan benefits
• Return to Work Program (RTWP) benefits
	• You will automatically be paid for earned, unused vacation, any vacation you bought and have not used in that year, and unused floating holidays
	• You may not contribute to the:
	  • Dependent Care Reimbursement Account (DCRA)
	  • Health Care Reimbursement Account (HCRA)
	  • 401(k) Savings Plan (RTWP participants may continue to contribute)
	• You stop accruing FPSL and vacation time
	• You do not receive hospital days, holidays, working unit seniority, and service credit for CDP and vacation

Become disabled during the first two weeks after being laid off or after beginning a leave of absence	• For employees working in California, CDP benefits are payable to the same extent and at the same rate as they would be payable under California's SDI • For employees working in other states, payment depends on the provisions of the state's mandated short-term disability plan, if any
Become disabled more than two weeks after being laid off or after the start of your leave of absence	No CDP benefits are payable

Appeals

If your claim is denied or terminated, in whole or in part, you will be advised by letter that your claim is being denied and provided with the reason(s) for the denial. If you disagree with the outcome, you or your beneficiary

may appeal it. Refer to the **Other Important Information** section of this handbook for details about documentation and the appeals process.

For More Information

For more information about CDP benefits, contact Benefits Administration at:

- (800) 500-4723, and select the option for the Employee Information Center
- PAX 23456 or (626) 302-3456, and select the option for the Employee Information Center
- Infocntr@sce.com (e-mail address)

You can also contact Sedgwick, CMS at 1-866-925-6789 or Disability Management.

For more information about California's SDI, call the State Disability Insurance Program at (800) 480-3287.

CDP Appendix

Special Rules for Certain Transferred Employees

If you joined the *company* as a result of an acquisition or merger, some special rules may apply to your coverage under the CDP. These special rules are outlined in the following chart.

<table>
<tr><td rowspan="2">Former GPU employees at the Homer City Generating Station who transferred to EME Homer City Generation LP in non-represented positions on March 18, 1999</td><td>Unpaid Sick Leave with GPU</td><td>Your accrued, unpaid full pay sick leave (FPSL) with GPU is recognized in the balance of your accrued unused full pay sick leave in the CDP.</td></tr>
<tr><td>Service</td><td>Your service with GPU is counted as service with EME Homer City Generation LP for the purpose of ongoing benefit accrual under the CDP.</td></tr>
<tr><td rowspan="2">Former Commonwealth Edison employees who transferred to Midwest Generation EME, LLC or Midwest Generation, LLC on December 15, 1999</td><td>Unpaid Sick Leave Opening Balance</td><td>If you are a non-represented employee, an opening balance of accrued full pay sick leave (FPSL) was established based on your Commonwealth Edison service as follows:<table><tr><td>• Less than 10 years</td><td>15 days</td></tr><tr><td>• 10 - 14 years</td><td>30 days</td></tr><tr><td>• 15 - 19 years</td><td>45 days</td></tr><tr><td>• 20+ years</td><td>60 days</td></tr></table></td></tr>
<tr><td>Service</td><td>If you are a non-represented employee, your service with Commonwealth Edison is counted as service with Midwest Generation for the purpose of on-going benefit accrual under the CDP.</td></tr>
<tr><td rowspan="2">Former Citizens Power employees who transferred to Edison Mission Marketing & Trading, Inc. on September 1, 2000</td><td>Unpaid Sick Leave Opening Balance</td><td>You were provided with an opening balance of accrued full pay sick leave (FPSL) based on your Citizens Power service as follows:<table><tr><td>• Less than 10 years</td><td>15 days</td></tr><tr><td>• 10 - 14 years</td><td>30 days</td></tr><tr><td>• 15 - 19 years</td><td>45 days</td></tr><tr><td>• 20+ years</td><td>60 days</td></tr></table></td></tr>
<tr><td>Service</td><td>Your service with Citizens Power is counted as service with Edison Mission Marketing & Trading, Inc. for the purpose of ongoing benefit accrual under the CDP.</td></tr>
</table>

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Long Term Disability Plan

Long Term Disability Plan revised December 19. 2012.

Overview and Important Features

The Long Term Disability (LTD) Plan is designed to provide partial income replacement to eligible *full-time* employees who are disabled. After a qualifying period of six continuous months or more, based on the LTD option you choose or are enrolled in by default, you may receive LTD benefits calculated at 50%, 60%, or 70% of your *base pay* on your last day worked before the first date of your disability, if you meet eligibility requirements.

Who Is Eligible

Active *full-time* employees are eligible for the LTD plan. *Part-time, part-time plus, temporary* and *leased* employees and *contingent workers* are not eligible to participate in the LTD plan.

You first become eligible for LTD coverage on your date of hire, provided you are *actively at work*. If you are not *actively at work*, coverage becomes effective on your first full day of work. See the **Eligibility** section at the beginning of this handbook for the specific *companies* and employee groups eligible to participate in this plan.

Enrolling For Coverage

Enrollment Deadlines

Newly eligible employees have 30 days from their date first eligible to enroll to make their elections for the remainder of the plan year. If you don't enroll during these 30 days, you will be automatically enrolled in the 60% coverage option effective on the date you were first eligible to enroll. This coverage status remains in place until you change it:

- During the annual enrollment, or

- Because of a qualified life event

Annual Enrollment

Each year during the annual enrollment, you have the opportunity to change your LTD option. If you change your LTD option, your new coverage begins on the following January 1. Any changes will not take effect unless you are confirmed *actively at work*. However, if you become disabled due to a pre-existing condition (see **Pre-existing** Conditions in this summary), your LTD benefit will be based on your LTD coverage option in effect during the three-month period immediately preceding your LTD option change. If you don't make a change during annual enrollment, you will keep the LTD option you had in the prior year.

Pre-existing Conditions

A pre-existing condition is an illness or injury for which you received treatment or services, or took drugs or medications which were prescribed or recommended by a *physician*, during the three-month period before you joined the plan or before you changed your LTD coverage.

During the **first 12 months** you are covered under the plan you are not eligible to receive LTD benefits for any disability that results from a pre-existing condition.

> *Example: Let's say you've been in the plan for three years. Then, you decide to change your coverage level from 60% to 70% of your* base pay*. At the same time, you are receiving treatment for a heart condition. Six months after you change your coverage level, you become disabled due to a heart attack. In this case, you would receive 60% of your* base pay *on your last day worked before the first date of your disability from the plan because your disability is due to a pre-existing condition and 12 months have not elapsed since you changed your coverage option.*

LTD Coverage Level Options

There are three LTD coverage level options you can choose from:

- 50% of *base pay*
- 60% of *base pay*
- 70% of base pay

Cost of Coverage

Your price tags for LTD depend on the coverage level you choose, your *base pay* and your age. *Company* contributions are given based on the 60% price tag. *Company* contributions and price tags are divided among your *deduction periods* throughout the year. See the ***Flex*** section for more details on price tags and *company* contributions.

Price Tags

Price tags for LTD coverage in your first year with the *company* are based on the following three factors:

- Your age on the January 1 preceding your date of hire
- Your *base pay* on your hire date
- The level of coverage you choose

In future years, price tags are based on:

- Your age on January 1
- Your *base pay* on the *company's* record keeping system as of September 1 of the prior plan year
- The level of coverage you choose

The price tag and *company* contributions for each available LTD option are shown in the personalized information you receive during the annual *Flex* annual enrollment period.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Company contributions

The *company* provides eligible *full-time* employees with contributions equal to the price tag of the 60% *base pay* option. (See the *Flex* section for more information on *company* contributions.)

Employee Contributions

If the annual price tag of the LTD option you have elected is more than your allotted LTD *company* contributions, you pay the difference through pre-tax payroll deductions and/or with other available *company* contributions you may have. If the annual price tag is less than the allotted LTD *company* contributions, you may use those remaining *company* contributions towards other *Flex* choices or receive them as taxable income in your paychecks.

If you choose this LTD coverage level option...	Your LTD *Company* Contributions will be...
50% of *base pay*	Higher than your LTD price tag. You may receive the difference as taxable income or use it toward your other *Flex* options.
60% of *base pay*	Equal to the price tag of your LTD option. You won't have to use other available *company* contributions or pre-tax dollars through payroll deduction to pay for your coverage.
70% of *base pay*	Less than your price tag. You'll pay for your additional coverage with either other available *company* contributions or through payroll deduction with pre-tax dollars.

If you don't receive enough pay during a pay period to cover your price tags, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. If you are in arrears after four consecutive pay periods, you will receive a written notice that you are being changed from payroll deduction to direct billing and you will be billed for future contributions you owe. If you fail to pay your contributions, your coverage will be terminated. Any amount that you have in arrears for payroll deductions during *deduction periods* prior to your change to direct billing that could not be collected at the end of the calendar year will be added to your W-2 statement as taxable income. If you leave the *company* or cease to be eligible for benefits, you will be billed for any outstanding deduction amounts.

If you're not receiving income directly from the *company* and payroll deductions are not possible, you will be billed monthly for your LTD coverage. You will be expected to pay for your LTD coverage with post-tax dollars by submitting monthly checks to Benefits Administration.

Your contributions and LTD *company* contributions will stop once the *company* is notified that your claim for LTD benefits has been approved. They won't resume until you return to work.

How the LTD Plan Works

You are eligible for LTD benefits after you have been unable to perform your regular and customary job for six continuous months. This initial six consecutive months of the disability period is referred to as the qualifying period. See **Qualifying Period** in this summary.

What "Disabled" Means

Disabled means that, due to illness or injury, you are unable to perform your regular and customary job for the first two years of your disability and any reasonable job for the *company* after two years. Your disability must be substantiated by medical evidence from a qualified *physician* specializing in the area of your disability. See **What "Medical Evidence" Means** in this summary.

You will also be eligible for LTD benefits if you become approved for Social Security Disability Insurance Benefits within 12 months of your initial denial of LTD with an effective date within your qualifying period. However, if the *company* offers you a reasonable job or the Return to Work Program, you must accept the job or participate in the Return to Work Program or your LTD benefits will end and your employment will be terminated.

Eligible terminated employees approved for Social Security Disability Insurance (SSDI) must still meet the LTD plan's definition of disability to remain eligible for LTD benefits.

Qualifying Period

The qualifying period begins on the first day of your disability or 31 days before the date you were first seen and treated by a *physician* for the injury or illness that caused your disability, whichever occurs later. It continues for the next six continuous months.

What "Reasonable Job" Means

A reasonable job is any gainful activity in any job classification for which you are or may reasonably become fitted by education, training, or experience. However, the meaning of "reasonable job" varies among employee groups, depending on where the job is located.

For employees of Southern California Edison, a reasonable job is located at any *company* within the zone (Northwestern, Basin, or Eastern) in which you were working on your last day at work.

What "Medical Evidence" Means

Medical evidence means evidence supported by a meaningful clinical evaluation and, where applicable, reasonable and appropriate diagnostic testing. The *physician's* report must state the reasons and factual basis for his or her conclusion that you are disabled. A *physician's* opinion that you are disabled is insufficient if it is not supported by such medical evidence.

The LTD administrator has discretion to review and evaluate all medical evidence for non-represented employees and to make factual determinations as to eligibility for LTD benefits.

Applying for LTD Benefits

Active Employees

Once you've been off work due to disability for approximately four consecutive months, the LTD administrator will send you an LTD claim package that includes all necessary claim forms. It's not necessary to submit any additional medical information if you'd like the LTD administrator to determine your eligibility based on the medical information already available to the LTD administrator. This information may include the medical certification and other information from the Comprehensive Disability Plan (CDP) as well as from the *company*'s Workers' Compensation administrator.

Once your LTD claim package is complete, mail your completed LTD claim package to:

Sedgwick, CMS
P.O. Box 14435
Lexington, KY 40512-4435
(800) 939-4911

Terminated Employees

If you are terminated from the *company*, either voluntarily or involuntarily, your LTD coverage will stop at the end of the day your employment terminates. However, if you are determined to have been disabled for a period of six continuous months, including your last day of employment, you may be eligible to receive LTD payments as long as your termination of employment date is prior to June 7, 2010. To be considered for benefits, you must request the LTD claim package from the LTD administrator and return the completed claim package in its entirety within six months of your termination date. If your termination of employment is effective prior to June 7, 2010, and you are already receiving LTD payments from the plan when your employment with the *company* is terminated, you do not have to reapply for LTD benefits. Payments will continue until an event occurs that is set forth under the section **When Disability Ends**.

Your eligibility and/or payments for LTD end if your employment is terminated on or after June 7, 2010, unless your employment is reinstated.

Once your LTD claim package is complete, mail your completed LTD claim package to:

Sedgwick CMS
P.O. Box 14435
Lexington, KY 40512-4435
(800) 939-4911

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

When LTD Payments Begin

Although you may be approved for LTD, your actual LTD payments will only begin as soon as **all** of the following situations have occurred:

- You have satisfied the qualifying period and are disabled
- Your claim for LTD benefits has been approved by the LTD administrator, based on the medical evidence
- Your other income is less than the amount you are eligible to receive under the LTD plan (See **Coordination with Other Income**).
- You (or your authorized representative) have completed, signed and returned the Right to Reimbursement, Medical Release, and Social Security Authorization agreement to the LTD administrator

After your initial application for LTD benefits has been approved, the LTD administrator will determine when your benefit payments will begin.

Your eligibility for LTD benefits will be determined within 45 days of receipt of your completed LTD claim package. If no LTD claim package is received, or if it is incomplete, then the decision will be made within 45 days of the completion of the qualifying period. The time to make a decision may be extended for two additional 30-day periods for a maximum of 105 days for matters beyond the control of the claims administrator. You will receive written notice of any extension, including the reasons for the extension.

Non-represented employees may be required to participate in an independent medical examination to determine eligibility for initial and continued benefits.

Effective June 7, 2010, a *physician* panel (three board certified *physicians* within an appropriate specialty) will review the following situations to determine either LTD benefit eligibility or continued LTD benefit eligibility:

- All substance abuse/mental health claims (effective June 7, 2010 there will no longer be a 24 month limit for substance abuse and mental health conditions)
- Non-compliance with your treatment plan
- Certification by unqualified providers
- Lack of objective medical findings

For your claim to be denied by the LTD administrator for one of the above situations, at least two of the three *physicians* must deny it. If LTD benefits are ultimately denied based on the medical judgment of the panel process, you can appeal the decision.

What is an Independent Medical Examination

An independent medical examination (IME) is an examination conducted by an independent *physician*. The independent *physician* is selected by the LTD administrator. An IME is in addition to any medical evidence you provide to the LTD administrator.

Non-represented employees must submit to an IME as often as is determined necessary by the LTD administrator or the Benefits Committee.

Amount of LTD Benefits

Based on the option you choose, your LTD benefits from all sources combined (see **Coordination With Other Income** in this summary) will total at least 50%, 60%, or 70% of your *base pay*.

Example: Suppose you've chosen the 70% base pay *option and you become disabled and eligible for LTD benefits. If your monthly* base pay *were $4,000, you would be entitled to a total monthly benefit of $2,800. If you were also entitled to $800 a month from Social Security, the LTD Plan would provide $2,000 of that $2,800 total monthly benefit.*

LTD benefit payments are calculated on a bi-weekly basis and paid to you in your regular weekly or biweekly paycheck. Any retroactive LTD benefits owed to you will be included in your first payment. Payments for periods of less than two full weeks are prorated. The biweekly benefit is divided by 14 days and the resulting dollar amount is multiplied by the number of days the benefit is payable.

Be sure to notify the *company* if your address, telephone number, or name changes while you are receiving LTD benefits.

Coordination with Other Income

If you are approved for LTD benefits, the LTD plan coordinates its payments with other income you are eligible to receive. You must notify the LTD administrator of any other income you are receiving when you make a claim for LTD benefits, as well as any other income you begin receiving at any time during the period you are receiving LTD benefits.

Other income includes but is not limited to:

- Earned income - Includes wages, salaries, bonuses, commissions, tips and net earnings from self-employment, excluding income from a business founded prior to the onset of disability. Earned income does not include alimony or child support
- Paid holidays
- Short-term disability benefits such as CDP, California State Disability Insurance (SDI), or any other state disability benefits
- Social Security Disability Insurance (SSDI)
- Social Security Retirement benefits
- Temporary Disability (TD), and/or Vocational Rehabilitation Maintenance Allowance (VRMA), or any equivalent benefits paid under Workers' Compensation
- The amount of any other disability, retirement, or unemployment benefits you receive pursuant to any law or under any retirement, profit sharing or savings plan (excluding any future cost of living adjustments). If you elect a lump sum distribution from any of these sources, the equivalent value of the single life annuity option will be used
- Benefits from your group disability plan

On or after February 1, 2010, Workers' Compensation Permanent Disability (PD) payment awards no longer offset (reduce) CDP, Long Term Disability (LTD) or Return to Work Program (RTWP) disability payments.

Other income does not include disability benefits provided under:

- The *company*'s group life insurance plan
- Permanent Disability benefits awarded by Workers' Compensation (prior to October 3, 2005 and after February 1, 2010)
- Social Security benefits for dependents
- Social Security Cost of Living Adjustments (COLAs)
- Benefits received from the Veterans Administration
- Benefits received from an individual private disability insurance policy

Examples of other sources of income that do not affect LTD benefit payments are:

- Income from investments
- Dividend and interest payments
- Income from property rentals
- Your *spouse's* earnings
- Alimony or child support

Overpayment of LTD Benefits

If you receive an overpayment of LTD benefits because you have received income from any of the sources that coordinate with LTD benefits, the LTD administrator will offer you the opportunity to repay the amount of the overpayment by check within 30 days of the date you are notified of the overpayment. If you prefer, your LTD benefits may be reduced or suspended, for a period up to 60 months, until the overpayment has been repaid in full.

Taxation of LTD Payments

Because you pay for LTD coverage with pre-tax contributions (including *company* contributions), benefits you receive from the LTD plan are fully taxable as ordinary income.

Applying for Social Security Disability Income Benefits

If you are approved for LTD benefits, it may be to your benefit to apply for Social Security Disability Insurance (SSDI) benefits. The *company's* LTD administrator offers assistance to employees in applying for SSDI. Once the LTD administrator receives information about your SSDI award, your LTD and SSDI benefits will be coordinated, and adjustments to your LTD payments will be made, if necessary. See **Coordination With Other Income** and **Overpayment of LTD Benefits** in this summary.

The LTD administrator may ask you to provide certain SSDI documents including a copy of or receipt for your initial SSDI application, status updates, and notification of denial or approval of SSDI benefits.

If you fail to provide the SSDI information within 90 days of the LTD administrator's request, the LTD administrator will automatically decrease your LTD benefits using an estimate of the SSDI benefits the LTD administrator estimates you are entitled to receive from Social Security, retroactive to your date of SSDI qualification. This is called an "estimated SSDI offset." After you provide the required SSDI information, your LTD benefit will be adjusted, if necessary. If you provide documentation that your SSDI benefits were denied, you will receive payment for the amount of the estimated SSDI offset that was deducted from your LTD benefits.

If you provide the LTD administrator with your approval for SSDI benefits, the estimated offset will be compared with your actual SSDI benefit, and any adjustment will be made retroactively.

Re-certifying Your Disability Status

Once you are approved for LTD benefits, you will be required to periodically submit continuous proof of your disability to the LTD administrator.

Proof of your continued disability requires medical evidence from a licensed *physician* specializing in the area of your disability. If you fail to provide the required medical evidence of your continued disability, you will no longer be eligible to receive plan benefits.

How Long Benefits Are Payable

In some situations, payment of LTD benefits may be limited to a 24 month maximum. If your disability began prior to June 7, 2010, a 24 month limit will apply to all situations where the primary diagnosis is substance abuse. The 24 month limit will also apply when the diagnosis is a mental health condition and objective findings supporting disability do not exist. This would include conditions that are treated by Marriage, Family and Child Counselors (MFCC), Licensed Clinical Social Workers (LCSW) and Licensed Psychologists (Doctors of Philosophy and Doctors of Education). This would also include medical conditions that although treated by Doctors of Medicine or Osteopathy, require only the use of anti-depressant or anti-anxiety agents with or without supportive psychotherapy.

Examples of when the 24 month limit for mental health conditions disorders will not apply include:

- The mental health condition is a result of a chronic serious health condition, such as Parkinson's disease, Alzheimer's disease, myocardial infraction, stroke, significant head trauma or infection
- The mental health condition is verified to be caused by Schizophrenia, Post Traumatic Stress Disorder, Bipolar Disorder, Anorexia, Bulimia, Obsessive Compulsive Disorder, Recurrent Major Depression, Delusional Disorder or Panic Disorder

For employees with less than or equal to five (5) *years of service*, whose disabilities begin on or after June 7, 2010, LTD benefits will be limited to two (2) years maximum, unless they have been approved for Social Security Disability Insurance (SSDI) on the two (2) year maximum date, in which case, benefits continue per

current schedule. For employees with greater than five (5) *years of service*, there is no change in the benefit schedule. *Years of service* for these purposes are determined as of the last day worked before the first date of your disability.

If the 24 month limit applies to your claim for LTD benefits, you will be notified at the time that your LTD claim is approved that a limit is in effect and you will be instructed on how to appeal the limit if you disagree with it.

If a 24 month limit does not apply, then as long as you remain disabled, as defined by the plan, LTD benefits will continue until the earliest of the date you return to work, recover, retire, terminate (on or after June 7, 2010), die, or meet the maximum duration period shown in the following table:

MAXIMUM BENEFIT DURATION	
If you were this age on the last day you worked...	**The maximum benefit duration (starting with the day your LTD benefits began) will be...**
Age 59 or under	First of the month in which you turn age 65
60	5 years, 1 month
61	4 years, 6 months
62	4 years, 1 month
63	3 years, 8 months
64	3 years, 3 months
65	3 years
66	2 years, 9 months
67	2 years, 7 months
68	2 years, 5 months
69	2 years, 3 months
70	2 years, 2 months
71	2 years
72	1 year, 11 months
73	1 year, 10 months
74	1 year, 9 months
75 or over	1 year, 8 months

When Disability Ends

For purposes of the LTD plan, your period of disability ends on the earliest of the:

- End of the month in which you are determined to no longer be disabled by the LTD administrator including *physician* panel determinations
- Date on which you fail to furnish medical evidence supporting your disability
- Date on which you fail to submit to an independent medical examination by a *physician* of the LTD administrator's choice or on a date the *physician* finds you are not disabled
- Last day of the month in which you are no longer under the care of a *physician*
- Date on which you retire under the terms of the *company*'s Retirement Plan
- Last day of a maximum duration of benefits period
- Date you return to work or die
- Your eligibility and/or payments for LTD end if your employment is terminated on or after June 7, 2010, unless your employment is reinstated

In some situations, payment of LTD benefits may be limited to a 24 month maximum.

Requalifying for LTD Benefits After a Brief Recovery

If you recover or return to work, but become disabled again due to the same disability, benefits can begin without another qualifying period, if you provide medical evidence that you are disabled.

Also, your second period of disability must begin within three months of your recovery or return to work.

If this happens, your two disability periods will be regarded as one period of disability.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If you are disabled by a second illness or injury that is either not related to the first disability or is separated by more than three months after you recover or return to work following your first disability, a new six-month qualifying period and medical evidence that you are disabled due to the second illness or injury will be required before LTD benefits can begin.

If Your LTD Benefits Are Denied or Terminated

If your LTD benefits are denied or terminated and you are medically capable of returning to your regular and customary job, your payroll location will be notified and you will be given a return-to-work date. If you fail to return to work on your return-to-work date, your employment may be terminated.

If you're no longer disabled, but are unable to return to your regular and customary job due to permanent medical restrictions, you may be eligible for the Return to Work Program.

If the LTD claims administrator denies your claim in whole or in part, you will be furnished with a written notice of the denial setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provision on which the denial is based
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken if you wish to appeal the claims administrator's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suite under ERISA with respect to any denial after the appeal of your claim.

If you appeal the denial or termination of your LTD benefits, you will not normally be expected to return to work until a decision has been made on your appeal. However, normally you will not receive LTD benefit payments during the appeal process, although you may be eligible to receive payment from Workers' Compensation, CDP or SDI. If your claim is denied in whole or in part, you or your beneficiary may appeal that denial.

What the LTD Plan Doesn't Cover

While the LTD plan pays benefits during most absences from work due to disability, it does not pay for all such absences. The LTD plan does not pay for disabilities due to or resulting from:

- A pre-existing condition that occurs during the first 12 months you are eligible for LTD coverage
- Intentionally self-inflicted injuries
- Your commission or attempted commission of a felony, assault, or battery
- War or any act of war (declared or undeclared) does not apply to disabilities beginning on or after June 7, 2010
- Insurrection, rebellion, or participation in a riot or civil commotion

On or after June 7, 2010 your disability period will also end if you are incarcerated more than 30 consecutive calendar days. Your benefit payments will end on the 31st day, but may resume upon your release, as long as you are otherwise eligible. Incarcerated means confined in any jail, prison, or other penal institution or correctional facility that is under state or federal jurisdiction. You do not have to be convicted of a crime for this clause to apply. You are considered confined even though you may temporarily or intermittently be allowed outside the facility (e.g., on work release, attending school, or hospitalized).

You will be eligible for LTD benefits if you become approved for Social Security Disability Insurance (SSDI) benefits within 12 months of your initial LTD claim denial decision notification date. The effective date of the SSDI decision must be within your LTD qualifying period. However, if the *company* offers you a reasonable job or the Return to Work Program, you must accept the job or participate in the Return to Work Program or your LTD benefits will end and your employment will be terminated.

Making Changes During the Year

In most cases, your LTD option remains in effect through December 31 of each year. However, you may make changes during the year if you have a *qualified life event*. The change in coverage is effective the later of the date of your *qualified life event* or the date you are *actively at work.*

Your LTD benefit change must be a result of, and consistent with, the qualifying event. Increases or decreases in coverage take place only if you are *actively at work*. See the **Events Affecting Your Benefits** section for more information on *qualified life events*.

Furthermore, should you become disabled due to a pre-existing condition within 12 months of changing your LTD option, your LTD benefit will be based on your LTD coverage option in effect during the three-month period immediately preceding your LTD option change.

Appeals

If a benefit claim is denied, in whole or in part, you may appeal it. The LTD claims administrator will make a determination on your continued eligibility for benefits based on all the medical documentation available. If you disagree with the administrator's decision you have the right to appeal the decision. If the decision on your claim is based on a medical judgment, it will be referred by the LTD claims administrator to a pre-established panel of board-certified *physicians* within the appropriate specialty. Your claim will be independently reviewed by three *physicians* from this panel. If two out of three *physicians* agree you are disabled, then your LTD benefits will be approved.

The Benefits Committee has the full and final power and discretionary authority to construe and interpret all provisions of the Long Term Disability Plan, to administer its provisions, to grant or deny benefits based on factual determinations, to establish, amend and rescind rules and regulations for efficient administration, to determine all questions relating to the rights and eligibility of participants, and to take such other action to administer the Plan as it deems appropriate. The decisions of the Benefits Committee shall be final and binding on all parties.

Appeals regarding these provisions should be directed to:

Sedgwick, CMS
Appeals Unit
P.O. Box 14446
Lexington, KY 40512-9951

When Eligibility for LTD Coverage Ends

If you...	This will happen...
Go on an approved leave of absence	Your pre-tax contributions and LTD *company* contributions stop at the end of the month in which the leave begins. Your LTD coverage ends at the end of the month following the month your leave begins.
Change to an ineligible status, your employment is terminated for any reason, or you retire	Your LTD coverage ends on that date. However, if your employment is terminated prior to June 7, 2010, and if you are in the qualifying period or are receiving LTD benefits, you will remain eligible for LTD benefits but only if you meet the LTD plan's definition of disability, regardless of whether or not you are approved for SSDI.

For More Information

If you have questions, you may call:

- Benefits Administration - PAX 23456, (626) 302-3456, or (800) 500-4723, select the option for the Employee Information Center
- The LTD claims administrator at (800) 939-4911
- Disability Management - PAX 20202 or (626) 302-0202

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Return to Work Program

Overview and Important Features

The Return to Work Program is designed to help disabled employees with permanent work restrictions return to regular, full-time employment. The program is customized to meet individual needs. Participants receive partial income replacement and may be eligible for training, educational opportunities, job placement assistance, and supplemental pay.

The maximum duration of the Return to Work Program is normally 2½ years, but this time may be extended in some circumstances.

Who Is Eligible

You're eligible to participate in the program if permanent work restrictions prevent you from performing your regular and customary job, but do not prevent you from performing a reasonable job for the *company* and you are a *full-time* employee.

Part-time, part-time plus, temporary and *leased* employees and *contingent workers* are not eligible to participate in the Return to Work Program.

To qualify for participation, your medical information must demonstrate the presence of permanent work restrictions that prevent you from performing your regular and customary job. In addition, your regular work location must be unable to accommodate your work restrictions.

Eligibility is based on medical information that is provided to the Return to Work Program administrator from several sources including the **Comprehensive Disability Plan (CDP)**, **the Long Term Disability Plan (LTD)**, **Workers' Compensation** , and you.

The Return to Work Program administrator will evaluate your medical information and notify you if you qualify. The administrator's decision regarding your eligibility for the program is final.

If you are receiving Vocational Rehabilitation Maintenance Allowance (VRMA) payments from Workers' Compensation or their equivalents, you will automatically be enrolled in the Return to Work Program and be eligible for all the benefits of the program.

Cost of Coverage

The *company* pays the full cost of this program out of its operating income.

How the Return to Work Program Works

Once you are accepted into the Return to Work Program, you and your Return to Work Program representative will work together to design a customized plan that is best suited to help prepare you to find a job either inside or outside the *company.* The Return to Work Program requires your active commitment to the plan developed for you. This commitment includes your being available during appropriate business hours for all appointments, interviews, scheduled meetings, testing, classes, and other Return to Work activities. As you advance through the program, your full participation in an intensive job placement effort will be necessary.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Development of your plan may involve:

- Assessing your work restrictions, employment history, education, skills, abilities and interests
- Modifying your current job so you can immediately return to work
- Identifying on-the-job or formal training to update your skills
- Providing placement assistance to help you find a new job
- Taking college courses to complete a degree
- Developing a vocational plan to help you meet your goals

You'll be asked to sign an agreement to implement the program that is developed for you.

Income Replacement

If you are approved for the Return to Work Program, the amount you receive will be coordinated with any income you are eligible to receive from other sources. The income you are eligible to receive (whether or not you actually receive it) from other sources while you're disabled will be subtracted from your Return to Work Program payments. This means that you receive, from all sources combined, the greater of 70% of your pre-disability *base pay* or your CDP extended benefit rate.

You must notify the *company* of any other income you are eligible to receive while receiving benefits under the Return to Work Program.

Other income includes but is not limited to:

- Earned income is income received from your employment or occupation for compensation or profit. This includes wages, salaries, bonuses, commissions, tips and net earnings from self-employment, excluding income from a business founded prior to the onset of disability. Earned income does not include alimony or child support
- Paid holidays
- Short-term disability benefits such as CDP, California SDI, or any other state disability benefits
- Social Security Disability Insurance (SSDI)
- Social Security Retirement benefits
- Temporary Disability (TD), and/or Vocational Rehabilitation Maintenance Allowance (VRMA) or any equivalent benefits paid under Workers' Compensation
- The amount of any other disability, retirement, or unemployment benefits you receive pursuant to any law or under any retirement, profit sharing or savings plan (excluding any future cost of living adjustments). If you elect a lump sum distribution from any of these sources, the equivalent value of the single life annuity option will be used
- Benefits from your group disability plan

On or after February 1, 2010, Workers' Compensation Permanent Disability (PD) payment awards no longer offset (reduce) CDP, Long Term Disability (LTD) or Return to Work Program (RTWP) disability payments.

Other income does not include disability benefits provided under:

- The *company's* group life insurance plan
- Permanent Disability benefits awarded by Workers' Compensation (prior to October 3, 2005 and after February 1, 2010)
- Social Security benefits for dependents
- Social Security Cost of Living Adjustments (COLAs)
- Benefits received from the Veterans Administration
- Benefits received from an individual private disability insurance policy

Examples of other sources of income that do not affect benefits under the Return to Work Program are:

- Income from investments
- Dividend and interest payments
- Income from property rentals
- Your *spouse's* earnings
- Alimony or child support

Overpayment of Return to Work Program Benefits

If you receive an overpayment of Return to Work Program benefits because you have received income from any of the sources that coordinate with Return to Work Program benefits, the Return to Work Program administrator will offer you the opportunity to repay the amount of the overpayment by check within 30 days of the date you are notified of the overpayment. If you prefer, your Return to Work Program benefits may be reduced or suspended, for a period up to 60 months, until the overpayment has been repaid in full.

Taxation of Return to Work Program Payments

Because the *company* pays entirely for the benefits you receive from the Return to Work Program, the payments are fully taxable as ordinary income.

Training and Education

If you need training to update your skills or acquire new skills for a career change inside or outside the *company,* you will work with your representative to determine the appropriate courses available through trade, technical, and business schools.

If you are currently enrolled in a community college certificate or associate degree program or a four-year college or university, or if you have completed substantial progress toward a college degree, your representative will help you determine whether further course work can be included in your program. The Return to Work Program may pay the cost for training classes and for college courses that are part of a certificate program. For some college courses, reimbursement may be available under the *company's* educational reimbursement program.

Job Placement

Your representative will work with you to develop your résumé, submit job applications, identify job leads, network, and arrange and prepare for job interviews.

To help you develop skills and network within the *company*, you may be offered temporary assignments as part of your Return to Work Program. Temporary assignments are voluntary. Priority for union temporary assignments is given to union employees with the longest tenure in the Return to Work Program. Each temporary assignment has a maximum duration of one year. Any time you work in a temporary assignment will not count against the maximum disability duration time limit in the Return to Work Program.

If the *company* offers you a reasonable job, you are required to accept the job or face termination of employment. A "reasonable job" is any gainful activity in any job classification for which you are or may reasonably become suited by education, training, or experience. However, the meaning of "reasonable job" varies among employee groups, depending on where the job is located, as shown in the following chart.

Where a "Reasonable Job" Is Located	
For these groups of employees…	**A reasonable job is located…**
Employees of Southern California Edison (SCE) except those represented by *IBEW* Local 47	Within the zone (Northwestern, Basin, or Eastern) in which you were working on your last day at work prior to the start of your disability
Employees of SCE represented by *IBEW* Local 47	Anywhere that is within the greater of: • One hour's driving time from your residence on the date your disability began • 35 miles from your residence on the date your disability began

Participating in the Return to Work Program

You are limited to a maximum of two complete Return to Work Program opportunities during your career.

Program Length

The maximum Return to Work Program length will generally be 2 ½ years. This time frame does not include time spent in temporary assignments or periods in which you are approved for LTD benefits.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

When Benefits End

Your participation in the Return to Work Program ends on the **earliest** of the following events:

- You recover and return to your regular and customary job or are determined by the *company* to be able to return to work.
- You are offered and refuse a "reasonable job" (**as defined under Job Placement**) after 12 months from your regular and customary last day worked. Employees in temporary assignments must accept any reasonable job offer at any time
- You are placed into another regular position within the *company*
- You accept employment outside the *company*
- You have reached the maximum duration of 2 ½ years in the Return to Work Program (excluding time spent in temporary assignments)
- You are approved for LTD benefits
- You fail to maintain the active commitment required of participants in the Return to Work Program
- You are laid off
- Your employment ends for any reason including retirement, resignation or termination
- You reach age 65
- You die

Your employment will be terminated if:

- You have not found a job by the time your benefits from the Return to Work Program have been exhausted
- You accept a position outside the *company* while receiving Return to Work Program benefits
- You refuse an offer of a reasonable job after 12 months from your regular and customary last day worked. Employees in temporary assignments must accept any reasonable job offer at any time
- You are able to return to your regular and customary job and fail to do so
- You have not successfully found another job within the *company* after reaching a total of five years (three and one-half years for disabilities that begin on or after October 3, 2005) of any combination of the following:
  - CDP benefits (including full pay sick leave, hospital days, and extended benefits)
  - Participation in the Return to Work Program
- The *company* has a reduction in force and your position is determined to be in an excess status
- The *company* or business unit for which you work is shut down, sold or merged with another company

You may be eligible for a second five-year (three and one-half years effective October 3, 2005) disability time period if you return to work for:

- More than 30 consecutive calendar days and again become disabled due to the same or a related disability
- One day and are disabled due to a disability unrelated to your original disability

A new five-year (three and one-half years effective October 3, 2005) disability period applies only if you are unable to perform a regular and customary job.

Special Payments

Employees of Edison Material Supply, LLC (EMS) and Southern California Edison Company (SCE) may be eligible for Supplemental Pay under the Return to Work Program, and a one-time cash bonus if you find your own job within 18 calendar months of entering the Return to Work Program.

Supplemental Pay

If you are a disabled employee of EMS or SCE and you are placed in a job (including a temporary assignment) within EMS or SCE that pays less than your *base pay* on your last day worked prior to your disability, you will receive Supplemental Pay. Your Supplemental Pay will compensate for the difference in the *base pay* rate between your old job and your new job. It will continue until your new job's *base pay* rate meets or exceeds your *base pay* rate on the last day you worked prior to your disability.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If you receive increases in pay at your new job (for example, through general increases, merit increases, or promotions), your Supplemental Pay will decrease by that amount so that your total monthly pay remains constant. Supplemental Pay is not considered part of your *base pay* rate.

Return to Work Bonus Program

You will receive a one-time bonus if, within the first 18 calendar months of your participation in the program and without the assistance of your Return to Work Program representative, you find your own job, inside or outside the *company* .

The bonus is $3,000 if you start the job within the first 12 calendar months of your participation in the Return to Work Program. The bonus is $1,500 if you start the job in the first 13 to 18 calendar months of your participation. For jobs identified as targeted, you will be eligible for a $5,000 bonus if you start the job within the first 12 calendar months of your participation in the Return to Work Program and $2,500 if you start the job in the first 13 to 18 calendar months of your participation. If you begin your new job on or after June 7, 2010, you must have returned to work for three (3) consecutive months to be eligible for the RTWP bonus.

If you work in a temporary assignment, you are not eligible for a bonus unless and until the assignment becomes your new regular job. To qualify for a bonus, the temporary job must become your regular job within the first 18 calendar months of your participation in the Return to Work Program. Time worked in a temporary assignment counts against the 18-month bonus eligibility period. Temporary assignments do not extend the length of the bonus eligibility period.

For More Information

For more information about the Return to Work Program, contact Benefits Administration at:

- (800) 500-4723,select the option for the Employee Information Center
- (626) 302-3456 or PAX 23456, select the option for the Employee Information Center
- infocntr@sce.com

You may also contact Disability Management at PAX 20202 or (626) 302-0202.

Workers' Compensation

Overview

Workers' compensation is a state-mandated insurance program that provides compensation to employees who suffer job-related injuries and illnesses. While the federal government administers a workers' compensation program for federal and certain other types of employees, each state has its own laws and programs for workers' compensation. For up-to-date information on workers' compensation in your state, contact your state's workers' compensation office. You can find links to the appropriate office in your state on the State Workers' Compensation Officials page of the U.S. Department of Labor's website.

Who Is Eligible

Every *company* employee is protected by workers' compensation, including *full-time, part-time, part-time plus* and *temporary* employees. *Leased* employees and *contingent workers* are not covered.

In general, an employee with a work-related illness or injury can get workers' compensation benefits regardless of who was at fault -- the employee, the employer, a coworker, a customer, or some other third party.

Most workers are eligible for workers' compensation coverage, but every state excludes some workers. Exclusions often include:

- business owners
- independent contractors
- casual workers
- domestic employees in private homes
- farm workers
- maritime workers
- railroad employees, and
- unpaid volunteers.

Check the workers' compensation law of your state to see whether these exclusions affect you.

Who Pays Workers' Compensation Benefits

In most states, employers are required to purchase insurance for their employees from a workers' compensation insurance company (also called an insurance carrier). In some states, however, very small companies (with fewer than three or four employees) are not required to carry workers' compensation insurance. In some states, larger companies that are clearly financially stable are allowed to act as their own workers' compensation insurance company (also called self-insuring).

When a worker is injured, the worker's claim is filed with the insurance company or self-insuring employer, which pays medical and disability benefits according to a state-approved formula.

Injuries Covered by Workers' Compensation

Workers' compensation covers most, but not all, on-the-job injuries. The workers' compensation system is designed to provide benefits to injured workers, even if an injury is caused by the employer's or employee's carelessness. But there are some limits. Generally, injuries that happen because an employee is intoxicated or using illegal drugs are not covered by workers' compensation. Coverage may also be denied in situations involving:

- Self-inflicted injuries (including those caused by a person who starts a fight)
- Injuries suffered while a worker was committing a crime
- Injuries suffered while an employee was not on the job, and
- Injuries suffered because an employee's conduct violated company policy.

Long-Term Problems and Illnesses

Your injury need not be caused by an accident -- such as a fall from a ladder -- to be covered by workers' compensation. Many workers receive compensation for injuries that are caused by overuse or misuse over a long period of time -- for example, repetitive stress injuries such as carpal tunnel syndrome or back problems.

Do I Have to be Injured at My Workplace to be Covered by Workers' Compensation

As long as your injury is job-related, it's covered. For example, you will be covered if you are injured while traveling on business, doing a work-related errand, or even attending a required business-related social function -- however, the laws in each state are different.

Can I Be Treated By My Own Doctor

In some states, you have a right to see your own doctor if you make this request in writing before the injury occurs. More typically, however, injured workers are referred to a doctor by their employer.

Workers' Compensation Benefits

The workers' compensation system provides replacement income, medical expenses, and sometimes, vocational rehabilitation benefits -- that is, on-the-job training, schooling, or job placement assistance.

If you become temporarily unable to work, you'll usually receive two-thirds of your average wage up to a maximum amount. You will be eligible for these wage-loss replacement benefits as soon as you've lost a few days of work because of an injury or illness that is covered by workers' compensation.

If you become permanently unable to do the work you were doing prior to the injury, or unable to do any work at all, you may be eligible to receive long-term or lump-sum benefits. The amount of the payment will depend on the nature and extent of your injuries.

What If My Employer Tells Me Not to File a Workers' Compensation Claim or Threatens to Fire Me If I Do

In most states, it is a violation of the workers' compensation laws to retaliate against an employee for filing a workers' compensation claim. If this happens, immediately report it to your Human Resources representative, the Ethics and Compliance Helpline or your local workers’ compensation office.

For More Information

For more information on workers' compensation benefits, contact your Human Resources representative or the nearest office of your state's division of workers' compensation.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Life and Accident Insurance

Life and Accident Insurance revised December 19, 2012.

Overview

This section of your handbook describes the Life and Accident Insurance benefit plans available through *Flex.*

These include the Employee Life Insurance Plan, the Dependent Life Insurance Plan, the Accidental Death and Dismemberment Insurance Plan and the Business Travel Accident Insurance Plan.

Under each plan, you'll find detailed information regarding eligibility, how to enroll and make changes in your coverage, the levels of coverage available, how and when benefits are paid, and the cost of coverage.

Generally, the *company* provides enough contributions for most eligible *full-time* and *part-time plus* employees to pay for the *company*-provided Basic Employee Life Insurance and Accident Insurance.

Employees may also enroll for:

- Supplemental Employee Life Insurance coverage in addition to any *company*-provided Basic coverage
- Dependent Life Insurance for their eligible dependents
- Supplemental Accident Insurance in addition to any *company*-provided Basic coverage, and coverage for their eligible dependents

The *company* also maintains a Business Travel Accident Insurance Plan for eligible employees who travel on *company* business.

Who Is Eligible

The eligibility rules below apply to Employee and Dependent Life Insurance, and Accidental Death and Dismemberment (AD&D) Insurance benefits provided through *Flex.*

Special rules for Business Travel Accident Insurance coverage are outlined in the Business Travel Accident Insurance Plan summary.

Employees

Most active *full-time* and *part-time* employees may participate in the Employee Life, Dependent Life and AD&D plans when hired. *Part-time plus* employees are also eligible to participate in these plans.

Temporary and *leased* employees and *contingent workers* are not eligible to participate.

Dependents

You may enroll your eligible dependents in:

- Dependent Life Insurance, provided you have Employee Life Insurance coverage for yourself
- AD&D insurance, provided you have AD&D coverage for yourself

Your eligible dependents include your:

- Spouse or domestic partner
- *Children*, up to the end of the month in which they reach age 26

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- Unmarried mentally and physically disabled *children* of any age, if coverage under this benefit program and disability began before age 26. The disability must be such that the *child* is incapable of sustaining himself or herself and must depend upon you for support. You must affirm your *child* is eligible prior to the end of the month in which the dependent reaches age 26 on a form approved by the *company* (or if you become initially eligible for coverage after your *child's* 26th birthday, you must affirm your *child* is eligible due to disability upon your initial enrollment). If an extension of coverage is approved by the *company*, coverage will be allowed beyond age 25 as long as the *child* meets the remaining eligibility requirements.

Continued coverage of an incapacitated *child* is subject to periodic re-certification when requested by, and on a form approved by, the SCE Benefits Committee. If you fail to provide a *physician's* certification upon request, your *child's* coverage will end coincident with the due date of the re-certification request.

Enrolling for Coverage

Enrollment Deadlines

When you are first eligible, you may enroll for Employee Life and AD&D coverage for yourself and Dependent Life and AD&D coverage for your eligible dependents for the remainder of that calendar year.

Coverage is effective on your date of eligibility. If you do not enroll within 30 days of first being eligible, you will receive default coverage as described in each of the plan summaries that follow, effective on your date of eligibility. Your coverage remains in effect until you change it — either during the annual enrollment period or because of a *qualified life event.* You must be *actively at work* for any increase to take effect.

If you become a *part-time plus* employee, the Employee Life, Dependent Life and AD&D coverage you had in your previous classification will continue.

Annual Enrollment

Each year during the annual enrollment period, you'll have the opportunity to change your benefit options. Changes made during annual enrollment generally take effect on January 1. However, if you elect to change your Employee Life Insurance coverage, and you are not *actively at work* on January 1, the change will not become effective until you return to work.

Generally, if you do not elect or change your Life and AD&D Insurance coverage during annual enrollment, you and your previously enrolled eligible dependents will have the same Life and AD&D Insurance coverage levels you had in the prior year.

However, if you are a *part-time* employee who does not receive *company* contributions, you will have no coverage as of January 1 if you fail to make an election during annual enrollment.

Certain limits apply to the amount of Employee Life Insurance coverage you may add — as a newly eligible employee, during annual enrollment or following a *qualified life event* — without providing **Evidence of Insurability** (described in the Employee Life Insurance summary).

Making Changes During the Year

Normally, your Life and AD&D insurance elections stay in effect through December 31 of each year.

You may, however, change your insurance coverage during the year if you have a *qualified life event* that affects your coverage needs (for example, if you gain or lose dependents). If you are not *actively at work*, your change to Employee Life Insurance will not become effective until you return to work.

Your benefit change must be a result of, and consistent with, the qualifying event.

For example, if you have a baby, you will be able to increase your Employee Life, Dependent Life, and AD&D insurance coverages.

You must request a change online at www.eixbenefits.com or by calling the *EIX Benefits Connection* at (866) 693-4947 within 30 days after your *qualified life event*. If you don't request a change within 30 days after a

qualified life event, the coverage you had before the change will stay in effect for the remainder of the calendar year unless you have a subsequent *qualified life event* and make your request within 30 days after that event. See the **Events Affecting Your Benefits** section in this handbook for more information.

Cost of Coverage

Most employees pay their share of Employee Life Insurance and AD&D Insurance costs with pre-tax dollars. Dependent Life Insurance coverage costs are paid with post-tax payroll contributions. AD&D costs associated with covering a *domestic partner* will be deducted with post-tax dollars for federal tax purposes. State taxation for *domestic partner* coverage varies by state. (For details, see Cost of Coverage in each plan summary.)

Your Beneficiaries

When you enroll for coverage the first time, you must designate a beneficiary. Your beneficiary (or beneficiaries) will receive your insurance benefits in the event of your death. Your AD&D beneficiary designation applies to all accident insurance coverage including, if applicable, Business Travel Accident Insurance.

You are automatically the beneficiary for any Dependent Life or Dependent AD&D coverage you elect; you cannot designate a different beneficiary for this coverage.

If you die and your designated beneficiary does not survive you and you did not designate a contingent beneficiary (or you failed to elect a beneficiary), or if you and your covered dependent die simultaneously, any benefit payable from the life and accident plans will be paid in the following line of succession:

- Surviving spouse, same-sex spouse, or registered domestic partner
- Surviving *child(ren)*
- Surviving parent(s)
- Surviving brother(s) and sister(s)
- Employee's estate

Changes to your beneficiary designations can be made by contacting the *EIX Benefits Connection* online at www.eixbenefits.com or by phone at (866) 693-4947. You will receive a beneficiary statement for each plan for which you made a change. For your change to be valid, you must sign the statement(s) as instructed and return them to the *EIX Benefits Connection* by the due date on the form or your requested beneficiary designation will not be in effect.

Non-Discrimination Testing

The plans covered under the *Flex* program are subject to discrimination testing rules and may not discriminate in favor of highly compensated employees. The *company* has the right to change the elections of certain employees to comply with applicable provisions of the Internal Revenue Code. If the discrimination testing requirements affect you, the *company* will notify you.

Employee Life Insurance

Employee Life Insurance revised December 19, 2012.

Overview and Important Features

The *company* recognizes the importance of providing for your family or others who may count on you for financial support. That's why all *full-time*, *part-time* and *part-time plus* employees are eligible for Employee Life Insurance.

Here are some other key features of the Employee Life Insurance Plan:

- Most *full-time* and *part-time plus* employees receive enough *company* contributions to pay for *company*-provided Basic Employee Life Insurance
- Employees may purchase supplemental Employee Life Insurance coverage that exceeds the *company*-provided amount
- Employee Life Insurance is group term life insurance and has no cash value
- If you die while covered, normally the plan will pay your beneficiary(ies) a lump-sum payment
- The plan enables terminally ill employees to receive benefits while they are alive

Some employees have coverage under a Paid-Up Life Insurance plan that was offered in the past. See the **Appendix** at the end of this summary for details on that plan.

Who is Eligible

You are eligible to participate in the Employee Life Insurance Plan if you are an active *full-time*, *part-time* or *part-time plus* employee.

Enrolling for Coverage

Enrollment Deadlines

Full-time employees are automatically covered for *company*-provided Basic Employee Life Insurance when they are hired.

You may enroll for supplemental Employee Life Insurance coverage within 30 days of first becoming eligible, with a *qualified life event* and during annual enrollment.

Part-time employees may elect to waive Employee Life Insurance coverage.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If you are a *full-time* employee and don't enroll within the first 30 days after you become eligible, you will be enrolled only for the *company*-provided Basic coverage of one times *annualized base pay* up to $50,000 of Employee Life Insurance coverage by default.

If you are a *part-time* employee you will be defaulted to no coverage.

If you become a *part-time plus* employee, the Employee Life Insurance coverage you had in your previous classification will continue unless you request to change it.

Annual Enrollment

Every year during annual enrollment, you'll have the opportunity to re-evaluate your Employee Life Insurance needs and change your coverage for the following calendar year.

Here's what happens on January 1 of the following year if you don't choose an Employee Life Insurance option during annual enrollment:

- If you are a *full-time* or *part-time plus* employee, or a *part-time* employee eligible to receive *company* contributions, you will automatically be enrolled for the same amount of coverage you had in the prior year, by default
- If you are not eligible to receive *company* contributions, you will not have any Employee Life Insurance coverage for the year

Coverage Period

If you are eligible for *company*-provided Basic Employee Life Insurance, your coverage normally begins on your date of hire. If you enroll for supplemental Employee Life Insurance within 30 days after you first become eligible, normally all of your Employee Life Insurance will be in effect from the day you first became eligible. In some situations, you must complete an Evidence of Insurability (EOI) and the insurance carrier must approve it for the elected coverage to be in effect. If EOI is required, you will be enrolled in the highest amount allowable without EOI until the EOI is approved. If you are not *actively at work* on that day, your Employee Life Insurance coverage will not take effect until the first day you are confirmed *actively at work*.

Annual Enrollment

If you make changes during annual enrollment, normally your newly elected Employee Life Insurance coverage will take effect on the following January 1. If you are not confirmed *actively at work* on that day, changes to your Employee Life Insurance coverage will not take effect until the first day you are *actively at work*.

If the Employee Life Insurance amount you elect requires Evidence of Insurability (EOI), that coverage will not take effect until the insurance carrier approves your application. **EOI** is described later in this summary.

Employee Life Insurance Options

Following are the Employee Life Insurance coverage options available to you.

Employee Life Insurance Options for Eligible Employees
• 1 times *annualized base pay*, up to $50,000
• 1 times *annualized base pay*, up to $50,000, plus 1 times *annualized base pay*
• 1 times *annualized base pay*, up to $50,000, plus 2 times *annualized base pay*
• 1 times *annualized base pay*, up to $50,000, plus 3 times *annualized base pay*
• 1 times *annualized base pay*, up to $50,000, plus 4 times *annualized base pay*
• 1 times *annualized base pay*, up to $50,000, plus 5 times *annualized base pay*
• 1 times *annualized base pay*, up to $50,000, plus 6 times *annualized base pay*
• 1 times *annualized base pay*, up to $50,000, plus 7 times *annualized base pay*
• 1 times *annualized base pay*, up to $50,000, plus 8 times *annualized base pay*

If you are eligible for Employee Life Insurance but are not *actively at work*, you will continue the amount of Employee Life Insurance coverage you had in effect when you stopped active work. During annual enrollment or

if you have a *qualified life event*, you may decrease, but not increase, your Employee Life Insurance coverage. You must be actively at work for any increase in coverage to take effect.

Employee Life Insurance coverage amounts changed in 1989, 1993, 2002, 2005 and again on January 1, 2010. The following charts show the amounts of Employee Life Insurance coverage that are available to eligible non-represented employees who were on disability prior to 1989, 1993, 2002, 2005 and 2010, and on or after January 1, 2010, and who have not returned to work.

Employee Life Insurance Options for Eligible Non-represented Employees Who Were Disabled on the Following Dates and Have Not Returned to Work	
If disabled on or after January 1, 2010	1 times *annualized base pay*, up to $50,000 1 times *annualized base pay*, up to $50,000, plus 1 times *annualized base pay* 1 times *annualized base pay*, up to $50,000, plus 2 times *annualized base pay* 1 times *annualized base pay*, up to $50,000, plus 3 times *annualized base pay* 1 times *annualized base pay*, up to $50,000, plus 4 times *annualized base pay* 1 times *annualized base pay*, up to $50,000, plus 5 times *annualized base pay* 1 times *annualized base pay*, up to $50,000, plus 6 times *annualized base pay* 1 times *annualized base pay*, up to $50,000, plus 7 times *annualized base pay* 1 times *annualized base pay*, up to $50,000, plus 8 times *annualized base pay*
If disabled from January 1, 2005 through December 31, 2009	1 times *annualized base pay*, up to $30,000 1 times *annualized base pay* 2 times *annualized base pay* 3 times *annualized base pay* 4 times *annualized base pay* 5 times *annualized base pay* 6 times *annualized base pay* 7 times *annualized base pay* 8 times *annualized base pay*
If disabled from January 1, 2002 through December 31, 2004	$15,000 1 times *annualized base pay* 2 times *annualized base pay* 3 times *annualized base pay* 4 times *annualized base pay* 5 times *annualized base pay* 6 times *annualized base pay*
If disabled from January 1, 1993 through December 31, 2001	$15,000 1 times *annualized base pay* 2 times *annualized base pay* 3 times *annualized base pay* 4 times *annualized base pay* 5 times *annualized base pay*
If disabled from January 1, 1989 through December 31, 1992	$10,000 1 times *annualized base pay* 2 times *annualized base pay* 3 times *annualized base pay* 4 times *annualized base pay* 5 times *annualized base pay*
If disabled before January 1, 1989	$5,000 $5,000 plus 1 times *annualized base pay* $5,000 plus 2 times *annualized base pay*

Maximum Amount of Coverage

There is a $2,000,000 maximum amount of coverage allowed under the Employee Life Insurance Plan.

Price Tags

Price tags for Employee Life Insurance coverage are determined by your age and the coverage amount you select. Price tags in your first year with the company are based on your:

- Age on the prior January 1
- Annualized base pay on your hire date

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

In future years, price tags are based on your:

- Age as of each successive January 1
- *Annualized base pay* on the *company's* record keeping system on the prior September 1

The *company* regularly reviews price tags, which may change from year to year as designated by the insurance companies to reflect actual experience under the plan. The price tag for each available option is shown in the personalized information you receive during annual enrollment.

If you were an eligible *full-time* employee and at least age 45 on August 1, 1988, the price tag for some of your supplemental Employee Life Insurance coverage (either one or two times pay) may be grandfathered at $0.50 per month for each $1,000 of coverage. *Company* contributions continue to be calculated at the rate for your Basic coverage. The grandfathered rates apply to the coverage amount you had in effect on December 31, 1988, for up two times pay. If you elect to increase your level of coverage (e.g., from one times pay to two times pay), the additional coverage is calculated according to the appropriated age-rated table. If you decrease your level of coverage (e.g., from two times pay to basic coverage only) and later elect to increase your level of coverage, you will no longer be eligible for grandfathered rates.

Company Contributions and Coverage

The *company* allocates a certain amount of contributions to eligible employees to cover all or part of the cost of their *company*-provided Basic Employee Life Insurance coverage. The following chart summarizes the amounts of *company* contributions available and the *company*-provided Life Insurance coverage:

Eligible Employees	*Company* Contributions	*Company*-Provided Coverage
Full-time employees *Part-time Plus* employees	Enough for coverage equal to 1 times *annualized base pay*, up to $50,000	1 times *annualized base pay*, up to $50,000
Part-time employees regularly scheduled to work 16 or more hours per week on an on-going basis	A lump sum amount that can be used for any *Flex* options for which they are eligible (See the ***Flex*** section in this handbook for more about lump sum *company* contribution amounts.)	No coverage

The *company*-provided coverage shown in the preceding chart is the amount that will default to you if you do not elect otherwise within 30 days of first becoming eligible.

Company Contributions for Employees Not *Actively at Work*

The *company* may continue to provide contributions to you if you are not *actively at work*, unless you are on an unpaid leave of absence (other than a FMLA leave). Employees who become disabled receive the *company* contributions in effect at the time of their disability. The amount depends on the date you were last *actively at work* and which employee group you belong to.

Employee Contributions

You pay for your Employee Life Insurance coverage with pre-tax payroll contributions.

If you don't receive enough pay during a pay period to cover your price tags, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. If you are in arrears after four consecutive pay periods, you will receive a written notice that you are being changed from payroll deduction to direct billing and you will be billed for future contributions you owe. If you fail to pay your contributions, your coverage will be terminated. Any amount that you have in arrears for payroll deductions during *deduction periods* prior to your change to direct billing that could not be collected at the end of the calendar year will be added to your W-2 statement as taxable income. If you leave the *company* or cease to be eligible for benefits, you will be billed for any outstanding deduction amounts.

If you're not receiving income directly from the *company* and payroll deductions are not possible (for example, if you're on an unpaid leave of absence or are receiving Workers' Compensation benefits), you will be billed and

expected to pay for your Employee Life Insurance options with post-tax dollars. If your payment is not received within 30 days of the due date indicated in your billing notice, your supplemental Employee Life Insurance coverage will end retroactively effective as of the last day of the month for which your full premium was received.

How Pay-based Benefits Are Determined

If your coverage is a multiple of your pay, the benefit is calculated by rounding your *annualized base pay* (at the time of your death) to the next higher multiple of $1,000—unless your pay is already a multiple of $1,000. That amount is then multiplied by your coverage level.

Example:

Suppose your annualized base pay *is $45,600 and you purchase an additional three times pay for Employee Life Insurance. Your coverage amount will be $184,000 ($45,600 rounded up to the next higher $1,000 = $46,000 x 3 = $138,000, plus $46,000).*

When Your *Base Pay* Changes

If your Employee Life Insurance coverage is a multiple of your pay and your *annualized base pay* increases during the year, your supplemental coverage will also increase to reflect that change. The new amount will take effect on the first day you are *actively at work* after the pay increase occurs. If your pay increase is retroactive, your coverage will increase on the day your pay increase is processed. The price tag for your coverage will not increase until the following January 1 unless you request to increase or decrease your coverage due to a *qualified life event*.

If your *annualized base pay* decreases during the year, your coverage will not be affected until the start of the next calendar year (January 1).

Evidence of Insurability (EOI)

Evidence of Insurability (also known as proof of good health) is an insurance company requirement for obtaining large amounts of life insurance coverage or significant increases in coverage. If you are required to complete an EOI health questionnaire and make your elections online, you may be able to complete the questionnaire online or it will be mailed to you. You will be notified of the amount of coverage you will retain if your EOI is not completed and returned to the insurance company or if your request is not approved. The insurance company may require an additional statement or a physical exam before approving high levels or significant increases in coverage. If you do not submit EOI when it is required, or if the insurance company does not approve the coverage level you choose, you will receive the highest coverage available to you without EOI.

In most cases, you will not need to provide EOI before your Employee Life Insurance can become effective. However, the insurance company requires EOI in the following circumstances:

- When you are first hired, if you choose coverage that is:
  - equal to more than four times your *annualized base pay*, or
  - an amount of $300,000 or more
- At the time of a ***qualified life event*** or during any subsequent annual enrollment period, if you increase your coverage to one of the following amounts:
  - more than one times *annualized base pay* higher than your current coverage
  - more than four times *annualized base pay*, or
  - $300,000 or more

Insurance amounts that require EOI take effect on the date the insurance company approves your application. If you need information on your EOI status, contact the *EIX Benefits Connection* at (866) 693-4947.

How Employee Life Insurance Benefits Are Paid

Death Benefits

If you die while your Employee Life Insurance coverage is in effect, your beneficiary(ies) can receive your death benefit in a single lump-sum payment or by deposit in an alliance checking account. The death benefit must be at least $5,000 to be eligible for deposit in an alliance checking account.

The amount of the benefit will depend on your coverage amount and whether you had received any payments under any Living Benefit provisions applicable to you, or if you had assigned any of your coverage to a viatical company. (See discussions for each of these situations below.)

To claim life insurance benefits, your beneficiary should contact the *EIX Benefits Connection*.

A certified copy of the death certificate is required.

Benefits Available Prior to Death

Under certain situations, the following types of benefits may be payable prior to your death if applied for and approved by the insurer:

- Living Benefits
- Viatical Settlements

If you assign your coverage through a gift assignment or to a viatical company, you will not be able to access any applicable Living Benefit. However, if you first access the Living Benefit, you may subsequently assign the remaining coverage to a viatical company.

If you qualify for any of the following benefits, contact the *EIX Benefits Connection* to request an application.

Living Benefit

If you have been covered for supplemental Employee Life Insurance for at least one year and a doctor certifies that you have six months or less to live, you may choose to have up to 75% of your supplemental Employee Life Insurance coverage paid to you. The maximum Living Benefit payment is $250,000. You may receive the Living Benefit in one lump-sum payment or in six equal monthly payments. Living Benefit payments are not taxable income for federal income tax purposes, but they may be taxable in some states.

Upon your death, the beneficiary(ies) will receive the amount of insurance in force less the amount of the Living Benefit payment(s) you have already received.

In the event that you continue your employment with the *company* following such medical certification, you will continue paying Employee Life Insurance premiums through normal payroll deductions.

Viatical Settlements

If a doctor certifies that you are terminally ill, you may make an irrevocable assignment of your supplemental Employee Life Insurance coverage to a viatical company. A viatical company is one that will receive your supplemental Employee Life Insurance benefit when you die. In exchange for your assignment, the viatical company will make a cash payment to you before your death. Life expectancy requirements may vary depending on the viatical company.

If you qualify and you assign your supplemental coverage to a viatical company, the viatical company becomes the owner and beneficiary of your policy. The payment you receive from the viatical company is not taxable income for federal income tax purposes, but may be taxable in some states. If you enter into a viatical agreement, your supplemental life insurance elections and beneficiary elections for Employee Life Insurance may not be changed.

The arrangements you enter into with a viatical company will determine whether any supplemental Employee Life Insurance proceeds will be paid to a beneficiary other than the viatical company.

If you qualify for this option, the viatical company you choose must submit the proposed agreement to the *EIX Benefits Connection* for approval. You may contact the *EIX Benefits Connection* at:

- (866) 693-4947
- www.eixbenefits.com

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Gift Assignment

You may also assign your coverage through a gift assignment, which means that all of your present and future rights as an insured are irrevocably transferred to the assignee — that is, the individual to whom you assign your coverage. The assignee has the right, title and interest to your coverage and may change the beneficiary at any time.

How Employee Life Insurance Is Taxed

The Internal Revenue Service (IRS) considers the value of employee life insurance over $50,000 to be taxable income. For income tax purposes, employee life insurance technically includes:

- *Company*-provided Employee Life Insurance
- Employee Life Insurance you purchase with pre-tax and post-tax dollars

If your total Employee Life Insurance coverage exceeds $50,000, the IRS-determined value of the amount over $50,000 will be added to your annual W-2 statement as taxable income. If, however, you are not receiving pay or disability benefits from the *company* and you must pay for your Employee Life Insurance with post-tax dollars, the amount you pay will be subtracted from the IRS-determined value and the difference, if any, will be added to your annual W-2 statement as taxable income.

The IRS determines the value of each $1,000 of insurance over $50,000 based on the rates shown in the following table:

If your age is:	The annual value of each $1,000 of coverage is:
Under 25	$ .60
25-29	.72
30-34	.96
35-39	1.08
40-44	1.20
45-49	1.80
50-54	2.76
55-59	5.16
60-64	7.92
65-69	15.24
70 and above	24.72

Example:

Suppose you are in the 35-39 age group and you have $100,000 of life insurance coverage. Also assume that the company *provides you with contributions for $50,000 of coverage and you pay for the difference of $50,000 of coverage with pre-tax dollars. The IRS will consider the value of $50,000 of your coverage to be imputed income ($100,000 - $50,000 = $50,000). The value is calculated as follows:*

$50,000 ÷ 1,000	=	*50*
50 x $1.08	=	*$54.00 imputed value.*

The imputed value of $50,000 of your life insurance – $54.00 – would be added to your annual W-2 statement as taxable income.

If, however, you purchased your coverage with post-tax dollars, the amount you paid would be subtracted from the $54.00 imputed value. In other words you would owe taxes on the difference between the amount you paid for your coverage and the IRS-determined value of that coverage—if there is a difference.

Situations Affecting Employee Life Insurance Coverage

There are a number of situations that could affect your coverage. This could happen, for example, if your status changes or you leave the *company*. Here is a quick reference chart describing some of these situations. See the **Events Affecting Your Benefits** section for other situations that may affect your coverage.

If you...

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Receive a salary increase while you are not *actively at work*	Your insurance coverage amount will not increase due to your salary increase until you are *actively at work*
Receive a salary decrease	Your insurance coverage amount will not decrease due to your salary decrease until the start of the next plan year (January 1)

If You Become Disabled

If you are under age 60 and are *permanently and totally disabled*, you may apply to have your premium waived. The insurance company must receive your application within 12 months of the day you stop working. If the insurance company approves your application, your premium will be waived as long as you continue to be *permanently and totally disabled* or until coverage ends at the earlier of the date you retire, reach age 65, or your employment with the *company* is terminated. The insurance provider may request you to submit proof of your continued disability.

When Coverage Ends

Your coverage ends on the day you change to an ineligible status, are laid off, or leave the *company*.

If you were laid off, you may be able to extend your coverage on a post-tax basis for up to two years.

Conversion to Individual Policies

If you are no longer eligible for Employee Life Insurance coverage, you may convert all or some of your Employee Life Insurance to whole life coverage (less the amount of any Retiree Life Insurance) by purchasing an individual policy within 31 days of the day you become ineligible for coverage (the day your employment with the *company* ends, for example). The insurance company determines your cost and the maximum coverage amount available to you.

Portability to Individual Policies

If your supplemental Employee Life Insurance coverage terminates you may be eligible to elect to purchase portable term life insurance if you were *actively at work* on the day before your coverage terminated and your coverage did not terminate due to your retirement. The minimum amount of coverage you may purchase is $20,000 and the maximum amount is the lesser of:

- The amount you are insured for under the plan,
- 5 times your annualized base pay, or
- $1,000,000

You must apply for portability and pay the first premium within 31 days after the date your supplemental life insurance coverage terminates.

You are not eligible to apply for portable term life insurance if:

- You are not *actively at work* on the date your supplemental life insurance coverage terminates
- Your supplemental life coverage terminates due to your retirement
- You are age 80 or over
- Your supplemental life coverage terminated due to your failure to pay the required premium under the plan
- Your supplemental life coverage amount is less than $20,000

Contact the *EIX Benefits Connection* if you want conversion or portability forms.

Appeals

If a benefit claim is denied, in whole or in part, you or your beneficiary has a legal right to request a review of that denial. Generally, if you disagree with the outcome, you may appeal it.

Refer to the Other Important Information section of this handbook for details about documentation and the **appeals** process.

For More Information

You can get information about the plan by contacting the *EIX Benefits Connection* at:

- (866) 693-4947
- www.eixbenefits.com

Employee Life Insurance Appendix

Paid-Up Life Insurance

If you were a *full-time* employee before August 1, 1983, you were eligible to enroll in a plan that includes both Paid-Up Life Insurance and *company*-provided employee term life insurance. Your coverage amount consists of the paid up amount you purchase each month plus the *company*-provided employee term life insurance equal to the difference between your purchased amount and the coverage for which you enrolled.

Effective January 1, 2002, the referenced Paid-Up Life Insurance coverage is being provided under a Group Universal Life Insurance Program.

The amount of your purchased insurance depends on the following factors:

- Your age
- The paid-up purchase rates
- The length of time you have been enrolled
- Whether you chose coverage of one or two times pay
- Whether you chose to have your coverage increase automatically if your pay increases

Any Paid-Up Life Insurance you have purchased will remain in effect throughout your lifetime, unless you cash surrender at any time after you leave the *company*.

Frozen Coverage

If you are participating in the Paid-Up Life Insurance Plan, your elections were frozen as of August 1, 1983. Since enrollment in this plan is frozen:

- You cannot increase or decrease your Paid-Up Life Insurance coverage election
- You cannot decline previously elected automatic increases in coverage. If you elected this option, your Paid-Up Life Insurance will continue to increase automatically as your pay increases unless you are no longer *actively at work*
- You cannot start automatic increases in coverage as your pay increases if you previously declined future increases in coverage

Your Contributions

Full-time employees who elected Paid-Up Life Insurance Coverage before August 1, 1983 pay for this coverage with post-tax dollars at the rate of $1 per month for each $1,000 of coverage.

If you joined the *company* prior to August 1, 1983, and elected Paid-Up Life Insurance coverage, you may stop purchasing your Paid-Up Life Insurance at any time by contacting the *EIX Benefits Connection*. The purchased portion of your Paid-Up Life Insurance will remain in effect. However, the *company*-provided employee term life insurance component of this plan will terminate.

Situations Affecting Paid-Up Life Insurance Coverage

There are a number of situations that could affect Paid-Up Life Insurance coverage, as shown in the following chart.

If you...	
Go on disability	• Your coverage continues • You may continue payroll contributions if you have sufficient earnings • If your earnings are not sufficient to cover your deductions, your deductions will stop. If you stop making contributions for this coverage, the purchased portion of your paid up coverage will remain in effect. However, the *company*-provided employee term life insurance component of this plan will terminate. You will not be eligible to re-enroll in this plan once you stop making contributions • If you are under age 60 and are *permanently and totally disabled*, you may apply to have your premium waived
Receive a salary increase while you are not *actively at work*	If you elected to have your coverage increase automatically if your pay increases and you are not *actively at work* on the day of your salary increase, your Paid-Up Life Insurance increased coverage will not take effect until the first day you are *actively at work*
Go on a family or personal leave of absence, or a *military leave of absence*	Your contributions stop. If you stop making contributions for this coverage, the purchased portion of your paid up coverage will remain in effect. However, the *company*-provided employee term life insurance component of this plan will terminate. You will not be eligible to re-enroll in this plan once you stop making contributions
Change to an ineligible status Are laid off Leave the *company* before retirement	You may keep any Paid-Up Life Insurance in force or surrender your policy for its cash value. To determine your policy's cash value or to surrender it for cash, contact the *EIX Benefits Connection* for appropriate forms
Leave the *company* at retirement	• You may retain or cash in any Paid-Up Life Insurance you have purchased • You may be eligible for a minimum (basic guarantee) amount of 25% of your Paid-Up Life Insurance coverage at the time you retire, provided you enrolled for coverage before October 1, 1978, and you reached at least age 50 as of May 1, 1978. Contact the *EIX Benefits Connection* for conversion forms • The option to cash in your policy is only available upon your retirement or termination from the *company*. If you are eligible, contact the *EIX Benefits Connection*
Die	A certified copy of the death certificate is required to claim benefits. Your beneficiary should contact the *EIX Benefits Connection* for assistance

More Information

If you have any questions about the Paid-Up Life Insurance Plan, call the *EIX Benefits Connection* at:

- (866) 693-4947
- www.eixbenefits.com

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Dependent Life Insurance

Dependent Life Insurance revised December 19, 2012.

Overview and Important Features

The Dependent Life Insurance Plan affords additional financial protection in the event of a dependent's death. You pay the cost of this coverage with post-tax dollars.

Depending on the make up of your family, you may purchase Dependent Life Insurance to cover any of the following:

- Your spouse (or domestic partner) only
- Your eligible dependent *children* only
- Your *spouse* (or *domestic partner*) and your eligible dependent *children*

You are always the beneficiary of any life insurance benefits payable on behalf of your dependents.

Who Is Eligible

Employees

Most active *full-time*, *part-time* and *part-time plus* employees are eligible to elect Dependent Life Insurance coverage for their eligible dependents. *Temporary* and *leased* employees and *contingent workers* are not eligible to participate. You are eligible to participate in the Dependent Life Insurance Plan on your date of hire.

Dependents

Please refer to the **Life and Accident Insurance Overview** for information on eligible dependents.

Enrolling for Coverage

Enrollment Deadlines

You may elect Dependent Life Insurance coverage for your eligible dependents for the remainder of the calendar year in which you are employed by the *company* if you do so within 30 days of your date of hire.

If you and your *spouse* (or *domestic partner*) are both employees of the *company*, you may cover each other for Dependent Life Insurance and/or you may each cover your dependent *children.*

If you don't enroll for dependent coverage within 30 days of your eligibility date, your dependents will not be covered for the year, unless you enroll them within 30 days after a *qualified life event* that is consistent with the event.

If you become a *part-time plus* employee, the Dependent Life Insurance coverage you had in your previous classification will continue.

Annual Enrollment

You have the opportunity each year to review your coverage needs during the annual enrollment period. Any changes you make during annual enrollment take effect on the following January 1. If you're eligible to receive *company* contributions and you don't enroll in or change your Dependent Life Insurance election during annual enrollment, on the following January 1 you'll automatically be enrolled for the same dependent insurance option you had in the prior year. If you are a *part-time* employee not eligible to receive *company* contributions and you do not choose Dependent Life Insurance during annual enrollment, your dependents will not have coverage beginning January 1.

Regardless of when you enroll, your Dependent Life Insurance generally remains in effect through December 31 of each year provided you remain an eligible employee. You may add or change dependent coverage during the year only if you have a *qualified life event* that affects your coverage needs (you get married, for example).

Cost of Coverage

The price tags for Dependent Life Insurance are shown in the personalized information you receive when you are first eligible and during each subsequent annual enrollment period. You pay for Dependent Life Insurance Coverage with post-tax payroll contributions.

Employees who receive a *company* contribution lump sum may use it to help pay for any *Flex* options for which they are eligible, including Dependent Life Insurance. (See the ***Flex*** section in this handbook for the amount of *company* contributions available.)

If you don't receive enough pay during a pay period to cover your *Flex* price tags, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. If you are in arrears after four consecutive pay periods, you will receive a written notice that you are being changed from payroll deduction to direct billing and you will be billed for future contributions you owe. If you fail to pay your contributions, your coverage will be terminated. Any amount that you have in arrears for payroll deductions during *deduction periods* prior to your change to direct billing that could not be collected at the end of the calendar year will be added to your W-2 statement as taxable income. If you leave the *company* or cease to be eligible for benefits, you will be billed for any outstanding deduction amounts.

If you're not receiving income directly from the *company* and payroll deductions are not possible (for example, if you're on an unpaid leave of absence or are receiving Workers' Compensation benefits), you will be billed for outstanding deduction amounts. If your payment is not received within 30 days of the due date indicated in your billing notice, your Dependent Life Insurance coverage will end retroactively effective as of the last day of the month for which your full premium was received.

Dependent Life Insurance Coverage Amounts

You do not enroll a specific dependent -- you elect the type and amount of Dependent Life Insurance coverage you want. If you are an eligible employee, you may elect the following Dependent Life Insurance options:

- Coverage for your *spouse* (or *domestic partner*) ($5,000, $15,000, $25,000, $50,000 or 1 to 4 times your *annualized base pay*, not to exceed the lesser of $300,000 or 50% of your life insurance coverage)
- Coverage for your *child(ren)* ($5,000, $10,000, $15,000 or $25,000 of coverage for each eligible *child*, regardless of the number of *children* you have)

Coverage for your *spouse* or *domestic partner* cannot exceed 50% of your Employee Life Insurance amount. *Part-time* employees electing Dependent Life Insurance must also elect Employee Life Insurance for themselves.

Evidence of Insurability (EOI)

Evidence of Insurability (also known as proof of good health) is an insurance company requirement for obtaining large amounts of life insurance coverage or significant increases in coverage. To provide EOI, you need to

complete the applicable EOI health questionnaire (available from the *EIX Benefits Connection*) and return it to the insurance company. The insurance company may require an additional statement or a physical exam before approving high levels or significant increases in coverage.

For Dependent Life Insurance for your *spouse* or *domestic partner*, the insurance company requires EOI if you choose coverage that is more than $25,000. EOI is not required for *child* life options.

If you don't complete the EOI online or submit the paper EOI when required, or if the insurance company does not approve the coverage level you choose, you'll receive the highest coverage available to you without EOI.

Insurance amounts that require EOI take effect on the date the insurance company approves your application. If you need information on your EOI status, contact the *EIX Benefits Connection* at (866) 693-4947.

How Dependent Life Insurance Benefits Are Paid

If a family member dies while covered under the Dependent Life Insurance Plan, death benefits will be paid to you in a lump-sum payment. A certified copy of the death certificate is required to claim benefits and you may be required to submit proof of your dependent's eligibility at the time of death. You have the option to assign proceeds from the policy to cover funeral expenses. Contact the *EIX Benefits Connection* to report a death.

If you predecease your dependent, or if you and your dependent die simultaneously, death benefits will be paid to:

- Employee's surviving spouse, same-sex spouse or registered domestic partner
- Employee's surviving *child(ren)*
- Employee's surviving parent(s)
- Employee's surviving brother(s) and sister(s)
- Employee's estate

Situations Affecting Dependent Life Insurance Coverage

Your dependent coverage normally ends when you choose to discontinue coverage or when your coverage ends. See the **Events Affecting Your Benefits** section for situations that may affect your coverage.

When Dependent Life Insurance Coverage Ends

Your Dependent Life Insurance will end if any of the following situations occur:

- Your Employee Life Insurance coverage ends (for example, when you change to an ineligible status or leave the *company* for any reason, including retirement)
- Your dependent is no longer an eligible dependent (for example, divorce, *child* reaches age 26, *child* becomes eligible for coverage under another employer-sponsored medical plan other than a parent's group health plan, etc.)
- You stop paying premiums

If you are laid off, and you extend your Employee Life Insurance, you may also extend your Dependent Life Insurance coverage for up to two years.

Conversion to Individual Policies

If your covered dependents are no longer eligible for Dependent Life Insurance, they may convert all or some of their Dependent Life Insurance to whole life coverage by purchasing individual policies within 31 days of the day you or your dependent becomes ineligible for coverage (the day your employment with the *company* ends, for example). The insurance company determines your cost and the maximum coverage amounts available to you.

Portability to Individual Policies

Your covered dependents may elect to purchase portable term life insurance if their Dependent Life Insurance coverage terminates as a result of your termination of employment, your death, or as a result of divorce. If

coverage is lost due to your termination of employment, portable term coverage is only available to your dependents provided you elect portable coverage for your supplemental Employee Life Insurance. To elect portable coverage, your *spouse* must be under age 80, your dependent *children* must be under age 25, and you must be *actively at work* on the day before their coverage is terminated. Dependents are not eligible to elect portable coverage if:

- Coverage has terminated as a result of premiums not being paid
- Coverage has terminated due to your own retirement
- Dependents are confined at home or in a hospital on the date coverage terminates

The maximum amount dependents can elect for portable term life insurance coverage is the amount they are insured for under the plan.

Dependents must apply for portability and pay the first premium within 31 days after the date their Dependent Life Insurance coverage terminates.

Contact the *EIX Benefits Connection* if you want conversion or portability forms.

Appeals

If a benefit claim is denied, in whole or in part, you or your beneficiary has a legal right to request a review of that denial. Generally, if you disagree with the outcome, you may appeal it.

Refer to the Other Important Information section of this handbook for details about documentation and the **appeals** process.

For More Information

You can get information about the plan, by contacting the *EIX Benefits Connection* at:

- (866) 693-4947
- www.eixbenefits.com

Accidental Death And Dismemberment Insurance

Accidental Death And Dismemberment Insurance revised December 19, 2012.

Overview and Important Features

Accidental Death and Dismemberment (AD&D) Insurance pays a benefit when a covered person dies or suffers certain physical losses as the result of an accident.

Please note the following:

- AD&D death benefits are payable in addition to any benefits payable under the life insurance plans
- Most employees receive enough *company* contributions to pay for the *company*-provided Basic Employee AD&D coverage
- In addition to your *company*-provided coverage, you may elect supplemental AD&D Insurance coverage
- Eligible employees may also elect AD&D coverage for their dependents.

Who Is Eligible

Full-time, *part-time* and *part-time plus* employees and their eligible dependents are eligible for AD&D insurance coverage under Edison's *Flex* program. You are eligible for this coverage on your date of hire. If you enroll for supplemental AD&D Insurance and/or Dependent AD&D Insurance within 30 days after you first become eligible, your AD&D Insurance will be in effect from the day you first became eligible.

Please refer to the **Life and Accident Insurance Overview** for information on eligible dependents.

Enrolling For Coverage

Enrollment Deadlines

In the year you are first hired, you may enroll for the remainder of that calendar year for AD&D coverage for yourself and your eligible dependents.

If you and your *spouse* (or *domestic partner*) are both employees of the *company,* you may cover each other for AD&D Insurance and/or you may each cover your dependent *children*. If you're a *full-time* employee and you don't choose an option during your first 30 days of becoming eligible, you will be enrolled for the Basic *company*-provided AD&D coverage amount by default. You will not have any supplemental AD&D coverage nor coverage for your dependents for the remainder of the calendar year, unless you elect it within 30 days of a *qualified life event*.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If you are a *part-time* employee and you don't choose an AD&D option during your first 30 days of becoming eligible, you will not have any accident insurance coverage for yourself or your dependents during the remainder of the calendar year –- unless you elect it within 30 days of a *qualified life event*. (See the *Flex* section in this handbook.)

If you become a *part-time plus* employee, the AD&D coverage you had in your previous classification will continue.

Annual Enrollment

You will have the opportunity to change your coverage each year during the annual enrollment period. Any coverage changes you make take effect on the following January 1.

If you're eligible to receive *company* contributions and you do not change your options during annual enrollment, on the following January 1 you will automatically be enrolled for the same amount of AD&D coverage you had in the previous year, if any.

If you are an employee who is not eligible to receive *company* contributions and you do not choose an AD&D insurance option during annual enrollment, you will not have coverage beginning the following January 1.

Accident Insurance Options

The following chart summarizes the coverage options available.

AD&D Insurance Options for Eligible Employees
• $50,000 • $50,000 plus 2 times *annualized base pay* • $50,000 plus 4 times *annualized base pay* • $50,000 plus 6 times *annualized base pay* • $50,000 plus 8 times *annualized base pay* • $50,000 plus 10 times *annualized base pay*

Price Tags

Price tags for AD&D coverage in your first calendar year with the *company* are based on your pay on your hire date. In subsequent years, price tags are based on your *annualized base pay* on the *company's* record keeping system as of the prior September 1.

The price tags for your AD&D insurance options are shown in the personalized information you receive when first eligible and during the annual enrollment period.

Company Contributions

The *company* allocates a certain amount of contributions to eligible employees to cover part or all of the cost of their *company*-provided AD&D coverage. The following chart summarizes the amounts of *company* contributions available and the *company*-provided AD&D coverage:

Eligible Employees	*Company* Contributions	*Company*-Provided Coverage
Full-time employees *Part-time Plus* employees	Enough for $50,000 of coverage	$50,000
Part-time employees regularly scheduled to work 16 or more hours per week on an ongoing basis	A lump sum amount that can be used for any *Flex* options for which they are eligible (See the ***Flex*** section in this handbook for more about lump sum *company* contribution amounts)	No coverage

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Employee Contributions

Employees may choose coverage options to supplement their *company*-provided Basic coverage, if any. You pay for your AD&D Insurance coverage with pre-tax payroll contributions. AD&D costs associated with covering a *domestic partner* will be deducted with post-tax dollars for Federal tax purposes. State taxation for *domestic partner* coverage varies by State.

If you don't receive enough pay during a pay period to cover your *Flex* price tags, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. If you are in arrears after four consecutive pay periods, you will receive a written notice that you are being changed from payroll deduction to direct billing and you will be billed for future contributions you owe. If you fail to pay your contributions, your coverage will be terminated. Any amount that you have in arrears for payroll deductions during *deduction periods* prior to your change to direct billing that could not be collected at the end of the calendar year will be added to your W-2 statement as taxable income. If you leave the *company* or cease to be eligible for benefits, you will be billed for any outstanding deduction amounts.

If you're not receiving income directly from the *company* and payroll deductions are not possible, you will be billed and expected to pay for your AD&D options with post-tax dollars. If your payment is not received within 30 days of the due date indicated in your billing notice, your AD&D Insurance coverage will end retroactively effective as of the last day of the month for which your full premium was received.

How Pay-based Benefits Are Determined

If your coverage is a multiple of your pay, your benefit will be rounded to the next higher multiple of $1,000, unless your pay is already a multiple of $1,000. That amount will then be multiplied by the coverage level you selected.

Example:

Suppose your annualized base pay *is $45,600 and you choose the $50,000 plus eight times* base pay *option. Your coverage amount is $418,000 ($45,600 rounded up to the next higher $1,000 = $46,000 x 8 = $368,000, plus $50,000).*

When Your *Base Pay* Changes

If your *annualized base pay* increases during the year, your supplemental AD&D coverage will also increase to reflect that change. The new amount will take effect on the day the pay increase occurs. If your pay increase is retroactive, your coverage will increase on the day your pay increase is processed. The price tag for your coverage will not increase until the following January 1 unless you have a change in eligibility, for example, *part-time* to *full-time* or represented to non-represented.

If your *annualized base pay* decreases during the year, your coverage will not be affected until the start of the next calendar year.

Dependent AD&D Coverage Amounts

Depending on the make-up of your family, if you elect family coverage for AD&D:

- Your *spouse's* (or *domestic partner's*) AD&D insurance amount will equal 50% of your AD&D coverage, up to $500,000
- Each of your *children's* AD&D insurance amounts will equal 10% of your AD&D coverage, up to $50,000 per *child*
- Your *spouse* (or *domestic partner*) and *children* may be eligible for an additional amount for tuition expenses

Maximum AD&D Benefit

There is a maximum benefit of $2,000,000 payable under the AD&D Insurance Plan. If you and your *spouse* (or *domestic partner*) are both employees of the *company* and cover each other and/or your eligible dependents, the maximum is counted against the total of both amounts of coverage.

How AD&D Insurance Benefits Are Paid

To claim AD&D benefits, you or your beneficiary should contact the *EIX Benefits Connection* for assistance. A certified copy of the death certificate is required to claim a death benefit.

AD&D Losses

You and your dependents are covered for losses that occur within one year and as the result of a covered accident that takes place while you are covered by the AD&D plan. The AD&D plan pays a percentage of your full coverage amount, based on your loss, as shown in the following table:

If you or a covered dependent suffers the loss of:	The plan pays this percentage of your AD&D insurance amount:
Loss of life	100%
Loss of two or more, hands or feet	100%
Loss of sight of both eyes	100%
Loss of one hand or foot and the sight of one eye	100%
Loss of speech and hearing (both ears)	100%
Paralysis: Quadriplegia Paraplegia Hemiplegia Uniplegia	 100% 75% 50% 50%
Loss of one leg or one arm	50%
Loss of one hand or one foot	50%
Loss of sight of one eye	50%
Loss of speech or hearing (both ears)	50%
Loss of all four fingers of the same hand	50%
Loss of thumb and index finger of the same hand	25%
Loss of hearing in one ear	25%

These are the plan's definitions for the loss of:

- Hands and feet – actual severance through or above wrist or ankle joint
- Eyes, speech or hearing – entire and irrecoverable loss of sight, speech, or hearing (both ears)
- Leg and arm – actual severance through or above knee or elbow joint
- Thumb and index finger – actual severance through or above the metacarpophalangeal joints
- Paralysis – quadriplegia, paraplegia, hemiplegia, uniplegia; loss of use of such limbs without severance must be determined by a *physician* to be complete and irreversible

If there are multiple injuries, the plan will pay the single highest benefit allowed by the plan for the loss involved. For example, if an accident results in the loss of one hand and the thumb and index finger on the other hand, the plan will pay 50% of your AD&D insurance amount.

Seat Belt/Supplemental Restraint Benefits

An additional amount may be payable for an insured's loss of life as the direct result of a covered motor vehicle accident while using a properly fastened seat belt. The amount would be equal to 10% of the *company*-provided coverage plus 10% of any supplemental coverage, up to a maximum of $25,000 on the supplemental coverage.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the covered accident.

A beneficiary may be eligible for an additional death benefit if the car is equipped with an airbag and a seat belt is used. The "Airbag" benefit will be equal to 5% of the *company*-provided coverage plus 5% of any

supplemental insurance, up to a maximum of $10,000 on the supplemental coverage. This benefit is only applicable if the deceased was wearing a seat belt and the airbag properly functioned and deployed.

Tuition Reimbursement Benefits

Tuition Reimbursement Benefits for Insured *Spouse* or *Domestic Partner*

Upon your death as a result of a covered accident, your surviving *spouse* or *domestic partner* may receive an additional amount payable for tuition if you elected family coverage for AD&D. The amount will equal the lesser of:

- The actual tuition charges for the program
- 10% of your AD&D benefit, or
- $10,000

Enrollment in a qualifying program in an accredited school for the purpose of retraining or refreshing skills needed for employment must occur within 12 months from your date of death and expenses must be incurred within 30 months from your date of death to be considered for reimbursement. Tuition reimbursement expenses must be payable directly to, or approved and certified by, the school.

Tuition Reimbursement Benefits for Insured *Children*

Upon your death as a result of a covered accident, each qualifying surviving *child* will receive an additional amount payable for tuition if you elected family coverage for AD&D. The amount will equal the lesser of:

- The actual tuition charges for the program
- 10% of your AD&D benefit, or
- $15,000

Enrollment in a qualifying program of higher education must occur within 12 months from your date of death. This benefit is payable annually for up to four consecutive years, but not beyond the date the *child* reaches age 25. Tuition reimbursement expenses must be payable directly to, or approved and certified by, the school.

Accidental Burn and Disfigurement Benefit

If you or a covered dependent suffers a burn and disfigurement that requires reconstructive or cosmetic surgery, the plan pays a percentage of your full coverage amount, based on your loss, as shown in the following table:

Percentage of Accidental Burn and Disfigurement to the body	The plan pays this percentage of your AD&D insurance amount:
75% to 100%	100%
50% to 74%	75%
25% to 49%	50%

Home Alteration and Vehicle Modification

When you or a covered dependent suffers a covered loss other than the loss of life, the plan will pay an additional 10% of the benefit amount (up to a maximum of $25,000) to assist in the cost of Home Alteration or Vehicle Modification needed as a result of the covered loss.

Coma

When you or a covered dependent suffers a coma, the plan will pay 1% of the total benefit per month up to 11 months, then 100% of the benefit after the 12th month.

Child Day Care

If you die from a covered accident and you are survived by a covered *child*, the plan will pay an additional 3% of the benefit amount, up to a maximum of $3,000 per year, for a maximum period of five years or until the covered *child* attains age 13, whichever occurs first. The covered *child* must be enrolled in a licensed child care center on the date of the covered accident or enrolls within 90 days of the covered accident.

What the AD&D Plan Does Not Cover

The AD&D plan will not pay for losses due to the following causes:

- Physical or mental illness
- Intentionally self-inflicted injuries
- Suicide (in Missouri, while sane), or any attempt at suicide
- Nuclear war or war between the U.S., France, former Soviet Union, China and United Kingdom
- An accident occurring while the insured individual is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid will be prorated for any such period of full-time active duty and returned by the *company*)
- Illness or disease
- An infection, except pus-forming infections from an accidental wound
- Operating, learning to operate, or serving as a member of a crew of an aircraft. Coverage is provided for insured employees while riding as passengers or as pilots/crew members in aircraft owned, leased or operated by the policyholder
- While in any aircraft operated by or under any military authority (except if it is a transport aircraft of the armed forces of a country)
- While in any aircraft being used for a test or experimental purpose

Situations Affecting AD&D Coverage

There are a number of situations that could affect your AD&D insurance coverage -- for example, if your status changes or you leave the *company*. Your dependents' coverage may also be affected. Here is a quick reference chart covering some of these situations. See the **Events Affecting Your Benefits** section for other situations that may affect your coverage.

If you...	
Receive a salary increase	• Any AD&D coverage you've elected will increase to reflect the change • Your price tag will not increase until the following January 1
Receive a salary decrease	Your insurance coverage amount will not decrease due to your salary decrease until the start of the next calendar year (January 1)

When Coverage Ends

Employee Coverage

If you change to an ineligible status, if you are laid off, or if you leave the *company* for any reason (including retirement), your AD&D insurance will end on the day the change occurs.

You may continue your AD&D insurance (if you are under age 70) by converting to an individual policy within 31 days of the day you separated from the *company*. The insurance companies determine the cost and maximum coverage amount for converted insurance.

If you die, your covered dependents over age 16 may convert their AD&D coverage within 31 days of your death.

Dependent Coverage

If your coverage ends, in most cases your Dependent AD&D insurance will also end. If your covered dependents change to an ineligible status, their AD&D insurance will end on the day the change occurs.

Appeals

If a benefit claim is denied, in whole or in part, you or your beneficiary has a legal right to request a review of that denial. Generally, if you disagree with the outcome, you may appeal it.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Refer to the Other Important Information section of this handbook for details about documentation and the **appeals** process.

For More Information

You can get information about the plan by contacting the *EIX Benefits Connection* at:

- (866) 693-4947
- www.eixbenefits.com

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Business Travel Accident Insurance

Overview and Important Features

Business Travel Accident Insurance is generally for *full-time*, *part-time* and *part-time plus* employees. It pays a benefit if a covered person dies or suffers certain physical losses as the result of an accident occurring while traveling on *company* business. Certain current and former executives are covered, as well, during travel that is not related to *company* business, as outlined below in this section. The *company* pays the full cost of this insurance.

Who Is Eligible

You are eligible for Business Travel Accident Insurance coverage if you are a:

- Full-time, part-time or part-time plus employee
- Pilot or copilot hired on a *part-time* basis to substitute for an employee pilot or copilot, while you are boarding, piloting, or leaving a *company* aircraft piloted by a licensed pilot
- Retired Chairman of the Board of Edison International or Southern California Edison Company
- Guest while on a trip sponsored by Edison International or any of its affiliates

Temporary and *leased* employees and *contingent workers* are not eligible for Business Travel Accident Insurance.

Coverage Period

You are automatically covered under the Business Travel Accident Insurance Plan on your hire date or the date you are classified in one of the groups listed under Who Is Eligible.

Cost of Coverage

The *company* pays the full cost of Business Travel Accident Insurance coverage.

Coverage Amounts

Coverage amounts for Business Travel Accident Insurance vary by employee group and the *company* you work, for as summarized below:

If you are . . .	Your Coverage Amount is . . .
A *full-time*, *part-time* or *part-time plus* employee, except as indicated below	The lesser of: • 2 times *annualized base pay* • $250,000
A substitute *part-time* pilot or co-pilot	$50,000

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

• An executive who is a senior officer, including elected vice presidents and above • An executive other than a senior officer	$400,000* $300,000*
A retired Chairman of the Board of Edison International or Southern California Edison Company	$400,000*
A guest on a trip sponsored by Edison International or any of its affiliates	$100,000 The plan will also pay up to $9,975 for medical coverage as a result of a trip-related accident

* This coverage also includes non-business related travel.

The plan will pay the single highest benefit allowed by the plan for the losses involved in a single accident. A single aircraft accident has a $5,000,000 maximum. This amount will be allocated proportionately among the beneficiaries of all covered victims.

How Business Travel Accident Insurance Benefits Are Paid

All Business Travel Accident Insurance Plan benefits are paid in a lump sum. The plan pays a percentage of the coverage amount based on the severity of a loss, as shown in the following chart:

If you suffer the loss of:	The plan pays this percentage of your Business Travel Accident Insurance coverage amount:
Loss of life	100%
Loss of both hands or both feet	100%
Loss of sight of both eyes	100%
Loss of one hand and one foot	100%
Loss of one hand or foot and the sight of one eye	100%
Loss of speech and hearing	100%
Paralysis: Triplegia Quadriplegia Hemiplegia Paraplegia Uniplegia	 100% 100% 75% 75% 50%
Loss of one leg or one arm	75%
Loss of one hand or one foot	50%
Loss of sight of one eye	50%
Loss of speech or hearing	50%
Loss of thumb and index finger of the same hand	25%

These are the plan's definitions for the loss of:

- Hands and feet – actual severance through or above wrist or ankle joint
- Eyes, speech or hearing – entire and irrecoverable loss of sight, speech, or hearing
- Leg and arm – actual severance through or above knee or elbow joint
- Thumb and index finger – actual severance through or above the metacarpophalangeal joints
- Paralysis – Triplegia, Quadriplegia, Hemiplegia, Paraplegia, Uniplegia; loss must be a complete and irreversible loss of the use of such limbs

If there are multiple losses from a single accident, the plan will pay the single highest benefit allowed by the plan for the loss involved. For example, if an accident results in the loss of one hand and the thumb and index finger on the other hand, the plan will pay 50% of your Business Travel Accident Insurance amount.

What the Business Travel Accident Insurance Plan Does Not Cover

The Business Travel Accident Insurance Plan will not pay for losses due to:

- Suicide or intentionally self-inflicted injuries
- War or act of war, declared or undeclared
- Illness not due to an accident
- An accident occurring while you are on full-time, active military duty
- An accident occurring while you are acting as a pilot or crew member of any aircraft other than *company* aircraft
- An accident while you are boarding, riding as a passenger in, or leaving any aircraft that:
  - Is owned or operated by the *company* but is not listed in the insurance policy
  - Is engaged in flight which requires a special permit or waiver from civil aviation authorities, unless the insurance company has given prior written consent
  - Does not have a valid airworthiness certificate and is not part of a country's transport service
  - Is piloted by someone who does not hold a valid and current certificate of competency for piloting the plane

Situations Affecting Business Travel Accident Coverage

There are a number of situations that could affect your Business Travel Accident Insurance coverage. See the **Events Affecting Your Benefits** section for situations that may affect your coverage.

Appeals

If a benefit claim is denied, in whole or in part, you or your beneficiary has a legal right to request a review of that denial. Generally, if you disagree with the outcome, you may appeal it.

Refer to the Other Important Information section of this handbook for details about documentation and the **appeals** process.

For More Information

You can get information about the plan by contacting the *EIX Benefits Connection* at:

- (866) 693-4947
- www.eixbenefits.com

Retirement Plan

Retirement Plan revised September 24, 2012; October 30, 2012.

Overview and Important Features

This summary describes the main features of the Retirement Plan as of January 1, 2012. Complete details of the plan are in the official plan document that governs plan operation and administration. The official document is the formal written expression of the plan and will govern if there are any differences between its provisions and the information in this summary.

The Retirement Plan, officially known as the Southern California Edison Company Retirement Plan, is designed to work with Social Security and the Edison 401(k) Savings Plan to provide income during your retirement. Its Cash Balance account feature makes your retirement benefit portable. Should you leave the *company* before you retire, you can take the value of your Cash Balance account balance with you and roll it over into an Individual Retirement Account (IRA) or other eligible retirement plan that accepts rollovers. The plan also provides the following benefits and features:

- Automatic participation
- No cost to you
- A vesting schedule that lets you earn a non-forfeitable right to 100% of your retirement benefits over three *years of service*
- A choice of payment options upon separation from service at any age
- Full vesting of your Cash Balance account and payment to your designated beneficiary if you die before you receive your retirement benefit

The Retirement Plan added the Cash Balance account feature in 1999. If you earned benefits under the Retirement Plan before this change and were an active employee on the date of transition to the Cash Balance feature, you received an opening balance and other transition benefits. Based on your age and service at the time of the transition, you may be receiving special monthly transition credits into your Cash Balance account for a period of time. You may also be "grandfathered," which means you continue to accumulate retirement benefits under the plan's prior formulas.

Certain rehired employees may be eligible for a Cash Balance account opening balance based on previous service with the *company*. For more information, see **Opening Balances** in the Appendix that follows this summary

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Who is Eligible

All *full-time*, *part-time*, *part-time plus* and *temporary* employees of the following "participating *companies*" are eligible to participate in the Retirement Plan:

- Edison International
- Edison Material Supply, LLC
- Southern California Edison Company

Employees represented by the following unions are eligible to participate in the Retirement Plan as a result of the collective bargaining process:

- International Brotherhood of Electrical Workers, Local 47
- Utility Workers Union of America, Local 246
- Utility Workers Union of America, Local 246A (San Onofre Firefighters Association)

Leased employees and *contingent workers* are not eligible to participate in the Retirement Plan.

See the **Eligibility** section at the beginning of this handbook for the specific employee groups eligible to participate in this plan.

Some employees may be eligible for Retirement Plan benefits other than the Cash Balance account. These include:

- Voluntary Retirement Offer (VRO)
- Enhanced Deferred Vested Benefits

Details are described in the Appendix to this summary

Enrolling in the Plan

Your participation begins automatically on your date of hire. You do not need to fill out an enrollment form.

Your Beneficiaries

Your beneficiary designation is used to name beneficiaries for your 401(k) Savings Plan, Retirement Plan, and any insurance coverage for which you are eligible. You may designate your beneficiary(ies) by contacting the *EIX Benefits Connection* by phone or online :

- (866) 693-4947
- www.eixbenefits.com

If you are married, your *spouse* is automatically your beneficiary. To name a beneficiary other than your *spouse*, you must have your *spouse's* approval in writing and signed by a notary public.

You may change your beneficiary at any time by completing a new beneficiary designation online or by calling the *EIX Benefits Connection*. A beneficiary designation authorization form will then be generated and mailed to you or available to print on-line. For your beneficiary designation to be valid, the form must be completed (including your *spouse's* written, notarized consent, if applicable) and returned to the *EIX Benefits Connection* by the due date stated on the form.

If you have a *same-sex spouse* or *registered domestic partner* when you die and you have not submitted a valid designation for another beneficiary, then your *same-sex spouse* or *registered domestic partner* will be your sole beneficiary.

If you die and you have no surviving *spouse, same-sex spouse*, *registered domestic partner,* or other beneficiary, your account balance will be paid to your estate.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The Cash Balance Account

The Cash Balance account features a formula that provides the security of a traditional pension plan with the simplicity of a savings account. The Cash Balance account accumulates monthly credits (dollars), but it is not subject to investment risk or market value fluctuations. The value of your benefit can only increase over time.

Every month, the *company* applies pay credits to your Cash Balance account. The amount of the credits is based on your service, your age, and your pay.

For each month that the *company* applies pay credits to your Cash Balance account, the *company* will also apply an additional $150 credit. This $150 monthly credit is also referred to as the retiree health care credit.

The *company* also applies interest credits to your account every month.

Certain groups of employees may have previously received monthly transition credits. See **Transition Credits** in the Appendix for details.

Funded entirely by the *company*, your Cash Balance benefit grows through pay credits, interest credits and retiree health care credits. You can track the growth of your Cash Balance account as you receive your quarterly statements. You can also review your Cash Balance account information through the *EIX Benefits Connection* at (866) 693-4947 or online at www.eixbenefits.com.

Age and Service Points

The plan uses your age plus your Cash Balance service to determine age and service points. "Cash Balance service" is generally your service as an employee while eligible to participate in the plan. Effective January 1, 1999, you earn one month of Cash Balance service for each month in which you are credited with at least one *hour of service*. The calculation of Cash Balance service for service prior to that date is described in the Appendix.

Your age and service points are computed using your age (in years and months) plus your Cash Balance service (in years and months).

Service as a *leased* employee or *contingent worker* does not count as service for the determination of age and service points.

You earn one month of service for each month in which you are credited with at least one *hour of service*. Your age and service points are recalculated as of the end of each month to determine the pay credits you're eligible to receive for that month. That means your credits can grow during the course of the year.

The following example shows how age and service points are calculated.

Sample Calculation of Age and Service Points on March 31, 2001

- Birth Date: June 17, 1955
- Date of hire: January 15, 2000
- Assumption: Employee works at least one hour per month as an employee eligible to participate in the plan

Age Points Calculation (rounded up to the nearest month)	
Calculation Date:	2001 - 03 - 31
Birth Date:	-1955 - 06 - 17
	45 - 09 - 14
Age Points:	**45 years, 10 months**

Service Points Calculation (rounded up to the nearest month)	
Calculation Date:	2001 - 03 - 31
Service Date:	-2000 - 01 - 15
	1 - 02 - 16
Service Points:	**1 year, 3 months**

Total Age and Service Points Calculation (age points plus service points rounded down to the nearest year)	
Age Points:	45 - 10
Service Points:	+ 1 - 03

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	47 - 01
Total Age + Service Points:	**47**

Pay Credits

You are eligible for pay credits ranging from 3% to 9% of your monthly *base pay* depending upon the number of age and service points you have earned.

- If you are a *full-time* employee, your pay credits are based on age, length of service, and monthly *base pay* in effect on the first day of the month
- If you are a *part-time*, *part-time plus* or *temporary* employee, your pay credits are based on age, service and the hourly *base pay* rate in effect on the first of the month multiplied by your regular straight time hours during the month

You may only earn pay credits for the months in which you are credited with at least one *hour of service*.

Pay Credit Schedule	
Age + Service Points	**Pay Credit Percentage**
Less than 40	3%
40-49	4%
50-59	5%
60-64	6%
65-69	7%
70-74	8%
75 or more	9%

Pay credits earned during a month are applied to your Cash Balance account on the last day of the month.

Additional Monthly Credit (Retiree Health Care Credit)

For each month that the *company* applies pay credits to your Cash Balance account, the *company* will also apply an additional $150 credit. This monthly credit is referred to as the retiree health care credit because it was implemented to help provide greater financial resources for your health care costs after retirement. You will not receive the additional credit for any month that you are not eligible to receive a pay credit. If you earn the additional credit during a month, the credit will be applied to your Cash Balance account on the last day of the month.

Interest Credits

Effective as of the last day of each month beginning February 29, 2008, your account receives a monthly interest credit based on the transitional third segment rate of a corporate bond yield curve specified by the Treasury Department for the month of August of the preceding year. Additional details regarding the determination of the transitional third segment rate can be found in the official plan document. Interest credits are applied monthly. The monthly rate used to apply interest credits to your account is computed by dividing the annual interest rate by 12.

At the end of each month, interest credits are applied to your account based on the value of your balance on the first day of that month.

The following example shows how pay credits and interest credits are accumulated on a monthly basis.

Sample Calculation of Pay Credit, Retiree Health Care Credit and Interest Credit applied for March 31, 2010

- Age and Service Points as of March 31, 2010: 52
- *Applicable third segment interest rate specified by the Treasury Department as of August 2009*: 5.47%
- Cash Balance account as of March 1, 2010: $50,000.00
- Monthly base pay rate as of March 1, 2010: $4,000.00
- Assumption: Employee works at least one hour during the month of March, 2010 as a *full-time* employee eligible to participate in the plan.

Interest Credit Calculated for March 31, 2010	
(a) Account Balance as of March 1, 2010	*$50,000.00*
(b) Plan's interest credit rate	*5.47%*

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

(c) Plan's interest credit rate as a monthly rate = (b) divided by 12	*0.4558%*
(d) Interest credit applied for March 31, 2010 = (a) times (c)	*$227.90*
Pay Credit Calculated for March 31, 2010	
(e) Monthly base pay *rate as of March 1, 2010*	*$4,000.00*
(f) Pay credit percentage based on 52 points as of March 31, 2010:	*5%*
(g) Pay credit applied for March 31, 2010 = (e) times (f)	*$200.00*
Retiree Health Care Credit for March 31, 2010	
(h) Retiree Health Care Credit for March 31, 2010:	*$150.00*
Cash Balance Account as of March 31, 2010	
(i) Account Balance as of March 1, 2010 = (a)	*$50,000.00*
(j) Interest credit applied for March 31, 2010 = (d)	*$227.90*
(k) Pay credit applied for March 31, 2010 = (g)	*$200.00*
(l) Retiree Health Care Credit for March 31, 2010 = (h)	*$150.00*
(m) Account Balance as of March 31, 2010 = (i) + (j) + (k) + (l)	*$50,577.90*

Transition Credits

Eligible employees who were accruing benefits under the Retirement Plan when Cash Balance features were added to the plan, as well as certain other groups of employees, may have received monthly transition credits based on age and service points. See **Transition Credits** in the Appendix for details.

Unused Sick Leave Benefits

Non-represented employees who retire from a participating or non-participating *company* may be eligible for the unused sick leave benefit under the following conditions:

- You are grandfathered (see **Grandfathering** in the Appendix) under the prior plan formulas and you retire at age 55 or older and have at least five *years of service* and the sum of the prior plan formula and the unused sick leave benefit affords you the greatest calculated plan benefit on your benefit commencement date
- You are grandfathered (see **Grandfathering** in the Appendix) under the prior plan formulas and you retire at age 65 or older and have at least one *year of service* and the sum of prior plan formula and the unused sick leave benefit affords you the greatest calculated plan benefit on your benefit commencement date
- You are not grandfathered, you had an accrued benefit in the Retirement Plan in 1999 when the Cash Balance feature was implemented, you were not a highly compensated employee (as defined by the Retirement Plan) for the 2005 plan year, you were not a represented employee on December 31, 2005 (or at time of retirement if earlier), you terminated employment in 2005, 2006 or 2007 (after attaining either age 55 and five *years of service*, or age 65 and one *year of service*), and the sum of your accrued benefit when the Cash Balance feature was implemented plus the unused sick leave benefit affords you the greatest calculated benefit on your benefit commencement date.
- You were eligible for the **Voluntary Retirement Offer (VRO**) described in the Appendix to this summary and the sum of the minimum benefit under the VRO and the unused sick leave benefit affords you the greatest calculated plan benefit on your benefit commencement date

You will receive payments for your unused sick leave days in monthly installments for up to 24 months. For each 22 days of unused sick leave, you will receive a one-month payment equal to 20% of your monthly *base pay* during your highest 36 consecutive months.

Example

If you have 242 unused days and your highest average monthly base pay *is $4,100, your unused sick leave benefit would be calculated as follows:*

242 / 22 = 11 monthly payments

$4,100 x 20% = $820 per month

If you have more than 24 months (24 x 22 = 528 days) of unused sick leave at the time of retirement, your monthly payments will be increased so that you receive payment for all your unused days within 24 months. Partial payments are made for periods of less than 22 days.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The amount of your unused sick leave payment is eligible for rollover to an Individual Retirement Account (IRA) or other eligible retirement plan that accepts rollovers. Additional tax penalties will apply to any monthly amount not rolled over if you were not at least age 55 at the time of your retirement.

If you die after you begin receiving your pension benefit but have not received all your unused sick leave payments, the remainder will be paid monthly to your eligible surviving *spouse* or as a lump sum payment to your estate. Unused sick leave payments made to your *spouse* are eligible for rollover to your *spouse's* IRA. Any unused sick leave will not be paid to your surviving *spouse* or estate if you die before you begin receiving your pension benefit.

Vesting

Vesting means earning a non-forfeitable right to collect what's in your account.

The Retirement Plan's vesting schedule changed effective February 1, 2008. Employees who work for the *company* on or after February 1, 2008 have the following vesting schedule:

Years of Vesting Service	Vested Interest Percentage
Less than 1	0%
1	20%
2	40%
3 or more	100%

You vest in your Cash Balance account at a rate of 20% per year for completing the first and second year of vesting service, and then you are 100% vested in the Retirement Plan after you complete three years of vesting service.

Cash Balance participants who had a separation from service prior to February 1, 2008 have the following vesting schedule:

Years of Vesting Service	Vested Interest Percentage
Less than 1	0%
1	20%
2	40%
3	60%
4	80%
5 or more	100%

If you leave the *company* for any reason, you have full right to the vested funds in your Cash Balance account. You earn one year of vesting service for each calendar year in which you complete 1,000 *hours of service*. If you complete less than 1,000 *hours of service* in a calendar year, you earn no vesting service for that year. You receive credit for 190 *hours of service* for each month in which you are credited with at least one hour.

Generally, you earn a year of vesting service for each calendar year in which you work at least six months. But, no matter how many hours you work, you cannot earn more than one year of vesting service in one calendar year. In addition, your vesting service also includes periods during which you are on a *military leave of absence*

There are no partial years of vesting service.

Example of three-year vesting schedule: Suppose you joined the company *on July 1, 2007, and you worked at least one hour each month for the rest of the calendar year. You would have earned one year of vesting service for calendar year 2007. If you continued to work at least one hour every month, you would have completed three years of vesting service on June 1, 2009.*

You also become 100% vested if you reach age 65 as an employee, or if you die while an employee.

You will forfeit any non-vested balance at the earlier of:

- The date you take a distribution of your plan balance
- After five consecutive one year breaks-in service

Any forfeiture you incur will be restored if you are re-employed by the *company*.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

When You Can Retire

Your normal retirement date is the first day of the month in which you reach age 65.

You may retire at an earlier or later date. You may retire as early as the first day of the month in which you attain age 55 as long as you have at least five *years of service*. If you continue to work after you reach age 65, you will continue to accumulate age and service points. See **Rules for Rehired Employees** in the Appendix for a discussion of actuarial adjustments related to the nonpayment of benefits for continued employment after reaching age 65.

Prior to reaching age 70½, you cannot begin payment of your benefit while you are an employee of the *company*, even if your *company* is not participating in this plan. If you are still working for the *company* after reaching age 70½, you can elect to start minimum benefit payments as of April 1 of the year following the year in which you reach age 70½. Contact the *EIX Benefits Connection* for further information.

How Retirement Benefits Are Paid

Payment Methods

If the value of your vested Retirement Plan benefit when you leave the *company* is less than or equal to $1,000, it will automatically be paid directly to you in a single lump sum (subject to mandatory withholding) unless you elect to have your vested plan benefit rolled over to an individual retirement account (IRA) or another eligible retirement plan.

If the value of your vested plan benefit when you leave the *company* is greater than $1,000, but less than or equal to $5,000, and you do not elect otherwise, your vested plan benefit will be automatically rolled over to an IRA in your name designated by the *company*. If your vested plan benefit is automatically rolled over, you will be able to subsequently roll over the funds from the automatic rollover IRA to another IRA of your choice. The current automatic rollover IRA provider will place rolled over balances from the plan in a money market account insured by the Federal Deposit Insurance Corporation. The *company* reserves the right to select another IRA provider or another investment product for automatic rollovers. Any investment product selected for this purpose will be designed to preserve principal and provide a reasonable rate of return and liquidity. If your vested benefit is automatically rolled over, you will bear the cost of any fees and expenses associated with the automatic rollover IRA. For additional information regarding the automatic rollover IRA provider and fees and expenses associated with the automatic rollover IRA, or if you have other questions regarding automatic rollovers from the plan, contact the *EIX Benefits Connection* at (866) 693-4947.

If the value of your vested Retirement Plan benefit is more than $5,000, you may defer distribution of your benefit until age 65 or take immediate payment as a monthly annuity or as a single lump-sum distribution. If you do not make an earlier claim for benefits, your benefit payments will automatically commence no later than April 1 of the year following the year in which you reach age 70½.

If you are eligible for Retirement Plan benefits under the Voluntary Retirement Offer, you have other payment options from which to choose (see **Voluntary Retirement Offer (VRO)** in the Appendix at the end of this summary).

Single Life Annuity Option

This is the automatic payment form if you're single, unless you elect a different payment option. It provides a monthly benefit payable to you for your lifetime. Your monthly payments under this option are larger than those under the Contingent Annuity options described below.

However, this option does not pay a benefit to a designated beneficiary or anyone else after your death.

50% Spouse's Pension

This is the automatic payment form if you're married, unless you and your *spouse* jointly choose a different payment option.

This option provides a monthly benefit payable to you for your lifetime. Upon your death, 50% of your monthly benefit automatically continues to your eligible surviving *spouse* over his or her lifetime. The *company* pays the full cost of this plan feature. However, if your *spouse* is more than five years younger than you are, the spousal benefit will be reduced to less than 50% of the monthly benefit paid to you to account for the longer time the spousal benefit is expected to be paid out.

Monthly payments to you under this option are larger than those under the Contingent Annuity options described below. However, a Contingent Annuity option could pay a larger monthly death benefit to your designated beneficiary.

If, after the benefit commencement date for this payment form, your *spouse* predeceases you, you will continue to receive a life annuity, but no further benefit will be payable after your death.

Contingent Annuity Options

This option provides a reduced monthly benefit payable to you for your lifetime. You may elect to have 50%, 75% or 100% of that amount paid after your death to your designated beneficiary (which may or may not be your *spouse*) as long as he or she lives. However, you may not elect a 100% contingent annuity (and may not be permitted to elect a 75% contingent annuity) for a non-*spouse* beneficiary who is more than 10 years younger than you.

Under this option, the amount you would receive during your lifetime is less than the amount you would receive under the Single Life Annuity or 50% Spouse's Pension. The amount of reduction depends on the age of both you and your beneficiary and on the percentage to be continued to your beneficiary after your death.

If you're married, you must obtain your *spouse's* notarized consent to elect this option.

You may not change your designated contingent beneficiary after your benefit commencement date. Your contingent annuity election will be canceled automatically if you marry before your payments begin or if you or your beneficiary dies before benefits begin.

If, after the benefit commencement date for this payment form, your designated contingent beneficiary predeceases you, you will continue to receive the reduced life annuity payable to you under this payment option, but no further benefit will be payable after your death.

Lump-sum Distribution

This option provides a single payment of the value of your entire benefit. Once you receive a lump sum distribution, no further Retirement Plan benefit will be payable to you, your *spouse*, your estate, your heirs, or anyone else.

If you're married, you must obtain your *spouse's* notarized consent to elect this option.

Distributions Due to Divorce

A court may order the plan to pay all or a portion of your Retirement Plan benefit to your former *spouse* or to your children. The Retirement Plan administrator will comply with the court order if, and only if, it is a Qualified Domestic Relations Order (QDRO). Read the following section for more details.

Qualified Domestic Relations Order (QDRO)

A Qualified Domestic Relations Order (QDRO) is a court order which satisfies certain minimum legal standards. Through a QDRO, a court can award a portion or all of your Retirement Plan benefit to one or more alternate payees, usually your children or a former *spouse*. If a potential alternate payee is seeking a QDRO from a court, the individual may provide the *company* a written notice of adverse interest claiming an interest in your benefit. If the *company* receives such a notice, an administrative hold will be placed on your Retirement Plan benefit. However, if your benefits are in pay status (currently being paid to you), an administrative hold will only be placed upon the *company's* receipt of an approved court certified joinder or restraining order, or the Retirement Plan's approval of your QDRO.

An administrative hold will prevent distributions from the Retirement Plan, even if you terminate employment or retire. It will also postpone payment of any unused sick leave benefits for which you may be eligible. If, at the end of the 18-month period after the administrative hold was first placed, it is determined that a domestic relations order is not a QDRO (or the issue as to whether such domestic relations order relating is a QDRO is not resolved), the hold on your account may be released in compliance with applicable law.

Before the *company* can divide and commence payment of your benefits, the plan's administrator is required to have a QDRO, which gives sufficient instruction on how to divide and pay the benefit.

A QDRO is a judgment, decree, or order, including approval of a property settlement agreement, made pursuant to a state's domestic relations or community property law. It generally has provisions for child support, alimony, or marital property rights to a *spouse*, former *spouse*, child, or other dependent of the plan participant.

The law requires a QDRO to meet certain requirements. It must identify the names, addresses, and social security numbers of the participant and alternate payee(s), the exact name of the benefit plan(s), and a formula or method for dividing and paying the benefit(s). A QDRO cannot require a plan to provide increased benefits (determined on the basis of actuarial value) or to pay any type or form of benefits that it would not otherwise pay.

Unless otherwise provided in a QDRO, separate benefits established for alternate payees due to a QDRO will be subject to complete and immediate distribution as a single lump sum at your earliest distribution date. If the present value of the alternate payee's separate interest in the plan is $5,000 or greater when the QDRO is established, the alternate payee may elect to defer the distribution—if the QDRO allows it.

The administrator for purposes of the submission and review of QDROs for the Retirement Plan is Buck Consultants' Domestic Relations Order Administration Group (DROA). You are encouraged to obtain DROA's approval as to the proper form and content under the Retirement Plan of any proposed QDRO dividing your benefits before filing it with the court. You may obtain a copy of the Retirement Plan's QDRO procedures and/or sample QDROs (model orders), without charge, by contacting the *EIX Benefits Connection* at (866) 693-4947 (the *EIX Benefits Connection* representative will transfer your call to DROA). Correspondence to DROA should be sent to the *EIX Benefits Connection* using the following addresses:

For U.S. Mail

EIX Benefits Connection
P.O. Box 199428
Dallas, TX 75219-9428

For Overnight Delivery

EIX Benefits Connection
Attn: ACS
Building 5, Floor 1
2828 N. Haskell Ave.
Dallas, TX 75204-2909

Taxes on Distributions

Before receiving any distribution from this plan, you will receive a Special Tax Notice describing the tax consequences of distributions. After you receive the Special Tax Notice, you have 30 days to consider the tax consequences of rolling your distribution over or taking an immediate distribution. You may waive your right to the 30-day decision period, but that does not obligate the plan to make payments within 30 days.

Taxes may vary depending on your age, your marital status, your other income and how you take distribution from the plan. State and local taxes may also apply to you. It's advisable to consult a qualified tax advisor before receiving a distribution from the Retirement Plan.

Monthly Annuity Payments

When you elect to receive your benefit, you will receive a tax withholding election form.

If you do not complete your tax withholding election form:

- Withholding for federal taxes will be calculated assuming you are "married with three deductions"
- If you reside in a state that has a state income tax, withholding for state taxes will be calculated using the default assumptions for your state of residence. The default for California residents is "married with three deductions." Withholding for state taxes will be calculated using your state of residence as shown on your last valid Federal Form W4 or Form W4P

If you change your state of residence you must complete a new tax withholding election form(s), even if you move to a state that does not have a state income tax. To request the applicable tax withholding forms, contact the *EIX Benefits Connection* at (866) 693-4947.

If you elect not to have federal and/or state income tax withheld from your retirement payments or if you do not have enough income tax withheld, you will be responsible for paying estimated taxes. In addition, you may have to pay penalties under the estimated tax rules.

Lump Sum Payments and Other Payments Eligible for Rollover

You can take certain payments from the Retirement Plan as:

- A complete or partial rollover to an Individual Retirement Account (IRA) or another eligible retirement plan that accepts rollovers
- A complete or partial payment to you

Payments eligible for rollover include:

- A single lump sum payment
- Monthly payments of unused sick leave (if applicable)

Your distribution choice will affect the tax you owe.

If you choose a **rollover,** the portion of your payment you elect to roll over:

- Will not be taxed in the current year and no income taxes will be withheld
- Will be taxed later when you take it out of the IRA or other eligible retirement plan
- Will be made payable to your named IRA or to other eligible retirement plan that accepts your rollover, for your benefit, and sent to your mailing address. It is your responsibility to make sure that your IRA or other eligible retirement plan receives the check in the time allotted for deposit

If you choose to have your plan benefits **paid to you:**

- You will receive only 80% of the taxable amount of the payment. The plan administrator is required to withhold 20% of the payment and send it to the Internal Revenue Service as income tax withholding to be credited against your taxes
- Your payment will be taxed in the current year unless you roll it over. You may be able to use special tax rules that could reduce the tax you owe. However, if you receive the payment before age 59½, you also may have to pay an additional 10% federal income tax. State income tax withholding and your obligation to pay an additional penalty is dependent on the state tax laws where you permanently reside

You have 60 days after receiving a payment to roll it over by depositing it in your IRA or other eligible retirement plan that accepts rollovers. The amount rolled over will not be taxed until you take it out of the IRA or the other eligible retirement plan. If you want to roll over 100% of your payment, you must find other money to replace the 20% that was withheld. If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld but not rolled over. Additional tax penalties may apply to any amounts not rolled over.

Important! The tax information in this document is intended to help you consider the tax implications of receiving your payments as a lump sum or as an annuity. You should carefully review the Special Tax Notice and consult with a tax advisor before making any payment elections.

How to Estimate Your Benefit

You can review your Cash Balance benefit information through the *EIX Benefits Connection* at (866) 693-4947 or online at www.eixbenefits.com

The Web site enables you to estimate the value of your benefit at a future date, using future pay and interest rate assumptions.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

How to Claim Your Benefit

You can choose to start receiving your Retirement Plan benefit effective the first day of any month after your separation from employment (your benefit commencement date is generally the date you choose to start receiving your Retirement Plan benefit).

If you decide to retire, notify the Employee Information Center at (800) 500-4723 of your decision to retire from active service 30 to 90 days prior to your expected retirement date. The Employee Information Center will provide you with additional important information you need before you leave active service. If you decide to resign, you must submit a written resignation to your manager at least two weeks prior to your anticipated last day worked.

To begin payment of your Retirement Plan benefit, contact the *EIX Benefits Connection* at (866) 693-4947, or go online at www.eixbenefits.com. You must provide at least a 30-day (but no more than a 90-day) notice before you want your benefits to begin. This will allow enough time for you to review your payment options, collect any required documentation, and return the necessary forms before their expiration date which is generally 90 days from the date they were requested.

A Benefit Commencement Package will be sent directly to you at your home mailing address. You should verify that the *EIX Benefits Connection* has your current home mailing address by calling (866) 693-4947 or checking online at www.eixbenefits.com

Please note that receipt of your benefit election forms does not obligate the plan to pay benefits on your benefit commencement date. Generally, you will receive your first payment about 30 days after your benefit commencement date, although documents submitted after your elected benefit commencement date can result in delayed payments. Any delayed monthly payments will be made retroactive to your benefit commencement date. Retroactive monthly payments will not include interest.

Your completed paperwork must be received and approved prior to your benefit commencement date for your payment to be paid on the first business day of the following month. Your election to commence benefits, form of payment and beneficiary designation cannot be changed on or after your benefit commencement date.

If your completed paperwork is received and approved on or after your benefit commencement date and before the paperwork expiration date, your benefit commencement date, form of payment and beneficiary designation may not be revoked. Your benefit will be processed to be paid on the next available payment cycle, generally the first business day of the month following 30 days after your complete paperwork was received.

Special rules require all participants who have separated from service or their beneficiaries to begin receiving benefits no later than April 1 following the year in which they attain age 70½. The Retirement Plan administrator will contact you or your beneficiary if you have not elected a benefit commencement date and you are required to begin receiving benefit payments. If you are still working for the *company* after reaching age 70½, you can elect to start minimum benefit payments as of April 1 of the year following the year in which you reach age 70½. Contact the *EIX Benefits Connection* for further information.

Certain documentation is required if you choose to receive any portion of your benefit as a lifetime monthly annuity and there is a continuing payment to another person upon your death. Required documentation includes a certified copy of your marriage certificate and a certified copy of the other person's birth certificate. A certified copy means the copy of the birth or marriage record as filed in the county records office. If you are unable to provide a certified copy of a birth certificate, you may submit (in order of preference) a baptismal certificate, passport, marriage certificate, military record, or naturalization papers. Original certificates are returned after review.

Situations Affecting Your Retirement Plan Benefits

There are a number of situations that could affect your Retirement Plan benefits. This could happen, for example, if your status changes or you leave the *company*. Here is a quick reference chart describing some of these situations. See the **Events Affecting Your Benefits** section of this handbook for other situations that may affect your benefits.

If you...	This will happen...
Are receiving benefits from the Comprehensive Disability Plan, any	You continue to receive pay credits (if applicable), retiree health care credits (if applicable), interest credits, and transition credits (if applicable). The

other short-term disability plan of the *company*, state disability, Return to Work Program, Workers' Compensation, or the Long Term Disability Plan	monthly *base pay* used is: • For *full-time* employees: Your monthly *base pay* in effect on the first day of the calendar month in which the leave began • For *part-time*, *part-time plus* or *temporary* employees: The average of your monthly compensation for the three calendar months preceding the calendar month in which your leave began
Are receiving Wage Continuation payments	You continue to receive interest credits and transition credits (if applicable). The monthly *base pay* is your monthly *base pay* in effect on the first day of the calendar month in which the leave began. You do not receive pay credits or retiree health care credits.
Go on an Unpaid Personal or Family Leave of Absence	You continue to receive interest credits and transition credits (if applicable). The monthly *base pay* used is: • For *full-time* employees: Your monthly *base pay* in effect on the first day of the calendar month in which the leave began • For *part-time, part-time plus* or *temporary* employees: The average of your monthly compensation for the three calendar months preceding the calendar month in which your leave began You do not receive pay credits or retiree health care credits.
Go on a *Military Leave of Absence*	You continue to receive interest credits and transition credits (if applicable). The monthly *base pay* used is: • For *full-time* employees: Your monthly *base pay* in effect on the first day of the calendar month in which the leave began • For *part-time, part-time plus* or *temporary* employees: The average of your monthly compensation for the three calendar months preceding the calendar month in which your leave began You do not receive pay credits or retiree health care credits during your leave. If you return to work with the *company* within the time period specified by law for the guarantee of reemployment rights, you will receive pay credits (if applicable) for the period of time you were on leave, retiree health care credits (if applicable) for the period of time you were on leave after January 1, 2006, and interest credits that apply to those pay credits and retiree health care credits, if any.
Transfer from a participating *company* to a non-participating *company*	You do not receive pay credits or retiree health care credits during your employment with a non-participating *company*. Age and service points and interest continue to accumulate while you're employed at a non-participating *company*. If you're eligible for transition credits at the time you transfer to a non-participating *company*, the transition credits will continue until exhausted based on the same rules as the participating *company* (see **Transition Credits** in the Appendix to this summary).
Transfer from a non-participating *company* to a participating *company*	If you previously participated in the Retirement Plan, your interest credits and any transition credits will continue. You will also begin receiving pay credits and retiree health care credits. If you had not previously participated in the Retirement Plan, you will begin participating like a newly hired employee; however, your total service with non-participating and participating *companies* will be used to calculate your service points for pay credits and vesting purposes. You will begin receiving retiree health care credits (if applicable).
Are in a participating *company* and transfer to an employee group represented by *IBEW* Local 47, *SOFA* or *UWUA* and then retire	You continue to receive pay credits, retiree health care credits, interest credits, and transition credits (if applicable) during your service. If you retire from active service as a represented employee you will also be eligible to receive the unused sick time benefit.
Leave the *company* and then are rehired	Your Cash Balance account will be restored and adjusted for any distributions you have already received (including any amounts forfeited) with interest credits applied up to your date of reemployment. Your prior service will be taken into account when calculating your service points.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	You will again begin to receive interest credits and transition credits (if applicable). You will not receive retroactive transition credits for the period of time you were separated from employment. If you are rehired by a participating *company* you will also receive pay credits and retiree health care credits (if applicable).
Are rehired and are receiving a monthly retirement benefit	See **Rules for Rehired Employees** in the Appendix to this summary.
Are rehired and have a deferred vested benefit under the Retirement Plan's prior provisions	The present value of your deferred vested benefit will be calculated and will become your opening balance in the plan. You will receive interest credits. If you are rehired by a participating *company*, your prior service will be taken into account when calculating your service points and pay credits. If you are eligible to receive pay credits, you will also receive retiree health care credits.

Notification of Address/Bank Change

It is important that you notify the *EIX Benefits Connection* as soon as possible if you have a change of address or you change your bank and/or direct deposit account. If any benefit checks are returned because you no longer reside at the address you furnished, your benefit checks will not be mailed to you until you provide your current address.

If any monthly pension benefit cannot be deposited by direct deposit because you changed your bank or your direct deposit account, your benefit check will be mailed to you at the most recent address on file.

If you are receiving a monthly annuity, you may change or cancel a direct deposit request, or modify a federal or state withholding election, online at www.eixbenefits.com.

Important Plan Information

Plan Limits

The following Internal Revenue Code rules may limit your benefit:

- Federal tax law limits the maximum benefit that may be paid to a participant under this plan. Very few participants are affected by this rule. If you are affected by this limitation, you will be notified when you request your benefit payment
- The Internal Revenue Service (IRS) limits the amount of compensation that may be taken into account under the plan. The limit for 2012 is $250,000; for 2013, the limit is $255,000. This amount may be adjusted in future years
- If the aggregate value of the Retirement Plan benefits of certain key employees as a group equals or exceeds 60% of the aggregate value of the accounts of all plan participants, the plan is considered to be "top heavy." If this should ever happen:
  - In any year that the plan is top heavy, the *company* will make a special minimum contribution to the accounts of all plan participants except key employees
  - The years required to be vested in the plan will be reduced

If the Retirement Plan becomes top heavy, affected employees will be notified and receive additional information.

Non-Discrimination Rules

Federal laws require that the plan satisfy certain nondiscrimination standards that could impact your plan benefits. You will be notified if these rules apply to you.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Non-assignment of Benefits

With the exception of Qualified Domestic Relations Orders (see above), the value of your benefit in the plan may not be assigned, sold, transferred, or pledged as collateral, nor may a creditor attach your value in the plan as a means of collecting a debt owed by you.

How Benefits and Service Are Lost

The following situations may result in the loss of part or all of your pension benefits:

- If you are receiving benefits and are rehired, your benefit payments may cease until you terminate employment again
- If the plan is terminated without enough assets to provide all pension and survivor benefits, your benefit may be affected; however, government insurance helps protect your benefit in such an instance (see **Plan Insurance** in this summary)
- If the Retirement Plan receives a special court order called a Qualified Domestic Relations Order (QDRO), all or part of your benefit may be paid to someone else (see **Distributions Due to Divorce** in this summary)

The Retirement Plan is operated under the assumptions that it is a qualified plan under the Internal Revenue Code, that employer contributions are tax deductible, and that no amounts are contributed in error. Any deviation from these assumptions could affect your benefit.

If your claim for benefits is denied in whole or in part, you have the right to appeal.

Claim and Appeal Procedures

Claims for plan benefits or for a determination of your rights under the Retirement Plan should be directed to:

EIX Benefits Connection
P.O. Box 199428
Dallas, TX 75219-9428
(866) 693-4947

If a benefit claim is denied, in whole or in part, you or your beneficiary has a legal right to appeal the denial of the claim. See **Claims and Appeals** in the Other Important Information section of this handbook for detailed information about claim and appeal procedures.

Discretionary Authority

The Benefits Committee has the full and final power and discretionary authority to construe and interpret all provisions of the Retirement Plan, to administer its provisions, to establish, amend and rescind rules and regulations for efficient administration, to determine all questions relating to the rights and eligibility of participants, and to take such other action to administer the Retirement Plan as it deems appropriate. The decisions of the Benefits Committee shall be final and binding on all parties.

Correction of Errors

Errors may sometimes occur in determining or paying plan benefits. This may be due to incorrect or incomplete data or other reasons. If such an error is discovered, it will be corrected. The Benefits Committee has the full and final power and discretionary authority to make corrections. Overpayments resulting from an error may be deducted from future benefit payments, if any. If you receive an overpayment, you will be required to repay the plan.

Plan Amendment or Termination

The Benefits Committee has power to amend or terminate the Retirement Plan at any time, at its discretion.

The Retirement Plan may also be terminated by:

- Resolution of the *company's* Board of Directors
- Judicial action if the *company* is bankrupt or insolvent, or upon complete dissolution, merger, consolidation, or reorganization, without provisions by a successor-company for continuation of the plan

To the extent permitted by law, the Board of Directors or the Benefits Committee may suspend contributions to the Retirement Plan, in whole or in part, at any time.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If the *company* terminates this plan for any reason, you will be notified. If the Retirement Plan is terminated, you will be automatically 100% vested in your accrued benefit, to the extent the plan is funded.

Plan Insurance

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC). If the plan terminates without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guaranty generally covers:

- Normal and early retirement benefits
- Disability benefits if you become disabled before a plan terminates
- Certain benefits for your survivors

The PBGC guaranty generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which a plan terminates
- Some or all benefit increases and new benefits based on plan provisions that have been in place for less than five years at the time a plan terminates
- Benefits that are not vested because you have not worked long enough for the *company*
- Benefits for which you have not met all of the requirements at the time a plan terminates
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay

Even if certain of your pension benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Retirement Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, contact:

- The **plan administrator** at the address or phone number listed in the Other Important Information section of this handbook
- The PBGC's Technical Assistance Division at 1200 K Street N.W., Suite 930, Washington, DC 20005-4026 or by phone at (202) 326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at (800) 877-8339 and ask to be connected to (202) 326-4000.

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

Plan Funding

All funds of the plan are held by a funding agent under a trust instrument. The name and address of the **funding agent** can be found in the Other Important Information section. Plan funds may be used only for the exclusive benefit of plan participants and their beneficiaries or to pay plan expenses not otherwise paid by the *company*. Plan funds may not be returned to the *company* except for contributions made by a mistake of fact or for which a deduction under Section 404 of the Internal Revenue Code is not permitted, or upon termination of the plan provided all liabilities to plan participants are satisfied.

Benefit restrictions, such as limitations on lump sum distributions, may apply, depending on the plan's funding status. Participants affected by funding-related benefit restrictions will be notified and receive additional information.

Appendix

This Appendix provides information about the Retirement Plan's transition to a plan with Cash Balance account features, as well as provisions of the Retirement Plan that were in effect before the transition.

The first part of this Appendix, Overview of Transition and Grandfathering Provisions, describes how the Cash Balance features were added to the Retirement Plan. It includes:

- An overview of important plan features that relate to how benefits were transitioned to a plan with a Cash Balance account. These features include: Opening Balances, Transition Credits, Grandfathering, and Age and Service Points
- A list of *companies* that have adopted the Cash Balance provisions of the Retirement Plan
- A detailed description of how accounts work for specific employee groups
- A table of special rules for rehired employees and rehired retirees

The second part of this Appendix, Prior Plan Formulas and Provisions, describes other special provisions of the Retirement Plan that are not features of the Cash Balance account. These include:

- Prior plan benefit formulas (also applicable to grandfathering)
- Voluntary Retirement Offer (VRO)
- Enhanced Deferred Vested Benefit

In this Appendix the term "prior plan" applies to the provisions in effect before the transition to the Cash Balance account feature in the Retirement Plan.

Overview of Transition and Grandfathering Provisions

Opening Balances

In 1999, the *company* redesigned its retirement benefits program. The prior plan was a traditional pension plan, where the benefit was calculated as a life annuity payable at a specified retirement date. The redesigned plan calculates benefits as an account balance that can be distributed at any age after separation from service. If your *company* or employee group adopted the Cash Balance features of the Retirement Plan, the lump sum value of your retirement benefit was converted to an opening balance for your Cash Balance account at the time the Cash Balance features were adopted.

The following assumptions were used to calculate the lump sum value of prior plan benefits to establish opening balances during 1999:

- Interest Rate - 5.25% (the November 1998 average 30-year Treasury bond rate)
- Life Expectancy - 1983 Group Annuity Mortality table weighted 50% males and 50% females

Transition Credits

If you were an employee who participated in the prior plan at the time your *company* or employee group adopted the Cash Balance features of the Retirement Plan, you are eligible to receive transition credits. Transition credits ranging from 3% to 6% of *base pay* are applied monthly. They can be applied to your Cash Balance account for up to eight years — beginning on the date your *company* or employee group adopted the Cash Balance features of the Retirement Plan and based on your years of vesting service as an Edison employee as of that date. Vesting service earned as a *leased* employee will not be used to determine the length of your Transition Credit period.

Transition credits are applied to your Cash Balance account only in months when you are credited with at least one *hour of service*. If you are eligible, you will receive monthly transition credits depending on your age and service points, as shown in the following schedule.

Transition Credits Schedule

Age + Service Points	Transition Credits (Percent of *Base Pay*)
Less than 35	3%
35-44	4%
45-54	5%
55+	6%

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Transition credits apply only to the Cash Balance account. They will not increase any benefit earned or calculated under the prior plan's benefit formulas. Effective January 1, 2000, you also receive transition credits in months when you are on a Family, Military, Personal, or Union Leave of Absence. Transition credits end on the earlier of:

- Your separation from service
- The scheduled end of your transition credit period

If you terminate service prior to the scheduled end of your transition credit period and are subsequently rehired prior to the scheduled end of your transition credit period, your transition credits will resume until you again separate from service or the scheduled end of your transition credit period (whichever occurs first). You will not receive transition credits for the period of time you were separated from employment.

Grandfathering

If you were an employee who participated in the prior plan at the time your *company* or employee group adopted the Cash Balance features of the Retirement Plan, and if at that time you were at least age 50 or had at least 60 age and service points, you are grandfathered.

When you are grandfathered, you participate in the Cash Balance features of the Retirement Plan, and also continue to accrue benefits under the prior plan formulas.

If you are a non-represented or former *Teamster*-represented grandfathered employee of a participating *company*, the benefit payable to you from the Retirement Plan is the greater of:

- The sum of the lump sum value of your benefit calculated under the prior plan formulas and provisions based on your *years of service* as an employee of the *company*, plus any unused sick leave benefit
- Your Cash Balance account benefit

As an example, on your Benefit Start Date:

- Your Cash Balance account totals $110,000
- Your prior plan formula ($90,000) plus your unused sick leave benefit ($10,000) total $100,000
- You will be paid the Cash Balance account benefit ($110,000)
- You would not receive the unused sick leave benefit

Effective February 1, 2008, the lump sum value of a grandfathered benefit is calculated using:

- Interest Rate - the three segment rates of the corporate bond yield curve specified by the Treasury Department for purposes of Internal Revenue Code section 417(e)(3) for the month of August of the preceding year.
- Life Expectancy - the applicable mortality table defined in Internal Revenue Code section 417(e)(3).

As the chart below shows, the three relevant segment rates specified by the Treasury Department* are used to convert the annuity that would otherwise be payable under a grandfathered formula into an actuarially equivalent lump sum distribution (the duration of the annuity for this purpose is the participant's assumed life expectancy at the time of the lump sum distribution**):

Use of Applicable Interest Rates to Calculate Lump Sum			
Year	**First Segment**	**Second Segment**	**Third Segment**
2013	**1.13%**	**3.71%**	**4.52%**
2012	**1.85%**	**4.62%**	**6.02%**
	This rate is used to calculate the present value of the monthly payments for the **first five years** of the annuity	This rate is used to calculate the present value of the monthly payments for the **next 15 years** of the annuity	This rate is used to calculate the present value of the monthly payments for any **years exceeding 20**

* The Treasury Department has specified the three segment rates noted above as the interest rates for August of the respective preceding year, determined for purposes of Internal Revenue Code section 417(e)(3).

** The assumed life expectancy is determined according to the Mortality Tables issued for purposes of Internal Revenue Code section 417(e)(3)).

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Age and Service Points

Age and Service points are used to determine what percentage of *base pay* to apply for pay credits and transition credits. It is also used to determine eligibility for grandfathering.

Employment as a *leased* employee does not count towards service points.

Companies That Have Adopted the Cash Balance Feature

Participating *Companies*

Participating *companies* are those that participate in the Cash Balance features of the Retirement Plan. Their employees receive pay credits and interest credits and may also receive transition credits for a limited period of time. Effective January 1, 2006, their employees may also receive retiree health care credits (not all employee groups of participating *companies* are eligible). Some employees who were participants in the Retirement Plan before the Cash Balance features were added are grandfathered. They continue to accrue benefits under the prior plan formulas. All eligible employees of the following *companies* participate in the Cash Balance features of the Retirement Plan upon hire:

- Edison Capital
- Edison International
- Edison Material Supply, LLC
- Edison O&M Services
- Edison Technology Solutions
- Mission Land Company
- Southern California Edison Company

Nonparticipating *Companies*

Nonrepresented employees of the following *companies* who were participants in the Retirement Plan on April 1, 1999, or who participated in the Cash Balance features of the Retirement Plan before transferring to one of the following *companies*, participate in some of the Cash Balance features of the Retirement Plan. They receive interest credits and may also receive transition credits for a limited period of time. They do not receive pay credits or retiree health care credits. Some employees who were participants of the Retirement Plan before the Cash Balance features were added are grandfathered. They continue to accrue benefits under the prior plan formulas. New hires are not eligible to participate in the Retirement Plan. These nonparticipating *companies* are:

- Edison Enterprises
- Edison Mission Energy
- Edison Mission Energy Services, Inc.
- Edison Mission Marketing & Trading, Inc.
- Edison Mission Operation & Maintenance, Inc.
- Edison Source — Minit Charger Work Unit (only employees covered under the BEN benefit program)
- Edison Utility Services
- EME Homer City Generation LP
- Mission Energy New York, Inc.

Nonrepresented employees who transferred to one of the following *companies* from Commonwealth Edison Company on December 16, 1999 participate in the some of the Cash Balance features of the Retirement Plan. They receive interest credits and may also receive transition credits for a limited period of time. They do not receive pay credits or retiree health care credits. Some transferred employees who fulfilled certain age and service requirements as of the date of acquisition are grandfathered. They accrue benefits under the prior plan formulas. New hires are not eligible to participate in the Retirement Plan.

- Edison Mission Energy Fuel Services, Inc. (only employees who were hired initially to work in Illinois on Midwest Generation matters)
- Midwest Generation EME, LLC
- Midwest Generation, LLC

Employees who transferred from Edison O&M Services to EMOM Services, Inc. on December 16, 2002, while participating in the Southern California Edison Company Retirement Plan, participate in some of the Cash

Balance features of that plan. They receive interest credits and may also receive transition credits for a limited period of time. They do not receive pay credits or retiree health care credits. Some employees who were participants of the Retirement Plan before the Cash Balance features were added are grandfathered. They continue to accrue benefits under the prior plan formulas. New hires are not eligible to participate in the Retirement Plan.

How Account Balances Are Established for Different Employee Groups

Eligible Non-represented Employees of Participating *Companies*

Opening Balance

Your opening balance was established on April 1, 1999, using your age, service, monthly average *base pay* for your highest 36 consecutive months (under the prior plan's Supplemental A formula) or 60 consecutive months (under the prior plan's Supplemental B formula), if applicable (see **Prior Plan Formulas and Provisions** later in this Appendix for details) and unused full pay sick leave days as of March 31, 1999. Your opening balance was calculated as the sum of:

- The highest of your age-65 benefit earned under all of the prior plan formulas (Basic formula, Supplemental A, and if applicable, Supplemental B) converted to a lump sum amount. (See Prior Plan Formulas and Provisions later in this Appendix for details.)
- An amount equal to 45% of the value of any applicable unused full pay sick leave days based on your monthly average base pay for the highest 36 consecutive months

Transition Credits

If you had at least one year of vesting service as of April 1, 1999, you are entitled to receive transition credits beginning April 30, 1999. Transition credits continue for the shorter of:

- Your full years of vesting service under the prior plan as of March 31, 1999
- Eight years (ends March 31, 2007)

If you did not have at least one full year of vesting service as of March 31, 1999, you are entitled to receive transition credits as follows:

- If you were hired prior to April 1, 1998, you'll receive transition credits until March 31, 2000
- If you were hired on or after April 1, 1998,you'll receive transition credits for the number of months you were credited with at least one *hour of service* between April 1, 1998 and March 31, 1999

Grandfathering

To be eligible for grandfathering, you must have been at least age 50 or have had at least 60 age and service points, and you must have been employed with the *company* on March 31, 1999.

Age and Service Points

Your service points as of March 31, 1999 equal the sum of:

- Vesting service as of December 31, 1998
- One-twelfth of a point for each month from January 1, 1999 through March 31, 1999 during which you performed at least one *hour of service*

Rules for Rehired Employees

A rehired employee who has received a distribution from the Retirement Plan does not have the option to repay the distribution to the plan. Eligible employees who are rehired by a participating or nonparticipating *company*

receive interest credits if an opening balance is established upon rehire. Only eligible employees rehired by a participating *company* receive pay credits.

Special Rules for Rehired Employees					
Your situation upon rehire...	**Your opening balance equals...**	**Your prior service counts toward...**	**Your benefit payments...**	**If you were originally eligible for transition credits...**	**If you were originally grandfathered...**
You have not begun receiving Retirement Plan benefit payments You never participated in the Cash Balance feature	Your age 65 accrued benefit earned during prior periods of employment converted to a lump sum based on your age and the interest rate in effect at rehire. If you are a *leased* employee or a *contingent worker* you are not eligible to participate in the Retirement Plan	Vesting and Cash Balance age and service points. Not applicable to a *leased* employee or to a *contingent worker*.	Cannot begin until after you leave the *company* or following the April 1 after you reach age 70½ (whichever is first)	Not applicable	Not applicable
You had begun receiving monthly Retirement Plan benefit payments You never participated in the Cash Balance feature	**If you are a *full-time* employee,** your age 65 accrued benefit earned during prior employment converted to a lump sum based on your age and the interest rate in effect at rehire less the present value of prior payments received with interest. **If you are a *part-time or temporary* employee,** your opening balance is zero. If you are a *leased* employee or a *contingent worker* you are not eligible to participate in the Retirement Plan.	Vesting and Cash Balance age and service points. If you are a *leased* employee or a *contingent worker* you receive no vesting or service points and you are not eligible to participate in the Retirement Plan.	**If you are a *full-time* employee,** payments are suspended upon reemployment and can resume after you leave the *company* or following the April 1 after you reach age 70½ (whichever is first) **If you are a *part-time or temporary* employee,** payments continue. When you subsequently retire, your benefit will be recalculated to account for any additional benefit accumulated. If you are a *leased* employee or a *contingent worker*, your payments will continue. Your monthly benefits will not be recalculated upon your subsequent separation from service.	Not applicable	Not applicable
You received a full lump sum distribution from the Retirement Plan	Zero If you are a *leased* employee or a *contingent worker* you are not eligible to participate in the Retirement Plan.	Vesting and Cash Balance age and service points. If you are a *leased* employee or a *contingent*	Cannot be repaid to the plan. You can begin receiving additional benefits you earn once you leave the *company* or following the April 1 after you reach age	Transition credits resume until end of the original scheduled end date.	You continue to be grandfathered. Pay and service during your prior period of employment are restored to calculate grandfathered benefits under the prior plan.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

You previously participated in the Cash Balance feature		*worker* you receive no vesting or service points and you are not eligible to participate in the Retirement Plan.	70½ (whichever is first) If you are a *leased* employee or a *contingent worker*, no recalculation will be performed upon your subsequent separation from service.	Not applicable to a *leased* employee or to a *contingent worker*.	Any benefit payable using the prior plan formula will be offset by benefits already distributed. Not applicable to a *leased* employee or to a *contingent worker*.
You have not begun receiving Retirement Plan benefit payments You previously participated in the Cash Balance feature	Your existing account balance. If you are a *leased* employee or a *contingent worker* you are not eligible to participate in the Retirement Plan.	Vesting and Cash Balance age and service points. Not applicable to a *leased* employee or to a *contingent worker*.	Cannot begin until after you leave the *company* or following the April 1 after you reach age 70½ (whichever is first)	Transition credits resume until end of the original scheduled end date. Not applicable to a *leased* employee or to a *contingent worker*.	You continue to be grandfathered. Pay and service during your prior period of employment are restored to calculate grandfathered benefits under the prior plan. Not applicable to a *leased* employee or to a *contingent worker*.
You had begun receiving monthly Retirement Plan benefits You previously participated in the Cash Balance feature	**If you are a *full-time* employee,** your age 65 accrued benefit earned during prior employment converted to a lump sum based on your age and the interest rate in effect at rehire less the present value of prior payments received with interest. **If you are a *part-time or temporary* employee,** your opening balance is zero. If you are a *leased* employee or a *contingent worker* you are not eligible to participate in the Retirement Plan.	Vesting and Cash Balance age and service points. If you are a *leased* employee or a *contingent worker* you receive no vesting or service points and you are not eligible to participate in the Retirement Plan.	**If you are a *full-time* employee,** payments are suspended upon reemployment and can resume after you leave the *company* or following the April 1 after you reach age 70½ (whichever is first) **If you are a *part-time or temporary* employee,** payments continue. When you subsequently retire, your benefit will be recalculated to account for any additional benefit accumulated. If you are a *leased* employee or a *contingent worker*, your payments will continue. Your monthly benefits will not be recalculated upon your subsequent separation from service.	Transition credits resume until end of the original scheduled end date. Not applicable to a *leased* employee or to a *contingent worker*.	You continue to be grandfathered. Pay and service during your prior period of employment are restored to calculate grandfathered benefits under the prior plan. Any benefit payable using the prior plan formula will be offset by benefits already distributed. Not applicable to a *leased* employee or to a *contingent worker*.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Suspension and Nonpayment of Benefits

Rehires: If you are rehired by the *company* as a *full-time* employee after commencing an annuity under this plan, your annuity will be suspended and may be permanently forfeited for each month you are paid for 40 or more *hours of service*. The plan will be administered under the presumption that you are being paid for 40 or more *hours of service* for each month of your continued employment. You must timely notify the *EIX Benefits Connection* with respect to each month for which the presumption should not apply (i.e., for which you are paid for less than 40 *hours of service*).

Late Retirement: If you continue active employment with the *company* after attaining age 65, no benefits will be paid to you during that period (unless you elect to commence minimum benefit payments as of April 1 of the year following the year in which you attain age 70½). When you retire, your accrued benefit may be adjusted to reflect the nonpayment of benefits for each month after attaining age 65 for which you are paid for less than 40 *hours of service*. The plan will be administered under the presumption that you are being paid for 40 or more *hours of service* for each month of your continued employment. You must timely notify the *EIX Benefits Connection* with respect to each month for which the presumption should not apply (i.e., for which you are paid for less than 40 *hours of service*).

If you retire after April 1 of the year following the year in which you attain age 70½, your accrued benefit may be adjusted to reflect the nonpayment of benefits for each month thereafter, regardless of the number of hours for which you are paid for each such month.

Contact the *EIX Benefits Connection* for further information.

Prior Plan Formulas and Provisions

This section summarizes the prior plan's benefit formulas and the plan provisions used to determine retirement benefits for grandfathered employees and employees who left the *company* with a deferred vested retirement benefit after August 1, 1983 but before the change to a Cash Balance account.

Participation in the prior plan began automatically on the first day of the month an eligible employee completed 1,000 *hours of service* in a 12-month period from date of hire. An eligible employee was any employee of any *company* that adopted the prior plan, excluding *leased* employees, *contingent workers* and persons whose collective bargaining agreement or other agreement with the *company* did not provide for participation in the prior plan.

There are three benefit formulas in the prior plan:

- Basic — This formula takes into account your career *base pay* and service while you are a participant in the plan
- Supplemental A — This formula replaces a certain percentage of your pay (averaged over the highest consecutive 36-month period) based on your *years of service* - less a Social Security offset
- Supplemental B — This formula replaces a certain percentage of your pay (averaged over the highest consecutive 60-month period) based on your *years of service* less a Social Security offset. To be eligible for this formula, you must have been hired before September 1, 1978 (or before September 1, 1979 if you are represented by *IBEW* Local 47)

All three benefit formulas are designed to calculate a monthly lifetime benefit to be paid beginning at age 65. The benefit is adjusted if you leave the *company* before age 65, if you begin receiving payments prior to age 65, or if you choose a payment form other than a lifetime annuity payable only to you.

You will receive the largest benefit payable under each of the formulas for which you are eligible.

If you are also eligible for a minimum benefit payable under the Voluntary Retirement Offer (VRO), you will receive whichever benefit is larger: the prior plan's benefit or the VRO benefit.

The following chart compares how your pay, service, and estimated Social Security benefits are used by each of the three benefit formulas of the prior plan:

Comparison of Prior Plan Benefit Formulas			
	Basic	**Supplemental A**	**Supplemental B**
Monthly *Base Pay*	Actual monthly *base pay*	Average of highest consecutive 36 months of	Average of highest consecutive 60 months of

	throughout your career	monthly *base pay*	monthly *base pay*
Service	Your months of plan participation	Your *years of service* as an eligible employee (including partial years). For purposes of the deferred vested pension, your *years of service* are projected to age 65	Your *years of service* as an eligible employee (including partial years). For purposes of the deferred vested pension, your *years of service* are projected to age 65
Benefit Accrual Formula	Add monthly pension units for every *year of service*	1.75% of monthly *base pay* times service up to 30 years (52.5% maximum at 30 years) plus 1% of monthly *base pay* times service over 30 years	3% of monthly *base pay* times service up to five years plus 2% of monthly *base pay* times service over 6-15 years plus 1% of monthly *base pay* times service from 16-30 years (50% maximum at 30 years) plus 0.5% of monthly *base pay* times service over 30 years
Social Security Offset	None	1.333% times service (up to a maximum offset of 40%)	1.5% times service (up to a maximum offset of 45%)
Adjustment for deferred vested pension	None	Benefit is multiplied by a fraction equal to *years of service* as of date of separation divided by *years of service* projected to age 65	Benefit is multiplied by a fraction equal to *years of service* as of date of separation divided by *years of service* projected to age 65

Years of Service

For the purposes of calculating benefit accruals, a *year of service* is a 12-month computation period in which you earn at least 2000 *hours of service*. For *part-time* employees, service is counted only for periods beginning on or after January 1, 1976.

If you earn between 1,000 and 2,000 *hours of service*, you will be credited with a partial *year of service* for the purpose of benefit accrual.

Social Security Offset

Both supplemental formulas include an offset to your benefit. This offset is calculated as a percentage of the estimated monthly benefit you will receive from Social Security.

Your Social Security benefit is estimated based on your actual earnings with the *company* as well as an estimate of your earnings from other employers before and after your employment with the *company*. Your retirement age affects your offset, as follows:

- If you retire before age 55, your offset is a percentage of the estimated Social Security benefit you'll be eligible to receive at age 65 - assuming you have level future earnings until age 65
- If you retire at or after age 55 and before age 62, your offset is a percentage of the estimated Social Security benefit you'll be eligible to receive at age 62 - assuming that you will have no future earnings until age 62
- If you retire between age 62 and age 65, your offset is a percentage of the estimated Social Security benefit you're eligible to receive on your date of retirement
- If you retire at age 65 or later, your offset is a percentage of the estimated Social Security benefit you're eligible to receive at age 65

If you are a grandfathered participant in the Cash Balance feature of the Retirement Plan, you may provide the *company* with your actual earnings history as recorded by the Social Security Administration. Your actual

earnings history will be used only to determine the amount of your grandfathered benefit calculated under the supplemental benefit formulas.

It will not be used to recalculate your opening balance for your Cash Balance account or VRO minimum benefit (if any).

The use of your actual Social Security earnings history may change the offset used to calculate your grandfathered benefit. This may increase, decrease, or cause no change in the amount of Retirement Plan benefits payable to you. You will be informed of the option to provide your actual Social Security earnings history when you leave the *company*.

Adjustment for Deferred Vested Pensions

For purposes of calculating the deferred vested pension, the supplemental benefit formulas of the prior plan: (i) project your *years of service* as of age 65 for the calculation of your benefit; then (ii) reduce the benefit payable by multiplying the benefit calculated under each supplemental formula by a fraction equal to your *years of service* as of your date of separation divided by your *years of service* projected to age 65.

When You May Commence Benefits under the Prior Plan Formulas

If you are grandfathered and you have a Cash Balance account, you may start receiving your benefit as early as the first of the month following the date you leave the *company*. You may defer receiving your benefit until age 65. If you do not make an earlier claim for benefits, your benefit payments will automatically start no later than April 1 of the year following the year in which you reach age 70½. If you remain in active service with the *company* after reaching age 70½, you can elect to start minimum benefit payments as of April 1 of the year following the year you attain age 70½. Contact the *EIX Benefits Connection* for further information.

If you have earned a vested benefit under the prior plan, but have never participated in the Cash Balance features of the Retirement Plan, you may start receiving your benefit as early as age 55, or earlier if you are eligible for the VRO minimum benefit. You may defer receiving your benefit until age 65. If you do not make an earlier claim for benefits, your benefit payments will automatically start no later than April 1 of the year following the year in which you reach age 70½.

Your grandfathered benefits will be actuarially adjusted to reflect benefit commencement beyond age 65 if you terminated employment before age 65.

Adjustment For Benefit Commencement Prior to Age 65

If you start receiving benefits before you reach age 65, your monthly retirement payment that would otherwise have been payable at age 65 will be reduced, because you are expected to receive benefits for a longer period of time. The reduction, or early retirement factor, is based on your age at the time benefits begin, as well as whether you separated from the *company* before or after age 55. The following table lists early retirement factors. The percentage is prorated for months as well as years.

	Early Retirement Factors	
Age When Benefits Begin	**For Employees Who Separate from Service After Age 55 With at Least Five *Years of Service***	**For Employees Who Separate from Service Before Age 55, or After Age 55 With Less Than Five *Years of Service***
65	100%	100%
64	100%	93.8%
63	100%	88.2%
62	100%	83.0%
61	100%	78.3%
60	97%	73.9%
59	93%	69.0%
58	89%	64.7%
57	85%	60.6%
56	81%	56.9%
55	77%	53.6%

Example of Early Retirement Pension under the Prior Plan Formulas

The following example illustrates the early retirement pension calculated under the prior plan formulas. The sample employee was earning $50,000 a year when she retired in the first of the month she attained age 55, after 30 *years of service*. The dollars and percentages shown are rounded to the nearest whole number.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Supplemental A Formula

Monthly base pay *for Supplemental A formula (average of highest consecutive 36 months)*	*$4,100*
Benefit accrual formula: 1.75% of monthly base pay *x* years of service *(.0175 x $4,100 x 30)*	*$2,153*
Monthly benefit before Social Security offset	***$2,153***
Estimated Social Security benefit (at age 62, assuming no earnings after early retirement)	*$887*
Social Security offset percentage: 1.333% x years of service*; maximum offset of 40% (0.01333 x 30 = 0.40)*	*x 40%*
Social Security offset amount	***($355)***
Supplemental A benefit payable at age 65 ($2,153 - $355)	***$1,798***

Supplemental B Formula

Monthly base pay *for Supplemental B formula (average of highest consecutive 60 months)*	*$3,900*
Benefit accrual formula: 3% of monthly base pay *x service up to 5 years (0.03 x $3,900 x 5)*	*$585*
PLUS	
2% of monthly base pay *x service from 6-15 years (0.02 x $3,900 x 10)*	*$780*
PLUS	
1% of monthly base pay *x service from 16-30 years (0.01 x $3,900 x 15)*	*$585*
Monthly benefit before Social Security offset ($585 + $780 + $585)	***$1,950***
Estimated Social Security benefit (at age 62, assuming no earnings after early retirement)	*$887*
Social Security offset percentage: 1.5% x years of service*; maximum offset of 45% (0.015 x 30 = 0.45)*	*x 45%*
Social Security offset amount	*($399)*
Supplemental B Monthly Benefit payable at age 65 ($1,950 - $399)	***$1,551***
Supplemental A Monthly Benefit payable at age 65	***$1,798***
Supplemental B Monthly Benefit payable at age 65	***$1,551***
Basic Monthly Benefit payable at age 65 (based on 30* years of service*)	***$1,350***
Largest Prior Plan Monthly Benefit payable at age 65 (greatest of $1,798, $1,551 or $1,350)	*$1,798*
Factor for early commencement of benefits at age 55	*x 77%*
Prior Plan Monthly Benefit payable at age 55	***$1,384***

Example of Vested Deferred Monthly Pension under the Prior Plan Formulas

The following example illustrates the vested deferred monthly pension calculated under the prior plan formulas or an employee who is not eligible for the Special 68 Points Feature. The sample employee was earning $50,000 a year when he terminated from service at age 45 with 20 *years of service*. The dollars and percentages shown are rounded to the nearest whole number.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Supplemental A Formula

Monthly base pay *for Supplemental A formula (average of highest consecutive 36 months)*	*$4,100*
Benefit accrual formula: 1.75% of monthly base pay *x projected service to age 65, up to 30 years (.0175 x $4,100 x 30)*	*$2,153*
PLUS	
1% of monthly base pay *x projected service over 30 years (.01 x $4,100 x 10)*	*$410*
Monthly benefit before Social Security offset ($2,153 + $410)	***$2,563***
Estimated Social Security benefit (with salary projected to age 65)	*$1,100*
Social Security offset percentage: 1.333% x projected service to age 65; maximum offset of 40% (0.01333 x 40)	*x 40%*
Social Security offset amount	***($440)***
Supplemental A benefit before adjustment for early separation ($2,563 - $440)	***$2,123***
Fraction applied due to separation prior to age 65: years of service *as of date of separation divided by* years of service *projected to age 65 (20 divided by 40 = .5)*	*x 50%*
Supplemental A Monthly Benefit payable at age 65	*$1,062*

Supplemental B Formula

Monthly base pay *for Supplemental B formula (average of highest consecutive 60 months)*	*$3,900*
Benefit accrual formula: 3% of monthly base pay *x projected service to age 65, up to 5 years (0.03 x $3,900 x 5)*	*$585*
PLUS	
2% of monthly base pay *x projected service from 6-15 years (0.02 x $3,900 x 10)*	*$780*
PLUS	
1% of monthly base pay *x projected service from 16-30 years (0.01 x $3,900 x 15)*	*$585*
PLUS	
0.5% of monthly base pay *x projected service over 30 years (0.005 x $3,900 x 10)*	*$195*
Monthly benefit before Social Security offset ($585 + $780 + $585 + $195)	***$2,145***
Estimated Social Security benefit (with salary projected to age 65)	*$1,100*
Social Security offset percentage: 1.5% x projected service to age 65; maximum offset of 45% (0.015 x 40)	*x 45%*
Social Security offset amount	*($495)*
Supplemental B benefit before adjustment for early separation ($2,145 - $495)	*$1,650*
Fraction applied due to separation prior to age 65: years of service *as of date of separation divided by* years of service *projected to age 65 (20 divided by 40 = .5)*	*x 50%*
Supplemental B Monthly Benefit payable at age 65	***$825***
Supplemental A Monthly Benefit payable at age 65	***$1,062***
Supplemental B Monthly Benefit payable at age 65	***$825***
Basic Monthly Benefit payable at age 65 (based on 20* years of service*)	***$800***
Largest Prior Plan Monthly Benefit payable at age 65 (greatest of $1,062, $825 or $800)	*$1,062*
Early Reduction factor if payment is started at age 55	*x 53.6%*

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Prior Plan Monthly Benefit payable at age 55	***$569***

Special 68 Points Feature for Non-represented Employees of Participating and Non-participating *Companies*

If you are a non-represented employee who terminates employment with a participating or non-participating *company* prior to becoming eligible for retirement (i.e., prior to attaining age 55 and five *years of service*), your prior plan formula will be calculated using the special 68 points feature if your whole years of attained age at termination of employment plus whole *years of service* as of December 31 of the year in which you terminate employment equals at least 68, and you meet one of the following two conditions:

- You are grandfathered (see **Grandfathering** in the Appendix) and terminate after August 1, 2000 with a benefit commencement date of September 1, 2000 or later and the sum of the prior plan formula and the unused sick leave benefit affords you the greatest calculated plan benefit on your benefit commencement date
- You are not grandfathered, you had an accrued benefit in the Retirement Plan in 1999 when the Cash Balance feature was implemented, you were not a highly compensated employee (as defined by the Retirement Plan) for the 2005 plan year, you were not a represented employee on December 31, 2005 (or at time of termination if earlier), and you terminated employment in 2005, 2006 or 2007

If you meet the conditions described above, your prior plan formula will be calculated with the following special features included:

- The benefit will be equal to the reduced accrued benefit as if the participant was retirement eligible (except that you will not be eligible for unused sick leave benefits)
- The Supplemental A and B formulas (as applicable) will be calculated without the project and prorate feature
- The Supplemental A and B formulas (as applicable) will use the early retirement age 62 Social Security Offset
- The reduction factors for early commencement will use those factors applicable to early retirement factors with extension to lower ages at 2% per year (prorated for partial years)

Voluntary Retirement Offer (VRO)

You may be eligible for a special retirement benefit under the VRO. If so, you're eligible to receive the benefit that is the greater of:

- The largest benefit calculated under the prior plan benefit formulas
- The "minimum benefit" under the VRO
- Your Cash Balance account

Who is Eligible

In 1996, a special "minimum benefit" was provided if you:

- Were a *full-time* employee on March 22, 1996
- Were a non-represented employee and at least age 47 on or before June 30, 1996
- Had earned four *years of service* credit for vesting purposes on or before December 31, 1995
- Had not terminated service as a represented employee prior to September 1, 1996
- Were not a member of an excluded group

Excluded Groups

The following employees are not eligible for benefits under the VRO:

- Employees of Edison Capital
- Employees of Edison Mission Energy except for Corporate Americas Region employees at Edison Mission Energy and Edison Mission Operations and Maintenance, Inc.
- Executives at salary grade 13 or above at Edison International
- Executives at Edison Mission Energy and Edison Mission Operations and Maintenance, Inc., including elected vice presidents

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

How VRO Benefits Are Determined

The VRO provides a minimum monthly Retirement Plan benefit calculated with age, monthly *base pay* and service "frozen" as of June 30, 1996.

On the applicable date, eight whole years were added to your age or service to calculate your VRO minimum benefit. First they were added to your age to equal a total of 55 years. (For example: age 47 plus eight years equals 55.) If you were over age 47 on the date of the calculation, the remainder of the eight years was added to your age and/or service in a manner that would produce the highest benefit amount.

The VRO minimum benefit was calculated using the prior plan's Supplemental A formula and estimated Social Security earnings on the date of the calculation. The minimum VRO benefit is not subject to re-calculation for actual Social Security earnings submitted by participants.

The VRO minimum benefit also includes the value of a single life annuity equal to the actuarial equivalent of a lump sum based on your actual age. The annuity value was computed at five percent of annual *base pay* as of March 18, 1996, plus 1% of annual *base pay* multiplied by years of actual service.

The VRO minimum benefit is based on service, monthly *base pay* and age through the dates specified above. Increased service and changes in your monthly *base pay* after those dates will not change your VRO minimum benefit. Your actuarial equivalent lump sum benefit will be dependent on both your age and the interest rate on the benefit starting date.

How VRO Benefits Are Paid

The minimum benefit is payable in one of three ways:

- A regular monthly annuity, which includes a survivor benefit
- A lump sum cash payment based on a single life annuity*
- A combination of 20% as a lump sum cash payment based on a single life annuity and 80% as a monthly annuity with a survivor benefit*

* If you are married at the time of your benefit distribution, notarized spousal consent is required to receive a lump sum or 20%/80% combination. The lump sum and 20%/80% forms of payment are not available to employees of Edison Mission Energy and Edison Mission Operations and Maintenance, Inc. who retire after December 1, 1996.

If You Die Before Receiving Your Retirement Benefit

If you die before benefit payments begin and your minimum VRO benefit is the highest benefit payable to your *spouse*, your *spouse* may elect a lump sum distribution of 50% of the lump sum payment that you would have been entitled to receive on the first of the month following the date of your death. If your *spouse's* lump sum VRO benefit is less than the actuarial equivalent of the survivor benefit under the prior plan (a monthly benefit) your *spouse* may choose the survivor's VRO lump sum described above. The difference between that amount and the actuarial equivalent of the regular pre-retirement survivor's benefit will be paid as an additional monthly benefit.

Enhanced Deferred Vested Benefit

Who is Eligible

Starting with 1995, a special minimum benefit is provided if you:

- Were a non-represented employee at any time during the period from January 1, 1995 through December 31, 1996
- Were born before January 1, 1952
- Complete at least 20 *years of service* on or before December 31, 2001
- Terminate service on or after age 50, but before age 55

How Enhanced Deferred Vested Benefits Are Determined

Under the prior plan, there is a special benefit calculation for employees who leave the *company* before age 55 with a Deferred Vested Benefit.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Employees who meet the above criteria and leave the *company* after age 50, but before age 55 will have their benefit calculated using their service as of December 31, 1996 and the early retirement factors available to participants who separate from employment at or after age 55.

If you are eligible for the Enhanced Deferred Vested Benefit, you may leave the *company* any time between your 50th and 55th birthdays and receive whichever of the following calculations provides the greatest benefit to you:

- The Enhanced Deferred Vested Benefit
- The Cash Balance account
- The benefit calculated under the prior plan's formulas (if you are eligible for grandfathering)
- The minimum benefit under the VRO

After December 31, 1996, if you are still with the *company*, your service will continue to accrue. Any increases in your salary will be used in calculating your benefit under the Cash Balance account and the prior plan (if you are eligible for grandfathering). However, service and salary counted for the purpose of the Enhanced Deferred Vested Benefit were frozen as of December 31, 1996. With continued service, your retirement benefits computed under either the Cash Balance account or the prior plan (if you are eligible for grandfathering) will gradually increase to equal or exceed the benefit computed under the Enhanced Deferred Vested Benefit.

401(k) Savings Plan

401(k) Savings Plan revised October 11, 2012; October 30, 2012.

Overview and Important Features

This summary describes the main features of the Edison 401(k) Savings Plan as of January 1, 2012. This document constitutes part of a prospectus covering Edison International Common Stock and plan interests that have been registered under the Securities Act of 1933. The Plan Prospectus covering the registered securities consists of this summary plan description and the Prospectus Supplement. Complete details of the plan are in the official plan document and trust agreement that govern plan operation and administration. The official document and trust agreement are the formal written expression of the plan and will govern if there are any differences between their provisions and the information in this summary.

The Edison 401(k) Savings Plan (formerly known as the Southern California Edison Company Stock Savings Plus Plan) is a long-term savings plan that allows you to enjoy a break on your current taxes while you save for your future. The plan enables eligible employees to:

- Save from 1% to 84% of eligible earnings, up to federal limits, on a pre-tax and/or post-tax basis
- Receive *company* matching contributions
- Invest all contributions in a wide array of investment funds
- Accumulate investment earnings on a tax-deferred and/or tax-free basis
- Borrow from their 401(k) assets while actively employed
- Earn a non-forfeitable right to *company* contributions over five *years of service*

Plan rules vary among employee groups. Rules for *company* matching contributions also vary. If you have prior service with any of the employers listed below, be certain to review the special plan provisions presented in the Appendix:

- Capitol Refrigeration Corporation
- Citizens Power
- Commonwealth Edison Company
- East Coast Capital
- GHV
- GPU GENCO Corporation
- Kimmel Motz
- Scott Polar
- Westec Security, Inc

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Who Is Eligible

Full-time and *part-time* employees may enroll in the 401(k) plan when hired. There is no waiting period. If you leave the *company* and are rehired as a *full-time* or *part-time* employee, you are eligible to enroll in the plan upon reemployment. *Temporary* and *leased* employees and *contingent workers* are not eligible to participate.

Part-time plus employees are also eligible to participate in the plan.

Enrolling in the Plan

If you're eligible, you may join the 401(k) Savings Plan at any time. When you first become eligible, you will receive an enrollment kit. Your enrollment kit includes a guide to the *EIX Benefits Connection* – an automated phone system and interactive website.

Through the *EIX Benefits Connection*, you may enroll by phone or online from a personal computer at any time. Simply call (866) 693-4947 or log on to www.eixbenefits.com and follow the voice or online instructions.

You will need a User ID and a Password to access the system. When you use your Password, you are authorizing transactions to be made on your behalf. Because your Password is your electronic signature, be sure to protect it and do not give it to anyone else.

When you enroll, you specify the percentage of your eligible earnings you wish to contribute. You also direct how you want to invest your 401(k) assets. In most cases, your 401(k) payroll contributions will begin within two pay periods after your enrollment request is processed.

Your Beneficiaries

Complete a beneficiary designation to name the person or people you want to receive your 401(k) benefit in the event of your death. You can designate or change your beneficiaries at any time on the *EIX Benefits Connection* Web site or by speaking to a representative and requesting a Beneficiary Authorization Form to be mailed to you. If you designate your beneficiary on line, you have the option to print off a Beneficiary Confirmation Form or a Beneficiary Confirmation Form will be mailed within 3-5 business days.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If you are married, your *spouse* is automatically your beneficiary. To name a beneficiary other than your *spouse*, you must have your *spouse* sign the spousal consent section of your Beneficiary Authorization Form and your *spouse's* consent must be notarized. You have the option to print off the Beneficiary Authorization Form or the Beneficiary Authorization Form will be mailed within 3-5 business days.

Return your Beneficiary Authorization Form, including notarized spousal consent, if required, to:

EIX Benefits Connection
P.O. Box 199428
Dallas, TX 75219-9428

If an online beneficiary designation is made but a signed Beneficiary Authorization Form is not returned within 90 days, it will be cancelled.

If you have a *same-sex spouse* or *registered domestic partner* when you die and you have not submitted a valid designation for another beneficiary, then your *same-sex spouse* or *registered domestic partner* will be your sole beneficiary.

If you die and you have no surviving *spouse, same-sex spouse*, *registered domestic partner,* or other beneficiary, your account balance will be paid to your estate.

Making Changes

You may change your investment choices or your contribution rate through the *EIX Benefits Connection* any time except Sunday 12:00 a.m. to Sunday 10:00 a.m. (when the system is down for servicing), Pacific time.

The following chart shows when your transactions will take effect.

Transaction	Timing
Change investment of current account balance	If request is processed before the stock market closes (generally by 1:00 p.m. Pacific time), the change takes effect the same business day,* unless trading restrictions apply If request is processed after the stock market closes, the change takes effect the next business day,* unless trading restrictions apply
Change investment of future contributions	Requests are processed daily and will take effect within two pay periods
Change contribution rate	Requests are processed daily and will take effect within two pay periods

* For purposes of the 401(k) plan, "business day" means any day that the stock market is open for business. If the market closes prior to 1:00 p.m., your change will not occur until the next business day the market is open. "Stock market" refers to the New York Stock Exchange.

Contributions cannot be made directly to the Self-Directed Brokerage Account (Charles Schwab calls this account the Schwab Personal Choice Retirement Account or PCRA). To trade in the Self-Directed Brokerage Account, you must process a transfer either through the *EIX Benefits Connection* website at www.eixbenefits.com or by phone at (866) 693-4947. You must transfer a minimum of $500. Fund transfer requests made by 1:00 p.m. Pacific time (or before the market closes) will be invested in the Schwab U.S. Treasury Money Fund (SWUXX) and available for trading the next business day.

There is a seven-day trading restriction on all plan investment funds except the Edison International Stock Fund. If you transfer money into an investment fund, you may not transfer any money out of that fund for seven full calendar days following the effective date of your transfer into the fund. This restriction does not apply to the investment of payroll contributions to the plan, loan repayments, and rollovers from another plan.

In addition to the seven-day trading restriction described above, transfers of money may also be subject to trading restrictions, redemption fees, or other measures adopted by plan investment funds to address market timing, excessive trading, or other concerns. There are important things to consider before transferring money into or out of the investment funds such as determining if any trading restrictions, redemptions fees, or other measures may apply. There are a number of resources to help you understand the plan's investment options, including fund fact sheets prepared by Morningstar which are available online at the *EIX Benefits Connection* website.

Account Valuation

The value of your account is determined as of the close of each business day for the New York Stock Exchange by considering your transactions for that day -- contributions, withdrawals, loans, loan repayments, distributions – and any gains, losses, chargeable expenses, etc. of each fund in which you are invested.

Unit accounting is used to value your account. For each fund in which you are invested, you own units. The number of units you have in a fund will change when you reallocate money between funds, contribute to a fund, or take a loan or distribution from your account. The value of each unit is called the net asset value (NAV). The NAV is determined as of the close of each business day for the New York Stock Exchange. The market value of your units in a fund is determined each night by multiplying the number of units you have in the fund by the NAV of the fund.

Your 401(k) Contributions

Pre-tax Contributions

You may contribute from 1% to 84% of your eligible earnings to the 401(k) plan on a pre-tax basis, up to annual Internal Revenue Service (IRS) limits. If you are 50 or older, or will be turning 50 during the plan year, you are eligible to contribute up to the catch-up contribution limit (see **Internal Revenue Service Contribution Limits** in the Appendix). Payroll will automatically stop your deductions at the appropriate limit, so you do not have to make a separate election to make a catch up contribution. You won't owe federal income taxes (or state income taxes in most areas) on your contributions and any earnings on them until you receive a distribution from the plan.

Although pre-tax 401(k) contributions reduce your taxable income, they won't affect your future Social Security benefits. That's because your 401(k) contributions are subject to Social Security taxes at the time of contribution.

Contributions are always made through payroll deductions. However, the plan does allow retroactive contributions following a *military leave.*

All of your pre-tax contributions, plus any related earnings or minus any losses are kept in your pre-tax account.

If you are a *full-time* employee, your eligible earnings are your hourly *base pay* multiplied by 80 hours if you are paid biweekly. If you are a *part-time* or *part-time plus* employee, eligible earnings are your regular straight-time hours times your regular hourly straight-time *base pay*.

Eligible earnings do not include temporary upgrade pay, overtime, shift differentials, bonuses, long term disability benefits, wage continuation, back pay, or any other special pay, fees or allowances over your usual *base pay*.

Roth Contributions

You may elect to make Roth contributions to your 401(k) account on a post-tax basis. You may contribute from 1% to 84% of your eligible earnings as Roth contributions, up to annual Internal Revenue Service (IRS) limits. If you are 50 or older, or will be turning 50 during the plan year, you are eligible to contribute up to the catch-up contribution limit (see **Internal Revenue Service Contribution Limits** in the Appendix). Payroll will automatically stop your deductions at the appropriate limit, so you do not have to make a separate election to make a catch up contribution. Your election will be irrevocable and will be made in lieu of all or a portion of the pre-tax contributions that you could otherwise make under the plan. Generally, Roth contributions and any earnings on those contributions (with the exception of EIX Stock Fund dividend payouts as discussed in How the Edison International Stock Fund Dividend Payout Option Works) are not subject to income taxes when you receive them, provided certain requirements are met (see Tax Information in this summary for further details).

Roth contributions and related earnings or losses are kept in your Roth account.

Other Post-Tax Contributions

If you contributed to the plan before January 1, 1984, you may have a post-tax 401(k) account separate from the Roth account. Those contributions were either deducted from your paychecks after income taxes were withheld or transferred from an old, terminated Employee Stock Ownership Plan.

If you have any post-tax contributions in the plan (other than Roth contributions), they are kept in a post-tax account (separate from the Roth account) along with any related earnings – which are allowed to build on a tax-deferred basis – or minus any losses.

Post-tax contributions made before January 1, 1984 are not subject to income taxes when you receive them. However, any investment earnings or losses will be subject to tax laws in effect at the time they are paid to you or your beneficiary.

Rollover Contributions

If you wish, you may transfer eligible distributions from a prior employer's qualified retirement plan, from a governmental 457 plan, from a 403(b) plan, or from an Individual Retirement Account (IRA) into this plan. This transfer is known as a rollover. You may make a rollover contribution even if you haven't started contributing to the plan. The sponsor or administrator of your prior plan or IRA must supply satisfactory evidence that your proposed rollover meets IRS requirements.

You may also roll over distributions of Roth contributions from another employer's retirement plan if it is a direct rollover. Roth rollovers will be kept in a separate Roth rollover account.

All rollover contributions are deposited in your pre-tax rollover account or Roth rollover account, respectively, and you direct how you want to invest them. Rollover contributions don't count toward annual IRS contribution limits. They are available for fund transfers, loans, and hardship withdrawals, as explained later in this summary.

If you leave the *company* and your 401(k) balance exceeds $5,000, you may roll over any lump sum distribution you receive from the *company's* Retirement Plan into the 401(k) plan.

To make a rollover contribution to the plan, obtain a 401(k) Savings Plan Rollover Request Form by calling or requesting the form online from the *EIX Benefits Connection.*

Contribution Escalation (Auto Save)

You can elect to have your pre-tax contribution rate automatically increased at any time through the *EIX Benefits Connection* by using Auto Save. Once your target rate is reached, your automatic increase election will end. You may elect to stop Auto Save any time through the *EIX Benefits Connection*. You cannot elect automatic escalation of your Roth (post-tax) contributions.

Company Contributions

The 401(k) Savings Plan allows your employer to make contributions to your 401(k) account. Participating employees are eligible to receive *company* matching contributions on some of their 401(k) savings.

You earn ownership of your *company* contributions and related earnings through *company* service over time. This is called vesting, which is described later in this summary.

Matching Contributions

The *company* will match some of the money you contribute to the plan. The *company* match is deposited in your *company* contribution account every pay period along with your own contributions. *Company* matching contributions do not apply to rollovers.

The amount that the *company* will contribute for your *company* and/or employee group is shown in a chart located in the **Appendix**.

Company Match True-Up

Employees are eligible for a *company* match true-up. The plan record keeper will make a special calculation each pay period to maximize the *company* match deposited to your account.

Here's how it works:

- Let's say you contribute 12% of eligible earnings from January through June and you are eligible to receive a *company* match on 6% of your annual eligible earnings.
- Let's also assume that a contribution of 12% of your eligible earnings for those six months equals 6% of your eligible earnings for the entire calendar year.
- Suppose that in July you stop your 401(k) contributions. However, since you had already contributed 6% of your annual eligible earnings for the year, the *company* match true-up will kick in. You will

continue receiving the *company* match each pay period until you have received the full match on 6% of your total eligible earnings for the year.

With this plan feature, employees who contribute more than 6% of their annual eligible earnings during the year will receive the full *company* match.

Annual IRS Contribution Limits

Each year, the IRS establishes an annual dollar limit on 401(k) contributions. If your contributions reach the dollar limit during the year, your contributions will automatically be suspended until the beginning of the following year.

Any *company* matching contributions will also be suspended until the beginning of the next year – unless you are eligible for the *company* match true-up described in this summary.

The IRS sets another limit each year on the total contributions that you and the *company* can contribute to your 401(k) account. See **Internal Revenue Service Contribution Limits** in the Appendix for these limits.

"Total contributions" for this purpose means your post-tax employee contributions, pre-tax employee contributions, and *company* matching contributions. It does not include any catch-up contributions, rollovers or earnings.

Each year the 401(k) plan is tested to see if your contributions plus *company* contributions exceed this legal limit. If they do, the excess with any associated investment earnings or losses for that plan year will be refunded to you as taxable income. Corresponding *company* matching contributions are forfeited and used to offset future *company* contributions.

The distribution of refunded excess contributions and earnings is taxable to you. If post-tax contributions are a portion of the refunded excess contributions, this portion of the distribution would not be taxable. However, distributions of Roth contributions may be taxable if certain conditions are not met (see Tax Information in this summary for further details).

Excess contributions are refunded in the following order:

- Unmatched post-tax contributions plus associated earnings or losses
- Unmatched Roth contributions plus associated earnings or losses
- Unmatched pre-tax contributions plus associated earnings or losses
- Matched post-tax contributions plus associated earnings or losses. Any matching contributions plus associated earnings or losses are forfeited to the plan and used to offset future *company* contributions
- Matched pre-tax contributions. Any matching contributions are forfeited to the plan and used to offset future *company* contributions
- Matched Roth contributions. Any matching contributions are forfeited to the plan and used to offset future *company* contributions

Vesting

Vesting means earning a nonforfeitable right to collect what's in your account. You're always fully vested in contributions you make to your account and their earnings. This includes any rollover contributions.

You become 100% vested in your *company* contributions at a rate of 20% for each *year of service* up to five years. You may become 100% vested before you have five years of vesting service if one of the following events occurs while you are an active employee:

- You reach age 65 (the Normal Retirement Age under the plan is the first of the month in which you attain age 65)
- You are declared permanently and totally disabled
- You die

When you leave the *company* for any reason, you are entitled to receive the amount of vested funds in your *company* contributions account.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

How You Earn Vesting Service

You earn a year of vesting service each calendar year in which you complete 1,000 *hours of service*. You get credit for 190 *hours of service* for each month in which you work at least one hour. Generally you will earn 1,000 hours if you work six months in a calendar year. In addition, your vesting service includes periods during which you are on a *military leave of absence.*

For example: If you joined the company *on July 31, 2002, and you worked at least one hour each month for the rest of the calendar year, you would earn one year of vesting service for calendar year 2002. If you continue to work at least one hour each month, you would complete five years of vesting service on June 1, 2006.*

Vesting Schedule for *Company* Contributions and Any Related Earnings	
Vesting Service	**Vested Percentage**
Less than one year	0%
One year	20%
Two years	40%
Three years	60%
Four years	80%
Five or more years	100%

Break in Service

You incur a break in service when you complete less than 501 *hours of service* in a calendar year. Solely for purposes of preventing a break in service, no more than 501 *hours of service* will be credited for absences due to disability or maternity or paternity reasons.

Special Vesting Rules for Certain Employees

If you are classified as a *leased* employee or *contingent worker*, you may not participate in the 401(k) Savings Plan. However, if you later become an eligible employee, you may be granted service credit for eligibility and vesting purposes under the terms of the plan if:

- You had worked at the *company* through a purchase order or indirectly through an agency, and
- You were under the direct supervision and control of *company* management after January 1, 1984

Other special vesting rules apply to transferred employees of certain acquired companies. See the **Appendix** at the end of this summary for details.

Investment Options

You choose how the assets in your 401(k) accounts are invested. The plan's recently redesigned investment options provide a range of investment risks and rewards for you to choose from to help meet your unique financial needs and investment style.

The plan offers 19 investment options which are grouped into three tiers: Tier 1 - Target Date Funds; Tier 2 - Seven Core Funds and the EIX Stock Fund; and Tier 3 - Self-Directed Brokerage Account. You can choose investment options from a single tier or a combination of tiers.

Tier 1: Target Date Funds — Ten Target Date Funds are available. These funds are designed for 401(k) investors looking to achieve a diversified portfolio by investing in one stand-alone fund. Each of the Target Date Funds is built from a combination of the Tier 2 Core Funds. The mix of Core Funds for each is professionally monitored by AllianceBernstein, an investment management firm, becoming more conservative over time as the Fund approaches its target date. Additional information regarding these Funds is included in Exhibit A.

Tier 2: Core Funds and the Edison International (EIX) Stock Fund — Tier 2 is made up of seven funds plus the EIX Stock Fund. The Tier 2 funds are designed to appeal to investors who have some experience investing and wish to build their own diversified portfolio from a variety of funds selected for the plan, representing a range of asset classes with varying degrees of risk and return. . The seven Core Funds are the Money Market Fund, Treasury Inflation Protected Securities Fund, Bond Fund, U.S. Stock Index Fund, U.S. Large Company Stock Fund, U.S. Small-Medium Company Stock Fund, and the International Stock Fund. Descriptions of these funds are in Appendix A.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Tier 3: Self-Directed Brokerage Account — With a Self-Directed Brokerage Account, you can invest in thousands of publicly traded securities, including equities, mutual funds, fixed income products, exchange-traded funds, real estate investment trusts, and taxable unit investment trusts. This account is designed for investors who have a good understanding of the general principles of investing and want the flexibility to access a large number of investment options, including individual equities, mutual funds and fixed income products. For more information about the options available through the Self-Directed Brokerage Account, visit the Self-Directed Brokerage Account website through the *EIX Benefits Connection* at www.eixbenefits.com. You can also find fee information about the Self Directed Brokerage Account by visiting the Self-Directed Brokerage Account website through the *EIX Benefits Connection*.

If you elect to make a combination of pre-tax and Roth contributions, your investment selection will apply to both your pre-tax and Roth accounts. You may not select a different investment allocation for your pre-tax and Roth accounts.

Choosing Your Investments

Employees receive investment education materials in their enrollment kits when they are first eligible. You should also refer to the Prospectus Supplement at the end of this summary for more detailed information on the investment options. You can call the *EIX Benefits Connection* and speak with a representative to request information about the various funds. The *company* will periodically provide additional investment education materials.

You can access investment education information and monitor your investment performance by logging on to www.eixbenefits.com. This website will enable you to see an online summary of your account, to reallocate your money, to change your contribution rate, or to model a loan.

If you need help with your investment decisions, review these materials carefully. This information is designed to help you learn about your investment options and assist you with your investment decisions.

If you aren't a sophisticated investor, it's a good idea to seek the guidance of a competent, independent professional financial planner or investment advisor. Your personal financial planner or investment advisor can help you determine the level of investment risk that's appropriate for your financial situation.

Employees have access to Financial Engines which offers you tools and services to manage your investments. Financial Engines offers both Online Advice (no charge to you) and Professional Management (for a fee).

If you're a do-it-yourself investor, access Online Advice through the *EIX Benefits Connection* at www.eixbenefits.com.

If you prefer to partner with an expert who will do the work for you, the Professional Management program is a personalized, discretionary asset management program being made available to plan participants who want to delegate investment management of their 401(k) accounts to professionals. This program offers the following:

Customized portfolios
Ability to personalize for risk, retirement age and consider outside retirement accounts
Ongoing management and regular monitoring of member accounts
Quarterly printed retirement updates
Access to investment advisor representatives

If you're interested in having Financial Engines manage your account for you, you'll pay a quarterly fee that comes to about $4 a month for each $10,000 of your account balance. Plus, there are discounts for balances above $100,000. You can cancel at any time.

However, this access does not constitute a recommendation by the *company* that you use Financial Engines for your investment advisor. In addition, your reliance on any opinions, statements, recommendations or other information provided by Financial Engines will be at your sole risk, and the *company* is not liable for any loss or damages resulting from such reliance.

Investing in the Edison International Stock Fund

The Edison International Stock Fund (EIX Stock Fund) is an Employee Stock Ownership Plan, or ESOP. Like other funds in the plan, the EIX Stock Fund has an investment objective. However, the EIX Stock Fund is unique because it is designed to invest primarily in Edison International common stock.

Generally, most of the assets of the EIX Stock Fund are invested in Edison International common stock. However, some assets are held in cash to meet day-to-day cash needs like loans and withdrawals, and to provide an appropriate level of liquidity to meet the EIX Stock Fund's ongoing daily cash outflow requirements.

If you invest in the EIX Stock Fund, you don't actually own shares of Edison International stock. The fund owns the shares. You own a portion — or "units" — of the fund. So, when it's time to vote on shareholder issues, you don't actually vote shares. You tell the plan's trustee how you want your portion of the fund voted, and the trustee votes the appropriate number of shares according to your election. If you don't return a proxy directing the trustee how to vote your portion of the fund, the trustee will generally vote your portion of the fund in the same proportion as the votes cast on behalf of participants who do provide timely proxy voting directions to the trustee.

The price the plan uses for the EIX Stock Fund will vary from the closing New York Stock Exchange (NYSE) price of Edison International stock as listed in newspapers. Generally, that's because the fund price used by the plan is based on the actual closing NYSE price and the value of cash holdings in the EIX Stock Fund, while the Edison International stock price listed in newspapers is a composite price that also includes late-posting trades, settlements, and adjustments.

If you invest in the EIX Stock Fund, dividends that are declared and paid by Edison International will be reinvested in your account to purchase more units in the fund unless you elect to have your dividends paid to you directly.

Dividends on Edison International common stock are declared by the Edison International Board of Directors at its discretion and subject to the financial condition of the *company*.

How the Edison International Stock Fund Dividend Payout Option Works

The dividend payout option can be offered because the EIX Stock Fund is an Employee Stock Ownership Plan, or ESOP (the dividend payout option is not permissible for other funds in the plan). If you choose the dividend payout option as described below, you can have the Edison International dividends allocated to the vested units in your account paid directly to you. Dividends allocated to non-vested units will continue to be reinvested in your account. Dividends are only paid or reinvested if Edison International declares and pays a common stock dividend.

You can choose to receive 25%, 50%, 75% or 100% of the dividends as a direct payment to you and reinvest the balance in the plan. Dividends are paid out only in amounts greater than $10. Smaller amounts are automatically reinvested, regardless of your payout election.

If you are eligible, the EIX Stock Fund dividend payout option gives you more flexibility in managing your finances. However, reinvesting your dividends can be a valuable part of the long-term growth in your plan account. Returns quoted for the EIX Stock Fund include dividends, so getting a payout check reduces the potential return of your plan account. The tax and investment considerations involved in your decision can be complicated. It may be appropriate to consult with a tax advisor or financial planner to fully explore and understand all of your options.

- When you enroll in the plan and elect to invest a portion of your account in the Edison International Stock Fund, your dividends will automatically be reinvested in your account to purchase more units in the fund.
- If you don't want all of your dividends reinvested, you may have some or all of them paid to you in cash (by check). To make this election, call the *EIX Benefits Connection*, or update your election on the *EIX Benefits Connection* Web site. Follow the instructions to specify the percentage of your dividends attributable to vested shares of Edison International stock you want to receive in cash (25%, 50%, 75% or 100%). If you select less than 100%, the remainder will automatically be reinvested in the fund. Once you make an election to have some or all of your dividends paid to you, it will remain in effect until you change it. The dividend payout is taxable to you and will be reported on a Form 1099-DIV. No taxes are withheld from the dividend payout, so you should be careful to assure you have sufficient withholding from other sources or make estimated tax payments to avoid tax penalties.
- You can change your dividend election at any time. To make a new election, call the *EIX Benefits Connection*, or update your election on the *EIX Benefits Connection* Web site, before the dividend election cutoff date described below.

The dividends paid out are deducted from your vested balance in the Edison International Stock Fund. In order to receive the pay out, you must be invested in the Edison International Stock Fund at 1 p.m. Pacific time (or, if

earlier, the close of the New York Stock Exchange) on the business day before the ex-dividend date described below and have a balance in the fund on the dividend payable date described below.

Because you own units of a fund that invests in EIX stock and cash, calculating the dividend payable to you is **not** as simple as using the publicly announced dividend rate on EIX stock and multiplying that rate by your fund balance. The fund must calculate a dividend allocation factor to calculate dividends payable to individual investors.

The total dividend payout for all shares of EIX stock owned by the fund is determined first, and then allocated among fund investors based on the number of units each investor holds.

Key Dates Affecting Investments in the Edison International Stock Fund (EIX Stock Fund) in the 401(k) Savings Plan*

Key Date	Description
Transaction date	• Participants who are invested in the EIX Stock Fund at 1 p.m. Pacific time (or, if earlier, the close of the New York Stock Exchange) on the business day before the ex-dividend date are eligible for dividends, if any are declared
Ex-dividend date	• Two business days preceding the record date. This is the date used to determine the amount of dividends to be credited to a participants account
Record date	• The date specified by Edison International; generally, the last business day of the calendar quarter
Dividend election cutoff date	• Ex-dividend date • Dividend payout/reinvestment elections must be made by 1 p.m. Pacific time (or, if earlier, the close of the New York Stock Exchange) on the dividend election cutoff date
Dividend payable date	• The date specified by Edison International; generally the last business day of the first month following quarter end • The date dividends are credited to participant accounts • If you have elected to have your dividends paid out to you, they will be deducted from your account on this date
Dividend checks mailed to you or directly deposited to your account	• Dividend payouts are scheduled to be mailed five to ten business days following the dividend payable date. However, the latest allowable mailing date under the plan document is 90 days following the close of the plan year

* Record dates and payment dates are determined by the EIX Board of Directors if and when dividends are declared. The *company* and the plan do not make or endorse any predictions as to future dividends, nor is the schedule to be considered material for soliciting the purchase or sale of Edison International common stock or investment in or transfer out of the Edison International Stock Fund.

Insider Information

Investors who possess material, nonpublic information about the Edison International *companies* when they provide instructions to take investment action regarding Edison International Common Stock, or assist others in doing so, are subject to penalties. This applies to purchases and sales of Edison International stock within the 401(k) plan, including through diversification, loans, and dividend reinvestment. Penalties could include a:

- Criminal fine of up to $5 million
- Jail term of up to twenty years
- Civil penalty of up to three times the profit gained or loss avoided

If you possess material, inside information, you are prohibited from making changes in your 401(k) elections that affect the Edison International Stock Fund balance until one full trade day has passed after disclosure of that information. Also, most officers can make such changes only during open trading windows, and certain officers are required to preclear such changes at any time through the Clearance Officer as described in the Edison International Companies' Insider Trading Policy. The Insider Trading Policy further describes the types and timing of restricted and prohibited transactions.

Account Statements

You can get your current account balance — updated nightly — through the *EIX Benefits Connection* — either by phone, (866) 693-4947, or over the Internet at www.eixbenefits.com. You may also generate a Dynamic Online Statement for any date, or range of dates, and print off the statement or save it to your personal computer.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

A few weeks after the end of each calendar quarter, a quarterly account statement is available on-line, and within a few weeks after the end of each year, you will receive a written annual statement of your account. Both the quarterly and annual statements will show the contributions and investment results for the previous calendar quarter's or year's fund transfers, rollovers, loan repayments and loan balances, withdrawals during the quarter or year, and the value of your account at the end of that quarter or year.

Loans

Borrowing money from your Edison 401(k) Savings Plan account may be an attractive alternative to taking a withdrawal. A plan loan lets you use your savings without the usual withdrawal restrictions or tax penalties. While loans may have a negative effect on your account balance, they allow you to use some of your 401(k) assets without completely sacrificing your long-term savings.

The plan offers two types of loans: general purpose and residential. Key features of each are summarized in the following chart.

Loan Feature	General Purpose Loan	Residential Loan
Reason for loan	Any reason	Only for purchase of your primary residence
Deadline for loan request	None	No later than 90 days after escrow opens and 30 days after it closes
Required documentation	None	Copy of escrow papers or purchase contract signed by buyer and seller
Maximum repayment amount	No more than 25% of *base pay* per pay period	The amount of your take-home pay on either of your last two paychecks preceding your loan request
Repayment period	12 to 48 months (one to four years)	12 to 180 months (one to 15 years)
Number of loans allowed at a time	Two overall — if you don't have a residential loan; or you may have one general purpose loan and one residential loan	One — If you currently have two general purpose loans, you must pay one loan off before you can take out a residential loan
Number of loans allowed in a calendar year	You may not take out more than one loan in a calendar year regardless if it is a general purpose or residential loan	You may not take out more than one loan in a calendar year regardless if it is a general purpose or residential loan

Who is Eligible for 401(k) Loans

To be eligible to take a loan, you must:

- Have a vested 401(k) account balance of at least $2,000
- Be an active *full-time*, *part-time* or *part-time plus* employee, a disabled employee or an employee on a leave of absence

Special **loan eligibility rules** in the Appendix at the end of this summary apply to transferred employees of certain acquired companies

How Much You Can Borrow

You can borrow any amount between $1,000 and $50,000 — but no more than the lesser of the following two amounts:

- 50% of your vested account balance
- $50,000 minus your highest outstanding loan balance in the past 12 months

The amount you can borrow is also limited by your ability to make repayments. Your loan repayment for a residential loan cannot exceed the amount of take-home pay you have on either of your last two paychecks immediately preceding your loan request. For a general purpose loan, your loan repayment amount each pay period can't be more than 25% of your *base pay* per pay period.

Loans are taken proportionately from all available investment funds in your account in the following order: Roth contributions, post-tax (made before January 1, 1984), Roth rollover, pre-tax rollover, pre-tax, and *company* match. Money invested within the Self-Directed Brokerage Account is eligible for, but not immediately available for, loans. To maximize the amount of your account available for a loan you may need to liquidate your brokerage account holdings and transfer those assets back into Tier 1 or Tier 2 funds.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Interest Rates

The interest you pay on your loan will be credited back to your 401(k) account along with your loan repayments. It is not deductible for federal or state income tax purposes.

The interest rate charged for a loan is the prime rate on the first business day of the month in which the loan is applied for, plus 1% (rounded down to the nearest quarter percent). The rate established for each loan is fixed. Except with regard to participants who go on *military leave*, the rate will not change for the duration of the loan.

Applying for a Loan

You can apply for a loan over the phone or online through the *EIX Benefits Connection*. When you call or log on, simply follow the voice or screen instructions. After you make a loan request and accept the terms, a loan package will be mailed to your home address.

General Purpose Loan Procedures

If you have requested a general purpose loan, your loan package will contain a Confirmation of General Purpose Loan Request and a Promissory Note and Disclosure Statement. File these documents with your financial records. No further action on your part is required.

The Promissory Note and Disclosure Statement explains the terms of your loan in full detail–including repayment grace periods and default conditions.

If you chose to have your loan proceeds directly deposited into your personal bank account, you may agree to receive a paper copy of the Promissory Note and Disclosure Statement for the loan you have requested after your loan proceeds are transferred from your 401(k) account to your selected financial institution. A paper copy will be mailed to you within two to three business days after your loan request is approved and processed, and your loan proceeds will probably have been direct deposited to your checking or savings account by the time your receive the paper copy.

Residential Loan Procedures

If you have requested a residential loan, your loan package will contain a Confirmation of Residential Loan Request (which is your loan application) and a Promissory Note and Disclosure Statement. You must return the loan application with required supporting documents substantiating the loan amount before your loan can be approved. Required supporting documents include:

- A purchase agreement or escrow instructions signed by the buyer and seller
- A "good faith estimate" if your requested loan amount includes closing costs

Residential loans must be for the purchase of your primary residence. If you don't return your residential loan application with supporting documents within 30 days of the date you requested the loan, your loan request will be canceled. You may choose to have your loan proceeds directly deposited into your personal bank account.

Timing of Loan Transactions

The normal turnaround time for receiving a loan is summarized in the following chart. Actual timing may vary, however, if procedures aren't properly followed (for example, if your residential loan documentation is incomplete or if you forget to sign your residential loan application).

Transaction	General Purpose Loans	Residential Loans
When a loan is approved	As soon as you accept the loan terms	Within two business days after the loan application and all required supporting documents are received
When a 401(k) account is reduced by the loan amount	Same day as request, if made by 1:00 p.m.* Pacific time on a business day**; otherwise next business day**	Same day as approval, if approved by 1:00 p.m.* Pacific time on a business day**; otherwise next business day**
When loan checks are mailed	Within three business days of loan approval date	Within three business days of loan approval date
When your personal bank account is credited if you choose direct deposit	Within three business days following your acceptance of the loan, if accepted by 1:00 p.m.* Pacific time on a business day**; otherwise four business days**	Within three business days following approval of the loan, if approved by 1:00 p.m.* Pacific time on a business day**; otherwise four business days**

* The stock market normally closes at 1:00 p.m. Pacific time. If the market closes prior to 1:00 p.m., loan funding will not occur until the next business day the market is open. "Stock market" refers to the New York Stock Exchange

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

** This assumes the stock market is open.

Repaying Your Loan

While you're an active employee, your loan repayments will be deducted from your paychecks on a post-tax basis. The principal and interest will be reinvested in your 401(k) account in the same fund(s) you selected in your most recent investment election for your future contributions.

Loan repayments are deposited in the following order to your 401(k) accounts: *company* match, pre-tax, pre-tax rollover, Roth rollover, post-tax and Roth.

Early Payoff Procedures

You can repay the full outstanding balance of your loan at any time. To request an early loan payoff, call or log on to the *EIX Benefits Connection*. When you request an early loan payoff:

- Payroll deductions continue until your loan payoff posting date
- Interest continues to accrue

Here's what happens next:

1. You will receive an Early Loan Payoff Invoice approximately seven to 10 business days after you first requested an early loan payoff. The invoice projects two different payoff amounts into the future. These payoff amounts assume that you will continue to have regular payroll repayments. You decide which payoff amount to submit based on the date on which you will pay off the loan. It also provides payoff instructions.
2. You will need a cashier's check or money order to pay off your loan early. If you send a personal check, it will be returned to you.
3. Your cashier's check or money order must be received at least six business days before the projected payoff date to ensure processing by that Friday.
4. If you don't pay off your loan by the last projected payoff date, no action is required by you. Your loan repayments will continue to be deducted from your paychecks.

Loan Default

A loan is considered to be in default if you do not make the scheduled repayments before the applicable grace period. Your loan will be in default if any of the following situations occur:

- You miss seven loan repayments (if paid biweekly)
- You still have an unpaid balance at the end of the maximum loan term
- You do not repay your loan within 60 days from your employment termination date unless you are eligible for and elect loan continuation within 30 days from your employment termination date (also known as a loan foreclosure)

When a loan is considered to be in default, the outstanding balance becomes immediately due and payable by the end of the month in which the default occurs. If the balance is not paid, it is considered a taxable distribution subject to ordinary income taxes plus possible early withdrawal tax penalties.

Failure to repay a loan while actively employed is called a "default." Failure to repay a loan after separation from service is called a "foreclosure." When a loan default or foreclosure occurs, the outstanding balance is considered a taxable distribution subject to ordinary income taxes plus any applicable early distribution penalties.

Under IRS regulations, a taxed loan (a loan that has defaulted and been reported as a taxable distribution) is still considered an outstanding loan from your 401(k) account. The amount available for future loans will be reduced by the amount of any taxed loans you have not repaid to your account. A taxed loan also counts toward the two-loan maximum limit.

You can repay a taxed loan including any accrued interest on an after-tax basis, but your repayments won't reverse the taxable event already reported to the IRS. Paying off a taxed loan will, however, increase the amount available to you for a future 401(k) loan. Also, any earnings on the repaid loan amount accumulate tax-deferred until they are distributed to you.

Situations Affecting Loans

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

There may be situations that could affect your ability to request a loan or to make scheduled loan repayments. The following chart summarizes loan repayment procedures in certain situations. See the **Events Affecting Your Benefits** section for other situations that may affect your participant loan.

If you...	This will happen...
Have insufficient funds in your pay check to make your loan repayment but are not on an approved leave of absence Do not make your scheduled loan repayment while on loan continuation	• Partial loan repayments cannot be accepted • You will generally receive a notice regarding your missed loan repayments that will explain how to make manual payments to make up the missed payment(s) and avoid default • Your loan will default and be reported to the IRS as a taxable distribution once you have missed seven biweekly loan repayments (see Loan Default section). To avoid a loan default, you may make manual payments. You may also select electronic loan direct debit. This means you may request to have your personal account deducted on a monthly basis on either the 10th or 15th of the month. Refer to the notice described above or speak with an *EIX Benefits Connection* representative for details
Have insufficient funds in your pay check to make your loan repayment and are on an approved leave of absence Go on an unpaid Personal or Family Leave of Absence	• Your loan repayments will stop and may be suspended for up to 12 months • If you return from the leave within 12 months, your loan will be re-amortized (using the new loan end date) to include the missed payments and the interest that accrued during the suspension of loan payments • If you don't return from the leave within 12 months, your loan will default and be reported to the IRS as a taxable distribution unless you repay the loan by the end of the 12 month period. To avoid default, you may make manual payments. You will generally receive a notice that will explain how to make manual payments to avoid default. You can also ask an *EIX Benefits Connection* representative for details

Go on a *Military Leave of Absence*	• Your loan repayments will stop and will be suspended for the period of your leave
	• Interest will continue to accrue, but at no more than 6%
	• When you return from the leave, your loan will be re-amortized using the original interest rate. The end date of the re-amortized loan will be set so that you will have the same amount of time remaining on your loan as you had when you went on your leave. *For example, suppose when your leave began you had 36 loan repayments left to pay. When you return, your re-amortized loan would provide for 36 payments to pay off your loan*
	• If you don't return from the leave and terminate employment, your loan will be immediately due and payable, and:
	  ◦ You must pay the balance within 60 days from the date of your separation
	  ◦ If you don't repay your loan by the end of the specified period, your loan will be foreclosed and reported to the IRS as a taxable distribution

Retire after attaining age 55 with five *years of service* Leave the *company* under a special *company* retirement program that provides for loan continuation Leave the *company* under a special *company* separation program that provides for loan continuation	• Unless you elect loan continuation within 30 days of separation or repay your outstanding loan balance, the loan will be foreclosed 60 days after your separation date • If you elect loan continuation, you must continue to make your scheduled loan repayments (see the **Loan Continuation** section) • If you request a lump sum distribution from the plan, your unpaid loan balance will be deducted from your distribution and counted for tax reporting and withholding purposes • To pay off your loan or elect loan continuation, speak with an *EIX Benefits Connection* representative
Leave the *company* for any other reason than listed above	• Any outstanding loans will become immediately due and payable • Within 60 days from your date of separation, any unpaid loan balance will foreclose and be reported to the IRS as a taxable distribution • If you request a lump sum distribution from the plan, your unpaid loan balance will be deducted from your distribution and counted for tax reporting and withholding purposes • To avoid a loan default, you may pay off your loan. You can ask an *EIX Benefits Connection* representative for details

Loan Continuation

If you leave the *company* under any one of the following circumstances, you may elect to continue your scheduled loan repayments under the loan continuation feature of the plan:

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- You retire under a *company* retirement program that provides for loan continuation
- You are involuntarily terminated under a *company* separation program that provides for loan continuation

To qualify for a loan continuation, you must maintain a 401(k) account balance equal to the amount of the outstanding loan balance or $5,000 whichever is greater. You may not continue loan repayments if you request a total distribution of your account balance.

You must request loan continuation within 30 days after your separation date by calling the *EIX Benefits Connection*.

You will receive a repayment schedule along with payment coupons approximately two weeks after you request the loan continuation.

You may also select electronic loan direct debit. This means you may request to have your personal account deducted on a monthly basis on either the 10th or 15th of the month. Enrollment in the Electronic Loan Repayment Program remains in effect as long as you are in an eligible status, or until you choose to cancel enrollment.

You will be responsible for making the loan repayments as scheduled. Your loan will default if you miss seven biweekly repayments.

Currently there are no transaction fees charged for loans. However the *company* has the right to establish transaction fees in the future.

Withdrawals While Actively Employed

You may withdraw part or all of the funds in your pre-January 1, 1984 post-tax contributions account (if any) before you leave the *company*.

Under certain hardship conditions, you may also withdraw money from your pre-tax contributions account, Roth account, Roth rollover account and rollover account while you're an employee.

Generally, while you are employed by the *company*, you may not withdraw any money from your *company* matching contributions account, or from any post-1988 dividends and earnings on your pre-tax contributions or earnings on Roth contributions.

However, if you have reached age 59½, you may withdraw up to your entire vested account balance, less your outstanding loan balance, in a single lump sum. The minimum in-service withdrawal amount is $1,000. In-service withdrawals are taken proportionately from all investment funds in your account in the following order: post-tax, Roth rollover, rollover, Roth, pre-tax and *company* match.

You can make a withdrawal as often as once each quarter through the *EIX Benefits Connection*.

Cash withdrawals will be taken proportionately from all available investment funds in your account in the following order: post-tax, Roth rollover, rollover, Roth, pre-tax, *company* match.

If you are eligible, you may also receive distributions partially or wholly in Edison International Stock, to the extent that your account balance is invested in the Edison International Stock Fund In order to receive the pay out, you must have a balance in the fund when distribution occurs. If you transfer money out of the EIX Stock Fund before the distribution, those amounts may only be distributed in cash.

The following chart shows which 401(k) assets you are allowed to withdraw.

Source of 401(k) Assets	Amount Available for Withdrawal*
Post-tax contributions made prior to January 1, 1984	Part or all
Roth contributions and Roth rollovers	Amount needed to satisfy approved financial hardship or age 59½ in-service withdrawals
Pre-tax contributions and related pre-1989 investment earnings, and rollovers and related investment earnings	Amount needed to satisfy approved financial hardship or age 59½ in-service withdrawals
Post-1988 investment earnings on pre-tax contributions	Age 59½ in-service withdrawals
Investment earnings on Roth contributions and Roth rollovers	Age 59½ in-service withdrawals
Company matching contributions and related earnings	Age 59½ in-service withdrawals

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

* **Special rules** in the Appendix at the end of this summary apply to transferred employees of certain acquired companies.

Withdrawing Post-tax Contributions

If you have a post-tax account attributable to contributions made before January 1, 1984, and you have not reached age 59½, you may withdraw part or all of the available funds in your account for any reason. Your withdrawal must be for at least the lesser of:

- $500
- The total post-tax account balance

Post-tax withdrawals are paid in cash or stock. For example, a withdrawal can be paid out in shares of *company* stock if the account value is invested in Edison International Common Stock.

If you have reached age 59½, post-tax contributions are available for in-service withdrawals as described above.

Special withdrawal rules in the Appendix at the end of this summary apply to transferred employees of certain acquired companies.

Hardship Withdrawals

In exchange for the advantages of deferring taxation on amounts contributed to the plan and the related earnings, the IRS only allows withdrawals of pre-tax, Roth, Roth rollover and rollover contributions for financial hardship reasons when no other resources are available. Withdrawals of post-1988 investment earnings on your pre-tax account, investment earnings on your Roth or Roth rollover accounts and *company* contributions and related earnings aren't allowed.

If you request and receive a hardship withdrawal, your pre-tax and Roth contributions to this plan will be discontinued for six months following receipt of the hardship withdrawal. You also may not make contributions to any other plan for the six months following receipt of the hardship withdrawal.

In deciding whether to grant a hardship withdrawal, the plan administrator will rely on the representation from the participant that the need cannot be met from other resources—unless the *company* has actual knowledge to the contrary. The expense must be unpaid, unreimbursed, and cannot be financed. A hardship request cannot be granted if the expense could be addressed by stopping contributions to the plan or by obtaining a distribution (other than a hardship withdrawal) or a loan from this plan or any other plan (of the company or any other employer). The following items are examples of expenses that do not qualify for financial hardship because the expense was met through other resources:

- A request to repay a relative or another individual who has provided a loan to purchase your primary residence
- A credit card bill used to pay for an unreimbursable medical expense
- A request to pay tuition that had been funded by a student loan

The total amount available for a hardship withdrawal is limited to whichever of the following amounts is less:

- The amount of pre-tax, Roth, Roth rollover and rollover contributions available in your account
- The amount needed to meet your financial hardship need plus up to 50% of the approved hardship amount to cover any taxes and early withdrawal penalties that may apply

If post-tax funds are available in your account, those funds will automatically be withdrawn first; then funds will be taken from your Roth rollover account; and then your rollover account; and then your Roth account; and then the balance of your withdrawal will be taken from your pre-tax account. You may make a hardship withdrawal only to cover the following expenses:

- Unreimbursed medical expenses and expenses necessary to secure medical care for you, your primary beneficiary, or your other eligible dependents
- Payment of tuition and related educational fees (including room and board expenses, but excluding cost of books, supplies, uniforms, student activity fees) for the next 12 months of post-secondary education for you, your primary beneficiary, or other eligible dependents
- The initial purchase of your principal residence (down payment and closing costs, but not mortgage payments). Whether a property qualifies as a principal residence will be determined in accordance with IRS requirements and guidance. Generally speaking, a principal residence is one that you intend to presently occupy on a regular basis after purchase
- Payments necessary to prevent your eviction from or the foreclosure on your principal residence

Dependents and Primary Beneficiaries

For purposes of hardship withdrawals under this plan, a dependent is any person you claim as an exemption on your federal income tax return (or who you could claim as an exemption if their earnings didn't exceed the IRS earnings limitation, if they didn't file a joint tax return with their *spouse*, or if you weren't treated as a dependent by another taxpayer). Your primary beneficiaries are those individuals (including but not limited to your *spouse*, *domestic partner*, *registered domestic partner*, *same-sex spouse*, or dependents) who you have designated or who are otherwise recognized as such under this plan.

Requesting a Withdrawal

You can request withdrawals by calling the *EIX Benefits Connection*. Withdrawal of your post-tax contributions (excluding Roth contributions) is done over the telephone and no form is required. For a hardship withdrawal, you must request a form by calling the *EIX Benefits Connection* or you may request the form online. Your completed form along with any required documentation must be returned to the *EIX Benefits Connection*. You will be notified within five days after your paperwork is received whether your hardship withdrawal request is approved or denied.

Transaction	Timing

Withdrawal of:
• Post-tax contributions
• Approved hardship withdrawals
• Age 59½ in-service withdrawals
	If your request is approved before 1:00 p.m. Pacific time:
	• Withdrawal is made the same day (if stock market is open)
	• Check is mailed within three business days
	• If transaction is approved after the stock market closes:
	  • Withdrawal is made the next business day
	  • Check is mailed within three business days

Special rules in the Appendix at the end of this summary apply to transferred employees of certain acquired companies.

You cannot take a loan or age 59½ in-service withdrawal and hardship withdrawal on the same date. You should speak with a representative to determine the order in which you should conduct these transactions. The order in which these transactions occur will affect the available amounts. Money invested within the Self-Directed Brokerage Account is eligible for, but not immediately available for, withdrawal. To maximize the amount of your account available for withdrawal, you may need to liquidate your brokerage account holdings and transfer those assets back into the Tier 1 and Tier 2 funds.

Distributions

When You Leave the *Company* (After Separation from Service)

If the value of your vested account balance when you leave the *company* is less than or equal to $1,000, it will automatically be paid directly to you in a single lump sum, subject to mandatory withholding, unless you elect to have your vested account balance rolled over to an individual retirement account (IRA) or another eligible retirement plan.

If the value of your vested account balance when you leave the *company* is greater than $1,000, but less than or equal to $5,000, and you do not elect otherwise, your vested account balance will be automatically rolled over to an IRA in your name designated by the *company*. Your pre-tax account and Roth (and Roth rollover) account are treated separately to determine if your vested account exceeds $1,000. If your vested account balance is automatically rolled over, you will be able to subsequently roll over the funds from the automatic rollover IRA to another IRA of your choice.

The current automatic rollover IRA provider will place rolled over balances from the plan in a money market account insured by the Federal Deposit Insurance Corporation (FDIC).

The *company* reserves the right to select another IRA provider or another investment product for automatic rollovers. Any investment product selected for this purpose will be designed to preserve principal and provide a reasonable rate of return and liquidity. If your vested account balance is automatically rolled over, you will bear the cost of any fees and expenses associated with the automatic rollover IRA.

For additional information regarding the automatic rollover IRA provider and the fees and expenses associated with the automatic rollover IRA, or if you have other questions regarding automatic rollovers from the plan, please contact the *EIX Benefits Connection* at (866) 693-4947.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If the value of your vested account balance is $5,000 or greater, you may choose one of the following distribution options:

Deferred distribution	Leave all of your 401(k) assets in the plan and defer your distribution until a later date, but no later than age 70**½**
Total lump sum distribution	Receive all of your plan assets shortly after you leave the *company*

If you wish to take a distribution, you can call the *EIX Benefits Connection* and speak to a representative, or you may make the request online.

Deferred Distributions

You must start receiving distributions by the end of the year in which you reach age 70½. Unless you have elected an earlier payment date, your entire account balance will be paid to you in a lump sum at the end of the year in which you reach age 70½.

Lump-Sum Distributions

You can elect a lump-sum distribution to be paid to you in any of the following forms:

- In cash (by check)
- As shares of Edison International Common Stock
- In a combination of cash and Edison International Common Stock

Stock distributions are limited to the amount of stock invested in your account on the date your distribution is processed.

You may also elect to have your lump-sum distribution paid directly as a:

- Rollover to another qualified plan
- Rollover to an IRA
- Rollover to a Roth IRA (if eligible)

Other employers' qualified defined benefit or defined contribution plans, such as a 401(k), 403(b), 457, profit sharing, or money purchase pension plan, may accept rollovers from the Edison 401(k) Savings Plan, but they are not required to do so. You should check with the plan's sponsor before electing a rollover.

Distributions for Permanent and Total Disability (PTD)

If you are declared *permanently and totally disabled* by the Benefits Committee while you are an active employee, you will be eligible to receive a lump sum distribution of your 401(k) account. However, your Comprehensive Disability Plan (CDP), any *company* short-term disability plan, California State Disability Insurance (SDI), or other state disability benefits must be exhausted before you can receive the distribution. If you are not fully vested, you will also become 100% vested in your *company* contributions account. If you meet the eligibility criteria for a PTD distribution, you will receive a notice explaining the details.

Administrative Holds

If the plan receives a written notice of adverse interest in which your *spouse*, former *spouse*, or dependent claims an interest in your 401(k) Savings Plan benefit or any written documentation of a divorce whether pending or final, an administrative hold will be placed on your account. An administrative hold will prevent you from receiving any type of payment, loan, withdrawal, or distribution from the plan until the claim is settled. In the meantime, however, you may change your investment elections, make fund transfers, and change your contribution rate if you wish.

Benefits Payable Under a Qualified Domestic Relations Order (QDRO)

A Qualified Domestic Relations Order (QDRO) is a court order due to divorce or legal separation and is only used to divide marital property or provide child support or alimony payments. Many states consider 401(k) plan benefits accrued during marriage to be divisible marital property, so the 401(k) Savings Plan benefit an employee accrues during the term of marriage can be considered divisible property by a court. A former *spouse* may receive a court awarded portion (or all) of an employee's account balance under a QDRO.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Although divorcing parties are free to agree to any mutually acceptable division of their property (or courts may issue a ruling without your approval), most frequently benefits are divided by awarding a former *spouse* a percentage or a fixed amount of the benefit accrued during the term of marriage.

QDRO Administrator

Before your account can be divided and payment of any benefits can be made, the QDRO Administrator is required to have a QDRO that gives sufficient instruction on how to divide and pay the benefit. Not all court orders are QDROs. The QDRO must identify the names, addresses, and Social Security numbers of the divorcing parties and any child or other dependent who is an alternate payee, the exact name of the benefit plan, and a formula or method for dividing benefits. If your divorce judgment contains these necessary elements, it may be accepted as a QDRO.

The administrator for purposes of the submission and review of draft QDROs for the Plan is Buck Consultants' Domestic Relations Order Administration Group ("DRA"). Correspondence to DRA should be sent to the *EIX Benefits Connection*, using the following addresses:

For US Mail
EIX Benefits Connection
PO Box 199428
Dallas, TX 75219-9428

For Overnight Delivery
EIX Benefits Connection
Attn: ACS
Building 5, Floor 1
2828 N. Haskell Ave
Dallas, TX 75204-2909

If you have questions about the QDRO process, you may also contact DRA by calling the *EIX Benefits Connection* at (866) 693-4947 from 7:30 a.m. to 5:30 p.m. Pacific Time, Monday through Friday, excluding holidays. When calling the *EIX Benefits Connection*, please be sure to mention that you are calling about a QDRO, and have the participant's Social Security number available for reference purposes. The *EIX Benefits Connection* representative will transfer the call to DRA.

Once a QDRO is filed and accepted by the court, the court-filed copy must be returned to the plan administrator for final approval before any payments from the 401(k) plan can be made. If your QDRO is satisfactory, you will be notified. If your Court Order does not qualify as a QDRO, you will be notified of any modifications required.

QDRO Payments

The awarded payment amount will be calculated according to the directives in the QDRO. An account will be established in the name and Social Security number of the former *spouse*. If the former *spouse* is also an employee of the *company* and already has a 401(k) account balance, a separate account will be established for the former *spouse* for purposes of the QDRO. Assets will be transferred from the employee's account to the former *spouse's* account.

The employee will be notified in writing as to the amount of the asset transfer and the effective date. The former *spouse* will receive a Password to access the account, along with applicable tax information and instructions on how to request a distribution.

The former *spouse's* account is required to be paid in full within 90 days from the date his or her account is established – unless the QDRO provides otherwise. The former *spouse* may request payment in the form of cash, Edison International Stock, or a combination of cash and stock. Payment may only be made in Edison International stock to the extent the account is invested in the Edison International Stock Fund. A QDRO distribution is eligible for a partial or complete rollover to an Individual Retirement Account (IRA) or another qualified plan.

Taxes on QDRO Payments

Any pre-tax payment amounts that are not rolled over will be subject to 20% mandatory federal tax withholding and may be subject to state withholding. Plan distributions will be taxed as ordinary income and additional taxes may be owed. A former *spouse* is urged to consult a financial planner or tax advisor before receiving a QDRO distribution. The plan administrator will send a tax notice and distribution instructions to the non-employee *spouse* after the plan receives the approved QDRO.

Distributions Due to Death

Your account balance becomes fully vested upon your death and will be distributed to your named beneficiary(ies). If you are married, your beneficiary is your surviving *spouse* unless you file a beneficiary form naming another beneficiary. The form must be notarized and signed by you and your *spouse*. If you have a *same-sex spouse* or *registered domestic partner* when you die and you have not submitted a valid designation for another beneficiary, then your *same-sex spouse* or *registered domestic partner* will be your sole beneficiary. If you die and you have no surviving *spouse, same-sex spouse*, *registered domestic partner,* or other beneficiary, your account balance will be paid to your estate. A Password Notice and account statement will be sent to your beneficiary once your assets are transferred to a beneficiary account. Your beneficiary must take a full distribution within 90 days after the account is established. If your beneficiary is a surviving *spouse*, the payment is eligible for rollover to an IRA or other qualified plan. If your beneficiary is an individual who is not your surviving *spouse* (or is a trust that meets certain requirements), the payment is eligible for a direct rollover to an inherited IRA established to receive a direct rollover on behalf of a non-*spouse* beneficiary.

Any outstanding loans will be defaulted approximately 60 days following your death and reported to the IRS as a taxable distribution. A surviving *spouse* or other beneficiary is urged to contact a tax advisor to determine the tax advantages, if any, of depositing the amount of the outstanding loan balance into an IRA and possibly avoiding immediate taxation.

Requesting a Distribution

To request a distribution, call the *EIX Benefits Connection* and speak with a representative, or you may request the distribution online. You will need to specify the method of payment and, if applicable, the amount to be rolled over to another qualified retirement plan, IRA or Roth IRA.

Your request should specify whether you would like your distribution in cash, shares of Edison International stock, or a combination of cash and stock. You may also specify whether you want a portion of your distribution to be withheld for state income taxes. See **Key Dates and Deadlines** in this summary for the timing of 401(k) plan transactions.

Tax Information

Your pre-tax contributions, rollover contributions, *company* contributions, and all earnings are subject to ordinary income tax when they are paid out to you as a hardship withdrawal, age 59½ in-service withdrawal or as a distribution.

Your Roth and Roth rollover contributions and related earnings may be subject to ordinary income tax when they are paid out to you, unless the distribution is a qualified distribution. A qualified distribution is a distribution that is:

- Made after the required 5-year period of participation beginning on the first day of the year in which you first made a Roth contribution; and
- Made on or after you reach age 59½, die, or become disabled

You must receive a Payments Rights Notice before your withdrawal or distribution check can be issued. You will receive a Payments Rights Notice with each quarterly Retirement Savings Portfolio statement or you may request a copy of this notice by calling the *EIX Benefits Connection*. After you receive the notice, you may take up to 30 days to decide whether to elect a direct rollover or to consider the tax consequences of not electing a rollover. You cannot receive a distribution or withdrawal from your account until after you receive the Payments Rights Notice, but you may waive your right to this 30-day notice. However, an election to waive the 30-day notice does not obligate the plan to make payments within 30 days.

Your taxes on withdrawals and distributions will vary depending on your age, your marital status, your other income and how your withdrawal or distribution is paid. State and local taxes may also apply to you. It's wise to consult a qualified tax advisor before taking any withdrawals or distributions from the plan.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Early Withdrawal Tax Penalties

If you are under age 59½ when you receive a hardship withdrawal or distribution, you may have to pay an additional 10% federal tax penalty plus a state tax penalty. These additional taxes are waived if the money is used for tax-deductible medical expenses, or if it is paid out as the result of a court order, *permanent and total disability*, termination of employment during or after the year you attain age 55, death, or as installment payments over your lifetime.

Mandatory Tax Withholding and Rollovers

If any portion of a withdrawal or distribution is eligible for rollover but is paid to the participant, federal law requires 20% of the eligible rollover amount to be withheld and sent to the IRS for payment of income taxes. The amount eligible for rollover is generally that portion of your account that is subject to ordinary income tax. It does not include post-tax contributions, except for eligible Roth contributions.

If any portion of a withdrawal or distribution is paid as shares of Edison International Stock, withholding will be limited to the cash you receive for any remaining shares and any cash you receive for fractional shares and dividends. Any ordinary income tax or tax penalties you owe on the value of the stock will become due and payable in the tax year in which you receive payment.

The mandatory 20% withholding rule does not apply to any portion of your payment that is not eligible for rollover, but is still taxable (such as a pre-tax portion of a hardship withdrawal or a required minimum distribution). In these cases, withholding may be applied under other rules, or you may elect not to have any taxes withheld. Contact a representative at the *EIX Benefits Connection* for election forms and related information, or you may request the forms online.

Taxation of Post-tax Contributions

Your post-tax contributions are generally not taxable when paid to you because you have already paid taxes on them. However, beginning with contributions you made in 1987, federal law requires withdrawals to be made from a combination of your contributions and related earnings on those contributions. The related earnings you withdraw are subject to ordinary income taxes plus any early withdrawal tax penalties that apply. Roth and Roth rollover contributions and related earnings are not taxable when they are paid out to you as a qualified distribution.

Ten-Year Averaging

If you were born before January 1, 1936, you are eligible to elect ten-year averaging only once in your lifetime. Also, you must have participated in the plan for five or more years. If you rollover any portion of your payment to an IRA or other qualified plan, this special tax treatment may not be available. Consult your personal tax advisor for guidance.

Estimated Taxes

Tax withholding, especially in the case of distributions of shares of Edison International stock, may not be adequate to cover the full tax due on a distribution that is not rolled over to an IRA. This may require you to pay estimated taxes at the time you receive your distribution.

Stock Fund Gains

If you invested in the Edison International Stock Fund prior to your distribution, you may be able to postpone tax on a portion of your gains (if any) if you take your distribution in Edison International Common Stock. If you take a distribution in shares, you will only be taxed based on your cost basis or the original cost of your investment. If you reinvest your money from the Edison International Stock Fund to another fund and later move it back to the Edison fund, your cost basis will change based on the new investment into the fund. The tax on any increase in the value of the stock above your cost basis that occurred while it was held in your account prior to your distribution will not be due until you sell or otherwise dispose of the stock.

This summary of taxation is based upon federal income tax laws in effect when this handbook was published. It is not intended to be a complete description of all the federal income tax rules that may apply to you. You may also be subject to certain state and local taxes, which have not been mentioned here. Estate and death taxes that may apply in some cases also have not been described. Any withdrawals or distributions you receive from the plan will be subject to tax laws in effect at that time.

Consult your personal tax advisor if you have any questions concerning taxes on your withdrawal or distribution.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The *EIX Benefits Connection*

The *EIX Benefits Connection* is an automated phone system and interactive website that gives you access to up-to-date account information. It also enables you to make changes to your account from a touch-tone phone or a personal computer.

You can use the *EIX Benefits Connection* to make the following transactions. You don't need a representative to assist you with these transactions; however, representatives can help you, if necessary.

- Enroll in the 401(k) Savings Plan
- Review your account balance and fund performance
- Obtain investment fund information including links to the mutual funds' websites
- Change your contribution rate
- Change the allocation of current funds and/or investment of future contributions
- Request and receive approval for general purpose loans
- Make requests for residential loans and early loan payoffs
- Perform loan modeling
- Inquire about amounts available for withdrawal
- Apply for post-tax withdrawals
- Apply for age 59½ in-service withdrawals
- Apply for distributions
- Change your dividend payment election
- Review plan provisions
- View and print forms from Your Secure Mailbox
- Obtain helpful information about saving and investing

You may request the following forms and other information through the phone system or a representative, or the *EIX Benefits Connection* Web site:

- Welcome brochure
- Account statement
- Fund prospectus for the Edison International Stock Fund
- Annual Fund Performance Report
- Hardship Withdrawal form
- Rollover or Roth Rollover Contribution
- Payment Rights Notice
- Determination Notice (if you're electing a rollover out of the 401(k) Savings Plan)

The *EIX Benefits Connection* is available 24 hours a day, 7 days a week, except Sunday 12:00 a.m. to Sunday 10:00 a.m., Pacific time.

EIX Benefits Connection	
Phone number for calls within U.S.	(866) 693-4947
Phone number for international calls	(847) 883-0804
Website address	www.eixbenefits.com

For questions about the plan, *EIX Benefits Connection* representatives are available by phone, Monday through Friday from 7:30 a.m. to 5:30 p.m., Pacific time.

Password Authorization Agreement

To access the *EIX Benefits Connection* automated phone system or interactive website you must enter your Password and your User ID. Without both of these numbers, you will not be able to execute any transactions.

When you use your Password, you electronically authorize the use of your Password instead of your handwritten signature to execute your transactions.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

You will need to call or logon to the *EIX Benefits Connection* after your date of hire to establish your Password. You will need to provide the last four digits of your Social Security number, hire date, birth date, and five digit zip code before the system or representative will allow you to create a User ID. You will be asked a series of personal questions, called Security Questions, so you can, in the future, log on even if you forget your Password. The Password will need to consist of four to 20 alphanumeric characters. If you are on the Web or speaking to a representative, you will be asked to create a hint for your Password. After you have selected your Password, a confirmation will be sent to your mailing address confirming your Password creation. It will not contain your new Password.

Take care to safeguard your Password from theft or misuse. Remember, your Password is your electronic signature, and it can be used with your User ID to authorize plan transactions. You should immediately change your Password if you suspect it has been stolen or misused by others and report this event to a representative in the *EIX Benefits Connection*.

If you have lost or forgotten your Password, and are unable to answer your Security Questions, you can request a new temporary Password through the *EIX Benefits Connection*. If you have an email address on file, you can request your temporary Password to be sent to you via email. If not, your temporary Password will be sent to you in the U.S. Mail. You will not be able to make changes until you receive your new Password.

Key Dates and Deadlines

Here's a quick guide to plan transactions and their key dates and deadlines.

Plan Transaction	How to Request	Timing
Enroll	Access the *EIX Benefits Connection* by phone or online	Enrollments are processed daily and will take effect within two pay periods
Change contribution rate	Access the *EIX Benefits Connection* by phone or online	Requests are processed daily and will take effect within two pay periods
Elect automatic pre-tax contribution rate escalation (Auto Save)	Access the *EIX Benefits Connection* by phone or online	Election may be made at any time and you may designate which month you wish your increased contribution rate to occur
Change investment of future contributions	Access the *EIX Benefits Connection* by phone or online	Requests are processed daily and will take effect within two pay periods
Change investment of current balances	Access the *EIX Benefits Connection* by phone or online	If request is processed before the stock market closes for the day (generally 1:00 p.m. Pacific time), the change takes effect the same business day,* unless trading restrictions apply If request is processed after the stock market closes (generally after 1:00 p.m. Pacific time), the change takes effect the next business day,* unless trading restrictions apply
Apply for a general purpose loan	Access the *EIX Benefits Connection* by phone or online	If loan is requested before the stock market closes for the day (generally 1:00 p.m. Pacific time), funding occurs the same business day.* Payment is mailed or directly deposited to your personal bank account within three business days If loan is requested after the stock market closes, funding occurs the next business day.* Payment is mailed or directly deposited to your personal bank account within three business days after funding
Apply for a residential loan	Access the *EIX Benefits Connection* by phone or online to request a loan application package	Loan will be approved within two business days after the loan application and all required supporting documentation are received If loan is approved before the stock market closes for the day (generally 1:00 p.m. Pacific time), funding occurs the same business day.* Payment is mailed or directly deposited to your personal bank account within three business days

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

		If loan approval is made after the stock market closes, funding occurs the next business day.* Payment is mailed or directly deposited to your personal bank account within three business days after funding If application is not returned within 30 days of request, request is cancelled
Apply for a hardship withdrawal	Access the *EIX Benefits Connection* by phone or online to request a hardship withdrawal application	Hardship withdrawal will be approved within two business days from receiving a completed application If withdrawal is approved before the stock market closes for the day (generally 1:00 p.m. Pacific time), funding occurs the same business day.* Payment is mailed or directly deposited to your personal bank account within three business days If request is approved after the stock market closes, funding occurs the next business day.* Payment is mailed or directly deposited to your personal bank account within three business days after funding
Apply for a withdrawal of post-tax contributions made before January 1, 1984	Access the *EIX Benefits Connection* by phone or online to request a withdrawal	If requested before the stock market closes for the day (generally 1:00 p.m. Pacific time), funding occurs the same business day.* Payment is mailed within three business days If request is made after the stock market closes, funding occurs the next business day.* Payment is mailed within three business days after funding
Apply for an age 59½ in-service withdrawal	Access the *EIX Benefits Connection* by phone or online to request a withdrawal	If requested before the stock market closes for the day (generally 1:00 p.m. Pacific time), funding occurs the same business day.* Payment is mailed within three business days If request is made after the stock market closes, funding occurs the next business day.* Payment is mailed within three business days after funding
Make a rollover contribution	Access the *EIX Benefits Connection* by phone or online to request a rollover a form	If contribution is approved and received by Friday of any week, it will be posted to your rollover account on the following Friday
Take a total distribution (applies only to terminated employees and retirees)	Access the *EIX Benefits Connection* , by phone or online	If requested before the stock market closes for the day (generally 1:00 p.m. Pacific time), funding occurs the same business day.* Payment is mailed within three business days If request is made after the stock market closes, funding occurs the next business day.* Payment is mailed within three business days after funding
Change dividend payment election percentage rate	Access the *EIX Benefits Connection* by phone or online	Change must be requested before the stock market closes on the Ex-dividend date (generally 1:00 p.m. Pacific time)
Change your Password	Access the *EIX Benefits Connection* by phone or online	You will receive a new Password notice within seven to ten business days of the request
Request loan continuation	Access the *EIX Benefits Connection* by phone within 30 days after retirement or termination under an involuntary separation program and press *0 to speak to a representative	You will receive a repayment schedule along with payment coupons approximately two weeks after you request to continue loan repayments

* For purposes of the 401(k) plan, "business day" means any day that the stock market is open for business. If the market closes prior to 1:00 p.m., your change will not occur until the next business day the market is open. "Stock market" refers to the New York Stock Exchange.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Situations Affecting 401(k) Benefits

There are a number of situations that could affect your 401(k) plan benefits, for example, if you become *permanently and totally disabled*, take a leave of absence, or leave the *company*. Here is a quick reference chart describing some of these situations. See the **Events Affecting Your Benefits** section for other situations that may affect your benefits.

If you...	This will happen...
Are rehired	• You may rejoin the plan upon reemployment if you are an eligible employee • If you invest in the Edison International Stock Fund, dividends will be reinvested in your account unless you elect otherwise
Are rehired and you forfeited *company* contributions when you left	• You will have five years from your rehire date to repay, in a lump sum, the full account balance distributed to you when you left • If you repay the full account balance, any forfeited *company* contributions will be restored to you • You will vest in the restored amount based on your total *years of service* before and after your rehire date

Other Situations Affecting 401(k) Benefits

There are several circumstances you should be aware of which could adversely affect your benefits.

- Federal law limits the amounts employees can save in tax-deferred plans like the Edison 401(k) Savings Plan. Because of these limits (which are indexed annually), some employees may not be able to contribute the full amount otherwise allowed each year. If you reach any of these limits, your contributions will automatically be stopped until the following tax year. If you think any of these limits may affect you, you may want to consider changing your contribution rate to the plan. See **Annual IRS Contribution Limits** for more information
- Your account balance reflects both contributions and investment gains or losses on those contributions
- The law requires different plan provisions to go into effect during any plan year in which more than 60% of account values are owned by certain key employees. You will be notified in the unlikely event that this occurs, if you are affected
- If you leave the *company* before you become 100% vested, you will forfeit the nonvested funds in your *company* contributions account upon distribution or a five-year break in service
- If you do not notify Benefits Administration of an address change, your statements, withdrawals and distributions may be delayed.
- If there is a conflict between claimants to your account, distribution may be delayed until the conflict is resolved
- Plan benefits may be affected if the plan is merged, amended, suspended, or discontinued. See **Plan Continuation** in the Other Important Information section of this handbook for more information

Non-Discrimination Rules

In addition to the IRS limits on contributions described above, federal laws require that the plan satisfy certain nondiscrimination standards that could result in the amount of your pre-tax contributions being returned to you and any matching contributions being removed from your account. You will be notified if these rules apply to you.

Claim and Appeal Procedures

Claims for plan benefits or for a determination of your rights under the Edison 401(k) Savings Plan must be made no later than 120 days after you or your beneficiary becomes aware (or reasonably should have become aware) of the facts establishing the claim. Claims should be directed to:

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

EIX Benefits Connection
P.O. Box 199428
Dallas, TX 75219-9428
(866) 693-4947

If a benefit claim is denied, in whole or in part, you or your beneficiary has a legal right to appeal the denial of the claim. See **Claims and Appeals** in the Other Important Information section of this handbook for detailed information about claim and appeal procedures.

Discretionary Authority

The Benefits Committee has the full and final power and discretionary authority to construe and interpret all provisions of the 401(k) Savings Plan, to administer its provisions, to establish, amend and rescind rules and regulations for efficient administration, to determine all questions relating to the rights and eligibility of participants, and to take such other action to administer the 401(k) Savings Plan as it deems appropriate. The decisions of the Benefits Committee shall be final and binding on all parties.

Plan Merger

If the plan merges with another qualified plan, your benefit will not be reduced.

Plan Amendment or Termination

The Benefits Committee has power to amend or terminate the plan at any time, at its discretion.

The plan may also be amended or terminated by:

- Resolution of the *company's* Board of Directors
- Judicial action if the *company* is bankrupt or insolvent, or upon complete dissolution, merger, consolidation, or reorganization, without provisions by a successor-company for continuation of the plan.

To the extent permitted by law, the Board of Directors or the Benefits Committee may suspend contributions to the plan, in whole or in part, at any time.

If this plan is terminated for any reason, you will be notified. If the plan is terminated, you will be automatically 100% vested in your accrued benefit.

Plan Insurance

Your benefits under this plan are not insured. The plan is a defined contribution plan and is not insured by the Pension Benefit Guarantee Corporation (PBGC).

Plan Funding

Employees contribute a percentage of pay and the *company* makes matching contributions from its operating income.

All funds of the plan are held by a funding agent under a trust instrument. The name and address of the funding agent can be found in the **Other Important Information** section. Plan funds may be used only for the exclusive benefit of plan participants and their beneficiaries.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Payment of Plan Expenses

The *company* currently pays the net administration costs for the 401(k) plan, including the net fees and expenses of the trustee and record keeper. This does not preclude the *company* from establishing participant transaction fees in the future.

Fees charged by investment fund managers are paid by the people who invest in those funds, whether they are individual investors or participants in a 401(k) plan. In addition to charging investment management fees, the investment funds also include charges for keeping records of individual accounts, responding to telephone inquiries, mailing of plan information and account statements, and other administrative activities. Since these latter services are provided by the plan, the fees investment managers charge are used to pay for these administrative services. The rates of return reported by each investment fund are shown after these fees have been paid out of plan assets.

Fees may be charged in connection with your use of the Self-Directed Brokerage Account investment option, including fees charged against your account when you purchase or sell investments within your PCRA. To obtain detailed information regarding fees that may apply, review the pricing information at www.eixbenefits.com or call the *EIX Benefits Connection* to request a copy.

The record keeper and other service providers for the plan may also receive fees and other indirect compensation. Most of the fees received by Edison's 401(k) plan record keeper are used to reduce the recordkeeping and communication expenses of the plan paid by the *company*

There are no charges to employees for reallocations of stock or other assets already owned by the plan trust. Fees are only incurred to the extent the transaction requires the plan to purchase or sell assets.

Assignment of Benefits

Benefits payable from the plan described in this summary are intended solely for the benefit of plan participants entitled to payments according to plan provisions. By law, plan benefits are not subject to your debts or obligations, or those of your beneficiaries, and may not be sold, transferred, assigned, or encumbered in any manner.

However, certain court orders could require that part of your account be paid to someone else — for example, your *spouse*, former *spouse*, child, or other dependent, under a Qualified Domestic Relations Order (QDRO).

Your ERISA Rights

As a participant in the Edison 401(k) Savings Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). See **Your ERISA Rights** in the Other Important Information Section of this handbook for details.

For More Information

If you have questions, you may call the *EIX Benefits Connection* toll-free at (866) 693-4947 or logon at www.eixbenefits.com.

This handbook contains a number of additional sections which, together with this summary and its Appendix and Prospectus Supplement, comprise the official summary plan description of the 401(k) Savings Plan. Please refer to the Eligibility, Other Important Information and Glossary sections of this handbook for more information about the way the plans are administered, your rights as a participant, and for definitions of terms that appear in *italics*.

401(k) Savings Plan Appendix

Company Matching Contributions

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Employees of Southern California Edison Company are eligible to receive the following *company* match on some of their 401(k) contributions. You become 20% vested in *company* contributions for each year of vesting service. See **Vesting**, in this section of your handbook, for details.

Company/Employee Group	*Company* Matching Contribution	Maximum Percent of *Base Pay* Matched
Southern California Edison Company	$1.00	Up to 6%

Internal Revenue Service (IRS) Contribution Limits

Each year, the IRS establishes limitations on the annual dollar limit that you can contribute to your 401(k) account, on total contributions that you and the *company* can contribute to your 401(k) account, and the eligible earnings on which your contributions can be determined. The limits shown are based on laws as in effect January 1, 2013. You will be notified if these limits are modified by future changes in law.

Year	Your Contribution	Catch-Up Contribution	Your Contributions and *Company* Contributions*	Eligible Earnings
2002	$11,000	$1,000	$40,000	$200,000
2003	$12,000	$2,000	$40,000	$200,000
2004	$13,000	$3,000	$41,000	$205,000
2005	$14,000	$4,000	$42,000	$210,000
2006	$15,000	$5,000	$44,000	$220,000
2007	$15,500	$5,000	$45,000	$225,000
2008	$15,500	$5,000	$46,000	$230,000
2009	$16,500	$5,500	$49,000	$245,000
2010	$16,500	$5,500	$49,000	$245,000
2011	$16,500	$5,500	$49,000	$245,000
2012	$17,000	$5,500	$50,000	$250,000
2013	$17,500	$5,500	$51,000 (Indexed in $1,000 increments **)	$255,000 (Indexed in $5,000 increments **)

* Your Contributions and *Company* Contributions cannot exceed the lesser of the respective year's dollar figure shown or 100% of your total pay (see **Annual IRS Contribution Limits** in this summary for more information).

** Based on increases to the Consumer Price Index (CPI)

Special Rules for Certain Transferred Employees

If you joined the *company* as a result of an acquisition or merger, some of the rules of your former employer's defined contribution benefit plan may be preserved under the Edison 401(k) Savings Plan. These special rules are outlined in the following chart.

Former East Coast Capital employees who transferred to Edison Capital on October 1, 1996	Eligibility	If you would have been able to participate in East Coast Capital's 401(k) plan as of October 1, 1996, you were eligible to participate in this plan on that date.
	Vesting	Your service with East Coast Capital is recognized for vesting purposes under the Edison 401(k) Savings plan if you would have been eligible to participate in the East Coast Capital 401(k) plan as of October 1, 1996.
Former Scott Polar and Kimmel Motz employees who transferred on May 1, 1998, and former GHV employees who transferred to Edison Source on June 3, 1998	Vesting	Your service with Scott Polar, Kimmel Motz, or GHV is recognized for vesting purposes under the Edison 401(k) Savings Plan.
Former Westec Security, Inc. employees who transferred to Edison Select on September 1, 1998	Vesting	Your service with Westec Security, Inc. is recognized for vesting purposes under the Edison 401(k) Savings Plan.
	Loans	New loan requests are subject to the Edison 401(k) Savings Plan loan rules which limit the number of outstanding loans you can have to two at a time. If you elected to roll over your total account balance from the Westec Security, Inc. defined contribution plan to the Edison 401(k) plan on November 14, 1998, you also had the option to transfer any existing loan balances into this

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

		plan.
Former GPU employees at the Homer City Generating Station who transferred to Homer City Generation on March 18, 1999	Vesting	Your service with GPU is recognized for vesting purposes under the Edison 401(k) Savings Plan.
Former Commonwealth Edison employees who transferred to Midwest Generation or Edison Mission Energy Services on December 15, 1999	Vesting	You are 100% vested in any account balances you transferred from the Commonwealth Edison Company defined contribution plan. You are also 100% vested in all *company* matching and profit sharing contributions, if eligible, made to your Edison 401(k) Savings Plan account.
	Loans	You were eligible to transfer up to five outstanding loan balances from the Commonwealth Edison Company defined contribution plan to the Edison 401(k) Savings Plan. New loan requests are subject to the Edison 401(k) Savings Plan's loan rules which limit the number of outstanding loans you can have to two at a time. *For example, if you transferred five loans, you must pay off at least four of them before you can take out a new loan from this plan.*

	Distributions Due to Death	The following rules for distributions due to death apply to you in addition to the Edison 401(k) Savings Plan's distribution rules:
		• **If you begin receiving plan distributions before you die,** your beneficiary(ies) must receive your account balance in payments that are at least as frequent as the payments you were receiving·
		• **If you die before receiving any distributions,** your beneficiary(ies) may receive your account balance as a lump sum or in installments. Distribution options vary depending on whom your beneficiary is, as described below:
		  • A *spouse* beneficiary may defer distributions until the date you would have attained age 70-1/2; he or she may elect to receive annual installments for up to 15 years
		  • A non-*spouse* beneficiary, within one year of your death, may elect distributions in up to 15 annual installments, but not over a period longer than his or her life expectancy
		  • A trust may elect a maximum of five annual installments
		  • If installments are not elected, a lump sum will be paid, although payment may be deferred up to five years from the date of your death

Former employees of Capitol Refrigeration Corporation who transferred to Edison Source on June 12, 2000	Vesting	Your service with Capitol Refrigeration Corporation is recognized for vesting purposes under the Edison 401(k) Savings Plan
Former employees of Citizens Power LLC who transferred to Edison Mission Marketing & Trading on September 1, 2000	Vesting	Your service with Citizens Power is recognized for vesting purposes under the Edison 401(k) Savings Plan

Prospectus Supplement For The Edison 401(k) Savings Plan

The securities described in this prospectus supplement have not been approved or disapproved by the

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Securities and Exchange Commission (SEC) nor has the SEC passed upon the accuracy or adequacy of this prospectus supplement. Any representation to the contrary is a criminal offense.

No person has been authorized to give any information or to make any representations, other than those contained in this supplement, about the investment offerings described in this supplement or described in any other document identified as a part of a prospectus that applies to the Edison 401(k) Savings Plan. If given or made, such information or representation cannot be relied upon.

This document constitutes part of a prospectus covering common stock and plan interests that have been registered under the Securities Act of 1933.

Prospectus Supplement

Southern California Edison Company (the "sponsor" or "company") is owned by Edison International and sponsors the Edison 401(k) Savings Plan (the "plan"), formerly known as the Southern California Edison Company Stock Savings Plus Plan. The plan is operated for employees of any participating Edison International company (a "Participating Company"). The common stock of Edison International is one of the investments the plan offers. Fifteen million shares were registered under the Securities Act of 1933 for that purpose by the registration statement filed with the Securities Exchange Commission on November 4, 2005. The plan Prospectus covering these registered securities consists of the summary plan description in this handbook as well as this Prospectus Supplement. This document provides additional information that's not included in the summary plan description.

1. Plan Qualification

The company received a favorable determination from the Internal Revenue Service (IRS) dated May 22, 2002 confirming that the plan satisfies the requirements of Sections 401(a), 401(k), and 4975(e)(7) of the Internal Revenue Code (the "Code"). The company will submit any subsequent plan amendments to the IRS in a timely manner and has made or will make all changes required by the IRS in order to qualify the plan under the applicable rules of the Code.

2. Section 404(c) Notice

The plan meets the requirements of Section 404(c) of ERISA and the related regulations. Under these regulations, the participant is solely responsible for the investment direction of his or her plan account. The company and the plan fiduciaries will not be held responsible for any losses which are the direct and necessary result of investment instructions given by the participant. This does not relieve the company of its obligations to select appropriate investment managers or funds for the plan's investment options, as well as to monitor their performance.

3. Investment of Funds

The current goals of the investment funds available under the plan are described briefly below. However, no one can assure you that these goals will be met. The goals of a fund and the fund managers may change from time to time. The company may also change the particular funds offered by the plan. The plan offers you many investment options. These options include:

Tier 1 Funds (as of December 31, 2011) -- Target Date Funds

A Target Date Fund is a premixed allocation of stocks, bonds and cash. Each of these funds is a complete, diversified investment program — a one-stop investment strategy in a single option. Each investment option in Tier 1 has a date in its name — generally called the fund’s “target date.” The mix of investments in each Target Date Fund becomes more conservative as its target date approaches. One Target Date Fund that doesn’t have a date in its name, the Retirement Allocation Fund, is the most conservative of the Target Date Funds and is not designed to become more conservative over time.

With the exception of the Retirement Allocation Fund, once you have chosen a fund, it changes over time. You don’t have to constantly monitor your account and make changes to your investment mix as the target date approaches. Instead, each fund is professionally managed to gradually shift to a more conservative approach — automatically. Investments in Target Date Funds aren’t guaranteed against loss of principal at any time — including at the time of the fund’s target date. Target Date Funds don’t guarantee sufficient income in retirement. In addition, as with all investments, you should check periodically to make sure that this type of investment is still right for you.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Each of the Tier 1 Target Date Funds is built from a combination of the Tier 2 Core Funds. The main difference among the Target Date Funds is the different percentages that each holds in the seven Core Funds. The following table describes what those percentages were as of December 31, 2011.

Core Fund Name	Retirement Allocation Fund	2015	2020	2025	2030	2035	2040	2045	2050	2055
Money Market Fund	32.5%	26.5%	17.7%	8.8%	2.0%	--	--	--	--	--
Treasury Inflation Protected Securities Fund	17.5%	17.5%	13.3%	7.2%	2.0%	--	--	--	--	--
Bond Fund	25.0%	25.0%	25.0%	25.0%	22.0%	14.0%	10.0%	10.0%	10.0%	10.0%
U.S. Stock Index Fund	7.5%	8.7%	11.9%	15.9%	20.1%	23.0%	24.0%	24.0%	24.0%	24.0%
U.S. Large Company Stock Fund	7.5%	8.7%	11.9%	15.9%	19.9%	23.0%	24.0%	24.0%	24.0%	24.0%
U.S. Small-Medium Company Stock Fund	2.5%	4.3%	7.0%	9.2%	11.8%	14.2%	15.0%	15.0%	15.0%	15.0%
International Stock Fund	7.5%	9.3%	13.2%	18.0%	22.4%	25.6%	27.0%	27.0%	27.0%	27.0%
	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

In general, allocation changes that AllianceBernstein deems necessary to meet each Target Date Fund's objective, will be made at the end of each quarter and on an ongoing basis. The target asset allocations for the funds dated 2040-2055 are currently identical. However, as each fund approaches 20 years from its target date, the asset allocation will gradually shift its emphasis toward a more conservative allocation beginning with the 2040 fund.

Target Date Funds are designed so that the asset allocations change over time. Age 65 was selected as the default age for all 401(k) Plan participants, but it may not default you into the Target Date Fund you would prefer, so it's important to remember that you may choose any Target Date Fund to invest in, regardless of your age. The dates are simply targets that the investment professionals use to determine the asset mixture.

Tier 2 Funds (as of December 31, 2011)

Money Market Fund

This fund invests in short-term obligations and deposits, including U.S. Treasury and agency obligations, corporate bonds, commercial paper, repurchase agreements, certificates of deposit, bankers' acceptances, time deposits and floating-rate notes. The maximum maturity of any instrument in the fund is 13 months. This fund may lend short-term cash at prevailing interest rates to the Edison International Stock Fund (EIX Stock Fund) to meet liquidity needs. The fund's objective is to maximize current income while preserving capital and liquidity. The fund's risk profile is extremely conservative due to the high credit quality and very short maturities of its investments. Because of this, returns are usually lower than those of other fixed income funds and stock funds.

☐Investment Manager: State Street Global Advisors, ☐Asset Class: Cash Equivalent, ☒Expense Ratio:

Treasury Inflation Protected Securities Fund

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The Treasury Inflation Protected Securities (TIPS) Fund is designed to replicate the risk and return profile of the Barclays Capital U.S. TIPS Index. The fund invests in inflation-indexed bonds issued by the U.S. Treasury. The fund seeks to provide investors a high-quality, cost-effective, index-based solution to their bond investment needs. Possible risks include real interest rate risk, deflation risk, and securities lending risk.

Investment Manager: BlackRock, Asset Class: Bond, Expense Ratio: 0.02%

Bond Fund

The Bond Fund is a multi-manager fund created for the Edison 401(k) Savings Plan consisting of two active managers and one passive manager. PIMCO's active fixed income strategy seeks to add value through the use of top-down and bottom-up strategies. Decisions are executed to optimize the risk/return characteristics of the portfolio. Dodge & Cox's active fixed income strategy seeks bonds that will provide relatively high streams of income and attractive price appreciation over an extended time horizon. Dodge & Cox emphasizes fundamental analysis and also considers economic trends. BlackRock's passive fixed income strategy seeks to track the performance of the Barclays Capital Aggregate Bond Index. The two active strategies are able to invest in high-yield and foreign securities, but only investment-grade bonds denominated in U.S. dollars are eligible for purchase by BlackRock. The Bond Fund is subject to various risks that include interest rate risk, credit risk, market risk, investment style risk, manager risk, securities lending risk, and possibly country/regional risk or currency risk. However, it is generally less risky than funds with equity exposure.

Investment Managers: PIMCO (55%), Asset Class: Bond, Expense Ratio: 0.22%
Dodge and Cox (20%), BlackRock (25%)

U.S. Stock Index Fund

The U.S. Stock Index Fund seeks to capture the earnings and growth potential of large U.S. companies. This passively managed fund tracks the Standard & Poor's 500 Index. The fund invests in the same stocks held in the S&P 500 Index. These stocks represent 500 of the largest and most established public companies in the U.S. (based on the market value of their shares), and account for more than 75 percent of the market capitalization of all publicly traded stocks in the U.S. The risk profile of the U.S. Stock Index Fund is approximately comparable to the risk of the group of stocks making up the S&P 500 Index. The returns of the fund will fluctuate within a wide range, and the fund could lose money over short or long time periods. The fund is subject to various risks that include market risk, investment style risk, and securities lending risk.

Investment Manager: BlackRock, Asset Class: U.S. Large Stock, Expense Ratio: 0.02%

U.S. Large Company Stock Fund

The U.S. Large Company Stock Fund is a multi-manager fund created for the 401(k) Savings Plan consisting of one active large-cap value manager, one active large-cap growth manager, and one passive large-cap blend manager. ICAP's actively managed strategy focuses on large-cap value investments that can exploit market inefficiencies by combining their valuation discipline with catalyst identification through independent, fundamental, global research. The portfolio consists of 30 to 35 of ICAP's most compelling large-cap stocks. BlackRock manages two institutional strategies for this fund. It manages an active large-cap growth strategy that focuses on bottom-up, detailed fundamental analysis to identify companies that exhibit either stable growth or accelerating earnings. The portfolio typically consists of 60 to 80 positions. BlackRock also manages a passive large-cap blend strategy that aims to fully replicate the S&P 500 Index, representing approximately 75 percent of the market capitalization of all publicly traded stocks in the U.S. The returns of the U.S. Large Company Stock Fund will fluctuate within a wide range, and the fund could lose money over short or long time periods. The fund is subject to various risks that include market risk, investment style risk, manager risk, and securities lending risk.

Investment Managers: CAP (33.3%), Asset Class: U.S. Large Stock, Expense Ratio: 0.29%: BlackRock – active (33.3%), BlackRock – passive (33.3%)

U.S. Small-Medium Company Stock Fund

The U.S. Small-Medium Company Stock Fund is a multi-manager fund created for the Edison 401(k) Savings Plan consisting of one active small/mid-cap value manager, one active small/mid-cap growth manager, and one passive small/mid-cap blend manager. Westwood's active small/mid-cap value strategy conducts bottom-up analysis to find firms where expected future profitability is significantly higher than what the current prices discount (asymmetric risk/reward profile). Individual holdings are generally 1 to 3 percent of the portfolio. Delaware's actively managed small/mid-cap growth strategy seeks firms that they believe can generate long-

term growth of intrinsic business value. Individual U.S. stocks typically have a portfolio weighting of 2 to 5 percent at purchase and a maximum of 8 percent at market value. BlackRock's passive small/mid-cap strategy seeks to track the Russell 2500 Index, an index which includes 2,500 of the smallest stocks based on their market capitalization and current index membership. The returns of the U.S. Small-Medium Company Stock Fund will fluctuate within a wide range, and the fund could lose money over short or long time periods. The fund is subject to various risks that include market risk, investment style risk, manager risk, and securities lending risk. Small and medium company stocks tend to have more fluctuations in value than large company stocks.

☐Investment Managers: Westwood (33.3%), Asset Class: U.S. Small-Medium Stock, ☐Expense Ra
Delaware (33.3%), BlackRock (33.3%)

International Stock Fund

The International Stock Fund is a multi-manager fund created for the Edison 401(k) Savings Plan consisting of two active managers and one passive manager. Thornburg's active investment strategy takes a bottom-up, longer-term approach, seeking promising firms with sound business fundamentals at a time when their intrinsic value is not fully recognized by the market. The strategy contains elements of deep value and growth. The portfolio typically holds 50 to 75 stocks. The other active manager is Dodge & Cox, through its Dodge & Cox International Stock mutual fund (Ticker Symbol: DODFX). Dodge & Cox's actively managed strategy is also a bottom-up, catalyst-driven approach seeking firms where the current valuation does not reflect the investment manager's view of the firm's long-term intrinsic value. Dodge & Cox's mutual fund typically does not invest more than 5 percent of its assets in any one issuer. BlackRock's passive investment strategy seeks to track the MSCI AC World Index ex. U.S., an index which measures the equity market performance of developed and emerging markets. The returns of the International Stock Fund will fluctuate within a wide range, and the fund could lose money over short or long time periods. The fund is subject to various risks that include market risk, country/regional risk, investment style risk, manager risk, currency risk, and securities lending risk.

Investment Managers: Thornburg (33.3%), ☐Asset Class: Non-U.S. Stock, ☐Expense Rati
Cox (33.3%), BlackRock (33.3%)

Edison International Stock Fund (EIX Stock Fund)

This fund invests in Edison International Common Stock and cash necessary for plan transactions. The return to investors results largely from a combination of movement in the price of the Edison International Common Stock (either up or down) and dividends paid. The return is also impacted by the net performance of the fund's holdings of cash or cash equivalents for liquidity purposes. Other factors impacting the net return of the fund are the investment management fee for the fund, brokerage commissions, and possibly other costs or expenses.

Because the fund invests almost exclusively in shares of Edison International Common Stock, it does not offer the ability to diversify within the fund. So it carries a higher degree of risk than the other investment options available under the Edison 401(k) Savings Plan.

The Edison International Stock Fund is subject to gains and losses as specific factors affect Edison International and as external factors affect the stock market as a whole. Because this fund is also an ESOP, dividends, if any, are automatically reinvested and used to buy additional shares of Edison International Common Stock on your behalf—unless you are eligible to elect and do elect to have dividends paid directly to you.

Edison International Common Stock is publicly traded on the New York Stock Exchange. Edison International neither encourages nor discourages plan participants from selecting the Edison International Stock Fund as an investment option. However, to help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. Spreading your assets among different types of investments can help you achieve a favorable rate of return, while minimizing your overall risk of losing money. This is because market or other economic conditions that cause one category of assets, or one particular security, to perform very well often cause another asset category, or another particular security, to perform poorly. If you invest more than 20 percent of your retirement savings in any one company or industry, your savings may not be properly diversified. Although diversification is not a guarantee against loss, it is an effective strategy to help you manage investment risk.

Investment Manager: State Street Global Advisors, Asset Class: Company Stock, ☐ESOP, Expense Ratio: 0.02%

From time to time one or more of the investment managers for the Edison 401(k) Savings Plan's Core Funds may engage in futures related investment activities affecting both Tier 1 and Tier 2 investments under the plan. Pursuant to Rule 4.5 of the Commodity Futures Trading Commission, the Edison 401(k) Savings Plan has

claimed an exemption from the definition of the term "commodity pool operator" under the Commodity Exchange Act (Act) and is therefore not subject to registration or regulation as a pool operator under the Act.

The Edison 401(k) Savings Plan is intended to satisfy the requirements of Section 404(c) of ERISA. This means that the sponsor, Edison International, the plan Administrator, and the Trustee are not liable for any investment losses resulting from investment elections you make.

Securities Lending

The fund managers for some of the investment options in the Plan may engage in securities lending. Securities lending involves loaning securities to other parties in exchange for cash or other collateral that is often re-invested during the term of the loan. A fee may also be charged to the securities borrower. The collateral is usually returned to the securities borrower in exchange for the loaned securities upon termination or maturity of the securities loan. Securities lending may result in marginally enhanced fund performance. The net income (if any) generated from securities lending and the related investment of collateral is divided between the fund and the fund manager or securities lending agent. Securities lending does involve risks, including the potential insolvency of borrowers and the possibility of losses from the investment of collateral received for loaned securities. The Edison International Stock Fund does not engage in securities lending, but some of the other funds in the Plan lineup may engage in securities lending. You may obtain more information about the securities lending policies or practices of specific funds (if they engage in securities lending) by reviewing their prospectuses (for mutual funds) or by contacting the *EIX Benefits Connection* (for pre-mixed portfolios and other institutional funds).

More Information About Investments

The following information is available to you on request through the *EIX Benefits Connection* by calling (866) 693-4947:

- Copies of all fund fact sheets for Tier 1 and Tier 2 investment options, and other material provided by the 401(k) plan regarding your investment options
- A list of the assets contained in each of the investment funds and the value of each asset (or the proportion it comprises)
- Information about the value of shares or units in each of the investment funds
- Information about the value of shares or units in each of the investment funds held by participants

The plan is administered under the direction of the Benefits Committee. The Secretary of the Benefits Committee has been delegated responsibility for oversight of the provision of investment information to participants and the implementation of participants' investment directions. The Benefits Committee and its Secretary can be reached at P.O. Box 800, Rosemead, CA 91770. You can obtain the name and phone number of the Secretary through the *EIX Benefits Connection*, by calling (866) 693-4947.

The company cannot verify the accuracy or completeness of such information–except with respect to the Edison International Stock Fund – and it makes no representations with respect to the ability of the funds to satisfy their goals, the achievement of any particular investment returns or any other aspect of the funds.

As with any investment, there are risks involved with investing in any of the funds mentioned above. Each investment fund offers its own risk and potential return. No assurances can be given that investment losses will not occur in connection with any of the funds or portfolios. The company cannot make any specific investment recommendations. The company also does not guarantee plan participants safety against investment losses.

None of the Edison 401(k) Savings Plan's investment options are insured or guaranteed by the U.S. government. Certain historical information concerning the past performance of the investment funds and portfolios is included in Exhibit A.

More specific information about any of the investment options is available by calling the EIX Benefits Connection at (866) 693-4947or at the www.eixbenefits.com website.

Special Rules for Officers and Directors

If you are an "officer" of Edison International, as defined in the Securities Exchange Act of 1934, as amended (the "Exchange Act"), a director of Edison International, or you own more than 10% of the outstanding shares of Edison International, you are subject to Section 16 of the Securities Exchange Act, relating to short-swing profits liability. Certain officers of Edison International affiliates may be considered officers of Edison International for this purpose. If you are subject to Section 16, your transactions in the Edison International Stock Fund may be subject to the short-swing profits liability provisions of Section 16(b). You are advised to consult with your own legal counsel for further information regarding the effect of Section 16 on your transactions in the Edison International Stock Fund. If you are subject to Section 16, you must obtain clearance from the Secretary of Edison International before you invest in, or transfer money in or out of, the Edison International Stock Fund.

Under the Securities Act of 1933, as amended (the "Securities Act"), an affiliate (i.e., a "controlling person") of Edison International may not sell shares of Edison International Common Stock unless the sales are separately registered or are made within the limitations of and subject to the conditions set forth in Rule 144 promulgated under the Securities Act (or another applicable exemption from the registration requirements of the Securities Act). Although it is possible that certain directors and executive officers may not be considered to be controlling persons, the question of control is a question of fact and is often difficult to resolve with certainty. The restrictions of Rule 144 apply to sales of shares from the Edison International Stock Fund, such as sales which occur when investments are transferred from the Edison International Stock Fund to another investment fund. Participants in the plan are advised to consult with their legal counsel as to their status as an "affiliate" of Edison International and as to the restrictions on such sales

Charges and Deductions

The fees, charges, and other expenses incurred by the trustee or fund managers in making investments are paid out of the fund for which the investments are made as part of the cost of the investment. This includes any brokerage fees for sales or purchases of Edison International Stock on the open market. Transaction fees for the Edison International Stock Fund are deducted at the time the shares are settled. There are no costs in connection with sales of Edison International Stock that occur within the Trust or movement of assets among the other funds. Also included in these costs are the fund's management fees.

Fees deducted from a fund reduce the investment return for that fund.

Confidentiality of Participant Voting and Plan Transactions

Each participant in the Edison International Stock Fund will be provided the opportunity to give the Trustee confidential instructions on how to vote the portion of the Edison International Stock Fund vested or conditionally credited to the participant on matters which are from time to time submitted to the vote of holders of shares of Edison Stock. Participants submit their voting instructions to a third-party proxy tabulator that reports only aggregate voting to the Trustee and Edison International, thereby maintaining the confidentiality of the identity and voting status of participants. The *company* does not have access to any voting instructions by individual participants in the Edison International Stock Fund. In addition, the record keeper directly provides to the proxy tabulator (over a protected data transmission system) a list of participants in the Edison International Stock Fund (and the portion of the Fund credited to each such participant) on the applicable proxy record date. A similar process is used for the exercise of tender and similar rights.

Securities held in other funds are voted by their respective investment managers.

In addition, plan transactions are confidential. Your deferral elections, loan requests, withdrawal requests, distribution requests, and investment elections are implemented by the plan administrator, record keeper and trustee on a confidential basis. You can submit instructions to the record keeper via telephone or the internet through the *EIX Benefits Connection* only by using your User ID and Password. Plan transaction information is confidential and only accessible to plan administrators who need the information for plan operation purposes.

The plan is administered under the direction of the Benefits Committee. The Secretary of the Benefits Committee has been delegated responsibility for oversight and coordination of confidentiality procedures among the plan fiduciaries. Accordingly, the Secretary of the Benefits Committee is responsible for ensuring that confidentiality procedures for the Edison International Stock Fund are sufficient to safeguard the confidentiality of information regarding the exercise of voting rights (including tender and similar rights) and the purchase, holding, and sale of interests in the Edison International Stock Fund. The Benefits Committee or its delegate is also responsible for appointing an independent fiduciary when advisable to avoid undue employer influence upon participants with regard to the exercise of shareholder rights under the Edison International Stock Fund.

The Benefits Committee and its Secretary can be reached at P.O. Box 800, Rosemead, CA 91770. You can obtain the name and phone number of the Secretary through the *EIX Benefits Connection*, by calling (866) 693-4947.

Incorporation of Certain Documents by Reference

The following documents, which have been filed by Edison International with the Securities and Exchange Commission (the "Commission"), are hereby incorporated by reference into this Prospectus Supplement:

(a) Annual Report of Edison International filed with the Securities and Exchange Commission on Form 10-K for the latest year ended.

(b) Current Reports of Edison International on Form 8-K filed with the Commission since the end of the latest year ended.

(c) Quarterly Reports of Edison International on Form 10-Q filed with the Commission for the quarters ended since the end of the latest year ended.

(d) The description of Edison International Common Stock contained on pages 4 and 5 of the Registration of Securities of Certain Successor Issuers filed on Form 8-B with the Securities and Exchange Commission by SCEcorp (predecessor of Edison International) on May 20, 1988.

(e) Annual Report of Edison 401(k) Savings Plan on Form 11-K for the latest year ended.

All documents subsequently filed by Edison International under Sections 13(a), 13(c), 14 and 15(d) of the Exchange Act and prior to the filing of a post-effective amendment which indicates that all securities offered have been sold or which deregisters all securities then remaining unsold shall be deemed to be incorporated by reference into this Prospectus Supplement and to be a part hereof from the date of filing of such documents. Any statement in this Prospectus Supplement or the above documents will be considered modified by changes in any other subsequently filed incorporated document.

Any person receiving a copy of this Prospectus Supplement may obtain without charge, upon oral or written request, a copy of any of the documents incorporated by reference herein (except for exhibits thereto, unless such exhibits are specifically incorporated by reference in the information that is incorporated) or any other documents required to be delivered to such person pursuant to Rule 428(b) under the Securities Act (e.g., documents updating this Prospectus Supplement or documents previously delivered that constitute part of the Prospectus Supplement, annual or quarterly reports to the Commission or to shareholders, and Edison International proxy statements). Requests should be made by calling the *EIX Benefits Connection* at (866) 693-4947. Requests may also be made in writing to the Secretary of the Sponsor's Benefits Committee at P.O. Box 800, Rosemead, CA 91770.

The Securities and Exchange Commission maintains a Web site that contains reports, proxy and information statements and other information regarding Edison International and other registrants that file electronically with the Commission at http://www.sec.gov. Edison International Common Stock is listed on the New York Stock Exchange. Edison International reports, proxy statements, information statements and other information concerning Edison International may also be inspected at the office of such exchange at the following address:

New York Stock Exchange
11 Wall St.
New York, NY 10005

Exhibit A

Fund Performance

Below are the historic returns of the Tier 2 investment funds. The Bond Fund, U.S. Large Company Stock Fund, U.S. Small-Medium Company Stock Fund and International Stock Fund were created for the Edison 401(k) Savings Plan. The historical rate of return information for each of these funds has been simulated by taking the monthly net-of-fee returns for each underlying fund manager and calculating a weighted average return based on their target weights. The "Expense Ratio %" for the Tier 1 and Tier 2 funds indicates the annual expenses for managing and operating a fund (including possibly Trustee, record keeper and other service provider expenses) expressed as a percentage of the net assets of the fund. The daily equivalent of the annual expense ratio is deducted from the fund each day, but some deductions may be made on a monthly or quarterly basis. For example, if the expense ratio for a fund is 0.37%, then $3.70 per $1,000 of average net assets is going towards fund expenses each year. Updated expense ratio information is available online at the *EIX Benefits Connection* website at www.eixbenenfits.com.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Tier 1: Target Date Funds	Expense Ratio %[1]
• Retirement Allocation Fund	0.22
• Target Date 2015 Fund	0.24
• Target Date 2020 Fund	0.28
• Target Date 2025 Fund	0.32
• Target Date 2030 Fund	0.35
• Target Date 2035 Fund	0.37
• Target Date 2040 Fund	0.37
• Target Date 2045 Fund	0.37
• Target Date 2050 Fund	0.37
• Target Date 2055 Fund	0.37

• Tier 2: Core Funds and EIX Stock Fund	1-Year	2-Year	3-Year	Expense Ratio %[1]
• Money Market Fund	0.2	0.2	0.3	0.05
• Treasury Inflation Protected Securities Fund	13.6	10.0	10.4	0.02
• Bond Fund	2.7	5.3	7.7	0.22
• U.S. Stock Index Fund	2.2	8.4	14.3	0.05
• U.S. Large Company Stock Fund	- 2.5	7.1	14.6	0.29
• U.S. Small-Medium Company Stock Fund	- 0.9	14.7	22.7	0.57
• International Stock Fund	- 14.0	- 1.3	10.9	0.45
• Edison International Stock Fund	10.9	12.6	12.5	0.02

[1] Expense ratios noted here are as of December 31, 2011 and are subject to change without notice.

No assurances can be given that investment losses will not occur in connection with any of the investment options available through the 401(k) plan. Each investment option offers its own risk and potential return. None of the funds are insured or guaranteed by the U. S. government or any other entity.

There is no guarantee against loss in the value of your 401(k) accounts or of any particular returns or gains as a result of your designation of any investment option. Fluctuations in the performance or value of each investment should be expected. Further, there can be no assurances that the objectives of the participants or the funds (or other investment options) will be realized. The performance of all of the various investment options will be affected by a number of factors such as general economic conditions, broad increases or decreases in prices in the equity markets, general changes in interest rates and the performance of particular securities or issuers.

Neither Edison International nor Southern California Edison Company can verify the accuracy or completeness of the information above (except with respect to the Edison International Stock Fund). Fund information has been provided by investment managers and/or Morningstar, Inc. Although data is gathered from reliable sources, completeness and accuracy cannot be guaranteed. The company cannot make any representations about the ability of any fund or other investment to achieve any particular investment return.

The investment objectives and investment policies of, and risks associated with, each of the funds is described more fully above under “Investment of Funds.” Additional information about each of the funds, including detailed fund fact sheets, can be found online at the *EIX Benefits Connection* website.

Holidays and Vacation

Overview

The *company* recognizes the value of occasional breaks away from the job for rest and relaxation, to spend time with your family, and to enable you to return refreshed and revitalized. Subject to the eligibility requirements described in this summary, you will receive your regular pay when you take time off for holidays and vacation.

Eligible employees may also elect to buy or cash out vacation days during annual enrollment.

Holidays

Overview and Important Features

The *company* observes a number of holidays on which eligible employees receive time off with pay. In addition to these observed *company* holidays, eligible employees also receive a number of floating holidays that may be taken at any time during the year with management approval.

Company Holidays

Who Is Eligible

Most *full-time* employees are paid for observed *company* holidays. *Part-time, part-time plus* and *temporary* employees who are scheduled to work on the day the *company* observes a holiday are eligible to receive pay for the hours they are regularly scheduled to work. *Leased* employees and *contingent workers* are not eligible for *company* holidays.

Company Holiday Schedules

The following holiday schedules reflect the observed *company* holidays. If you are a *full-time* employee and the day the *company* observes a holiday falls on your regularly scheduled day off, the holiday will be observed on the work day just before or just after the date, whichever is closer.

Southern California Edison Company observes the following holidays:

- New Year's Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veteran's Day
- Thanksgiving Day
- Thanksgiving Friday
- Christmas Day

Company Holiday Pay When Employment Ends

Employees who terminate their employment with the *company* will not be paid for *company* holidays that occur after the last day of employment.

Floating Holidays

Who Is Eligible

In addition to observed *company* holidays, *full-time*, *part-time* and *part-time plus* employees are eligible for *company*-paid floating holidays. *Temporary* and *leased* employees and *contingent workers* are not eligible for floating holidays.

Number of Floating Holidays Per Year

If you are eligible, the number of floating holidays you receive each calendar year depends on the *company* you work for. You may receive fewer floating holidays if you work less than a full year. (For more information see

Floating Holidays in the Year You Are Hired and **Floating Holiday Pay When Employment Ends** later in this section.)

Full-time employees of Southern California Edison Company receive 24 floating holiday hours per calendar year. *Part-time* and *part-time plus* employees receive eight floating holiday hours per calendar year.

When You May Take Floating Holidays

If you are an eligible employee, you may — with your supervisor's approval — take floating holiday hours at any time.

Unused Floating Holidays

If you are a *full-time* non-represented employee and you do not use all of your floating holiday hours in the calendar year, your unused hours are automatically banked into the following year. However, the amount of hours banked plus the amount of hours scheduled to accrue in the following year cannot be more than twice the amount of hours you are scheduled to accrue in the following year. If the amount of hours to be banked is more than the amount scheduled to accrue in the following year, the amount scheduled to accrue will be reduced to only allow for the maximum of two times the amount scheduled to accrue. For example, if you have 32 hours to be banked to the following year and you are scheduled to accrue 24 hours in the following year, your accrual in the following year would be reduced to 16 hours instead of 24 hours. This would provide you with 32 hours banked from prior year plus the reduced accrual of 16 hours, which equals 48 hours. Your total would be equal to twice the amount you were scheduled to accrue.

If you are a *part-time* or *part-time plus* non-represented employee and you do not use all of your floating holiday hours in the calendar year, your unused hours are automatically banked into the following year. However, you may never have more than 16 floating holiday hours per calendar year. If you have more than 8 floating holiday hours banked into the following year, you will be limited to the number of hours you'll receive for that year (the difference between what is banked and 16 hours).

If you are unable to use one or more floating holidays because you are disabled and receiving benefits from the Comprehensive Disability Plan (CDP), you may be paid for your unused floating holidays after the end of the year.

Floating Holidays in the Year You Are Hired

If you are hired as a *full-time* employee before July 1, you will receive 24 floating holiday hours in the year you are hired. If you are hired on or after July 1, you will receive 16 floating holiday hours in your year of hire. If you are hired as a *part-time* employee, you will receive eight floating holiday hours, regardless of your hire date.

Floating Holidays if You Change Your Employment Classification

If you change your employment classification (from *full-time* to *part-time* or *part-time plus*, or from *part-time* or *part-time plus* to *full-time*), you will automatically be paid for any unused floating holiday hours allotted under your previous classification that exceed the number of hours allotted under your new classification. The number of floating holiday hours allotted under your previous classification will count toward the number of hours allotted under your new classification. For example, if you are allotted eight floating holiday hours as a *part-time* employee and change to *full-time* employment and are now entitled to 24 floating holiday hours, you will only be credited an additional 16 floating holiday hours for a total of 24 when you change employment classification. However, if you changed from *full-time* to *part-time* employment, you will not be allotted additional floating holiday hours, but would be automatically paid for any unused floating holiday hours that exceeded eight hours.

Floating Holiday Pay When Employment Ends

If you are a non-represented employee who terminates employment or retires, your total unused floating holiday hours will be paid out in your final paycheck.

Situations Affecting Holidays

There are a number of situations that could affect your *company* or floating holidays. See the **Events Affecting Your Benefits** section for situations that may affect your holidays.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Vacation

Overview and Important Features

Eligible employees accrue vacation hours based on their service with the *company*.

You may use your vacation hours at any time during the year (with your supervisor's approval) for paid time off from work. Subject to certain limitations, for example, unused bought vacation, you may carry some or all of your unused vacation time over to the next year.

Vacation Accrual

Full-time employees begin to accrue vacation (accrued as "vacation hours") on their first day of work, and receive a pro-rated amount of vacation (accrued from hire date to December 31) in the year they are hired.

Vacation for *full-time* employees is accrued daily on a calendar year basis (January 1 - December 31). Vacation hours posted in January are not fully accrued until December 31 of the year the hours are posted. An employee's accrual rate (amount posted in January) is based on the year of service the employee will be in by December 31 of the year hours are posted. Years of service for vacation accrual are determined by the employee's vacation in-service date.

Your vacation accrual and your vacation in-service date may be adjusted if you have a deductible absence, become eligible to have prior service bridged, or have a change in employment classification (e.g., you change from *full-time* to *part-time* employment).

Vacation In-Service Date

Your original vacation in-service date begins as your date of hire as a *full-time* employee. If you have a deductible absence, your vacation in-service date will be reduced by the total number of days of the deductible absence, as described below. Periods of employment classified as *part-time* or intermittent {excluding the period June 1, 1981 through April 1, 1988} are not credited towards the vacation in-service date.

Deductible Absence

For the purposes of accruing vacation, years of service excludes any deductible absence you may have. The following types of absences are considered a deductible absence and will cause your vacation in-service date to be adjusted:

- Suspension exceeding 30 calendar days
- Layoff
- Disability after exhaustion of all CDP benefits
- Strike
- Periods of non-employment*

* If you are rehired as a *full-time* employee for at least 12 months, your vacation in-service date may be adjusted to include eligible periods of prior employment.

Vacation Accrual for *Part-time* and *Part-time Plus* Employees

Part-time non-represented employees who are regularly scheduled to work 16 or more hours per week for the entire calendar year and *part-time plus* employees accrue 40 hours of vacation per calendar year. Eligible *part-time* employee's vacation begins accruing the first month they are hired. *Part-time plus* employee's vacation begins accruing the first month they are classified as *part-time plus.* Vacation accrues on a monthly basis. Newly hired eligible *part-time* employees receive a prorated amount of vacation hours in the first calendar year

of hire based on the month they are hired. *Part-time plus* employees receive a prorated amount of vacation hours in the first calendar year of *part-time plus* classification based on the month they are classified *part-time plus*.

Vacation Accrual for *Full-time* Employees

Vacation accrual schedules vary by *company*.

The vacation accrual schedule shown below applies to *full-time* employees of Southern California Edison Company.

Year of Service You are in as of December 31	Number of Vacation Hours
1-4	80
5	88
6	104
7-11	120
12	128
13	136
14	144
15	152
16-20	160
21	168
22	176
23	184
24	192
25	200
26	208
27-29	216
30-31	224
32 and over	240

Vacation Scheduling

Vacation requests must be approved by management. Employees are permitted to reschedule vacation if they become ill or injured during their regularly scheduled vacation period. When a *company* holiday is observed during an employee's scheduled vacation, that day will not be counted as a vacation day.

Each January, vacation hours for *full-time* employees are posted on their paycheck. The hours posted are not "fully accrued" until December 31 of the year they are posted on your paycheck.

Employees must ensure they have enough vacation hours to cover the time off being requested. Time off that exceeds the employee’s available vacation for the year, as posted on their paycheck, must be charged to either Floating Holiday or Approved Time-off Without Pay.

Vacation Pay When Employment Ends

When you terminate employment or retire payment of any unused accrued vacation hours will be included in your final paycheck. If you used more vacation hours than you had accrued at the time you terminate employment or retire, you have an obligation to repay the *company* for those overdrawn vacation hours.

Unused Vacation

Unused accrued vacation may not be cashed out at the end of the year unless you are on a leave of absence for more than 14 days.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

You may, however, defer your unused hours (excluding unused bought hours) to the next year. There are two types of deferred vacation:

- **Banked Vacation**. Any vacation hours you don't use by December 31 (excluding unused bought hours) are automatically banked into the following year. However, the amount of hours banked plus the amount of hours scheduled to accrue in the following year cannot be more than twice the amount of hours you are scheduled to accrue in the following year. If the amount of hours to be banked is more than the amount scheduled to accrue in the following year, the amount scheduled to accrue will be reduced to only allow for the maximum of two times the amount scheduled to accrue. For example, an employee who is scheduled to accrue 80 hours of vacation in the following year has 120 hours left over from previous years to bank. In the following year, the employee would only accrue 40 hours of vacation time instead of the 80 hours scheduled to accrue. This would provide the employee with the maximum allowed amount of 160 hours, or two times the amount scheduled to accrue in the following year.
- **Vacation Deviation**. If work requirements imposed by the *company* or Jury Duty prevent you from using your vacation and your unused vacation hours exceed the amount eligible to be banked and accrued as described above, you may request a vacation deviation. This allows you to request that the excess hours (excluding unused bought hours) will be available in the following year. To request a vacation deviation, you must obtain both your supervisor's and department vice president's approvals. Your approved request must be submitted to the Employee Data Integrity Team (EDIT) by December 7th. If you are prevented from using vacation hours due to illness or injury, you may request that the hours be deviated to the following year. To request a vacation deviation due to illness or injury, you must obtain both your supervisor's and department vice president's approvals. Employees on disability for more than 14 days at the end of the year must contact Human Resources Disability Management by December 7th to request that any available vacation hours be deviated or their vacation hours at risk will automatically be cashed out.

Vacation hours deviated do not count against the limits for maximum vacation as described above in Banked Vacation. However, if you don't use these hours in the year to which they are deviated, they become hours you may bank for the next year and are then subject to the maximum -- that is, they are included in determining whether your annual accrual plus your banked hours would exceed the limit. If so, your accrual would be reduced accordingly.

Situations Affecting Vacation

There are a number of situations that could affect your vacation hours. Here is a quick reference chart describing some of these situations. See the **Events Affecting Your Benefits** section for other situations that may affect your coverage.

If you...	This will happen...
Become disabled while on a scheduled vacation, floating holiday or jury duty	Your disability period may begin on the date your disability occurred. You may be required to submit medical certification of your disability and the date it began. If properly certified, your vacation, floating holiday or jury duty time (if applicable) will be credited back to you.
Become disabled, are receiving Comprehensive Disability Plan benefits and will return to work prior to December 31	You continue to accrue vacation, but you may not use vacation while you are disabled. Your unused accrued vacation will be deferred until you return to work.
Become disabled, are receiving Comprehensive Disability Plan benefits, and will return to work before December 31, but not in time to use all your vacation by the last pay period of the year	You continue to accrue vacation, but you may not use vacation while you are disabled. You may request a vacation deviation of your accrued vacation hours that exceed the amount you are scheduled to accrue next year. Refer to the "Unused Vacation" section for details regarding the vacation deviation process. If you bought vacation and still have unused bought vacation hours after the last pay period of the year, you will receive payment for them on the

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	last payday of the year. You will receive information in November regarding the year-end payment process for remaining bought vacation hours.
Become disabled, are receiving Comprehensive Disability Plan benefits, and will not return to work prior to the last pay period of the year	You continue to accrue vacation, but you may not use vacation while you are disabled. If your accrued vacation hours exceed the limit for banking to the following year, the hours over the limit will automatically be cashed out, unless you request a vacation deviation for the vacation hours that exceed the amount you are scheduled to accrue next year. You must contact your payroll location before December 7 and request that they contact Disability Management to have the excess hours deviated. Refer to the "Unused Vacation" section for details regarding the vacation deviation process. If you bought vacation and still have unused bought vacation hours after the last pay period of the year, you will receive payment for them. You will receive information in November regarding the year-end payment process for remaining bought vacation hours.
Become disabled, have exhausted your full-pay sick leave, and begin receiving reduced pay (Comprehensive Disability Plan extended benefits) for your disability	You continue to accrue vacation, but you may not use vacation while you are disabled. You can, however, request pay in lieu of unused accrued vacation but not in lieu of bought vacation. Unused bought vacation is only paid out at year end. You will receive information in November regarding the year-end payment process for remaining bought vacation hours.
Become disabled, exhaust all of your Comprehensive Disability Plan benefits, and are receiving Long Term Disability benefits, Wage Continuation or Return to Work Program benefits	You no longer accrue vacation time. You will automatically be paid for your unused earned vacation and any vacation you bought and have not used in that year up to the amount that has been deducted for bought vacation from your paychecks.
Change employment classification (from *full-time* to *part-time* or *part-time plus*, or from *part-time* or *part-time plus* to *full-time*)	If you change from *full-time* to *part-time* or *part-time plus* employment, you will automatically be paid for any unused vacation previously accrued. If you change from *part-time* or *part-time plus* to *full-time* employment, you will retain any unused vacation hours previously accrued. If you used more vacation hours than had been accrued as a *part-time* or *part-time plus* employee, the excess (negative) hours will be netted against the hours added under your new *full-time* classification.
Change to an employee classification or status not eligible for Vacation Buying	If you bought more vacation than you have used, you'll receive payment for the bought vacation hours you did not use.

Vacation Buying and Cash Out

Vacation Buying and Cash Out revised December 19, 2012.

Overview and Important Features

Eligible employees may cash out up to 40 hours of vacation each year. Generally, under *Flex*, employees with less than 16 years of service may buy one to five days (in eight hour increments) each year provided the number of days bought and scheduled to accrue does not exceed 20 days (160 hours).

If you select a vacation buying option, you cannot change that option until the next annual enrollment. Once you buy them, you cannot cash them out, or bank or deviate them to the next year. You might consider cashing out vacation hours if you have more vacation allowance than you're able to use in a year. Once you cash out vacation hours, you cannot buy them back.

If you are eligible:

- During *Flex* annual enrollment, you may elect to buy or cash out vacation hours for the following calendar year
- Your election to buy or to cash out vacation hours is irrevocable. You cannot change it during the year, even if you have a *qualified life event*.
- You cannot buy and cash out vacation hours in the same year
- If you buy vacation hours and don't use all your vacation by the last pay period of the year, you will receive a cash payment for the unused bought hours

Vacation hours you buy are considered "elective" hours and are used after all other vacation time (accrued, banked and deviated).

Who Is Eligible

Most *full-time* employees of the *company* are eligible to buy and cash out vacation hours.

Vacation Cash Out is available to *part-time plus* employees. *Part-time plus* employees are not eligible for Vacation Buying.

Vacation Buying and Vacation Cash Out options are not available to *part-time, temporary* and *leased* employees *and contingent workers*.

Election Deadlines

Annual Enrollment

The opportunity to buy or cash out vacation takes place once a year -- during the *Flex* annual enrollment period. You are not allowed to buy or cash out vacation for the calendar year in which you are hired. To be eligible to buy or cash out vacation for the calendar year following the year in which you are hired, you must have been hired before December 2 and made your election before January 1 of the year immediately following your hire date.

Your election to buy or cash out vacation doesn't automatically continue from year to year. A new election is required each annual enrollment if you wish to buy or cash out vacation in the following year.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Once you elect a Vacation Buying or Vacation Cash Out option, you may not change it, even if you have a *qualified life event*.

How Vacation Buying Works

You may buy from eight to 40 hours of additional vacation, in eight-hour increments.

However, the number of vacation hours you buy plus the number of vacation hours you are scheduled to accrue in the following year can't exceed 160 hours. Therefore, most employees with less than 16 years of service are eligible to buy vacation hours because the vacation they accrue in a year is less than 160 hours. .

If you buy vacation, the number of hours you bought will be shown as Vacation Hours "Bought" on your paycheck stub in January and will increase your available vacation for the year.

Using Bought Vacation

You use the vacation you buy after you have used all other vacation to which you're entitled for the year. That includes your normal vacation allowance for the year plus any hours you were allowed to bank or deviate from earlier years.

If you are on a compressed work schedule, you will be charged for vacation time according to the number of hours that you are scheduled to work. For example, if you take a full vacation day on a day that you are scheduled to work nine hours, you will be charged nine hours of vacation time.

Bought Vacation at Year End

If you do not use all of your vacation hours by the last pay period of the year, you will automatically receive payment for the unused bought hours on the last payday of the year. In November, information will be sent to your home regarding the year-end payment process.

Unused bought vacation hours cannot be banked or carried over to the following year.

Price Tags

You buy vacation in eight-hour increments. The price tag is your hourly *base pay* on the *company's* record-keeping system as of September 1 of the prior plan year multiplied by eight. You pay for the additional vacation through payroll deduction, with pre-tax dollars.

The *company* provides contributions for you to spend on your *Flex* benefit options. You may use *company* contributions you don't spend on other benefits to buy vacation hours. *Company* contributions and payroll deductions are divided among your *deduction periods* each year. See the ***Flex*** summary for more information on *company* contributions.

If you don't receive enough pay during a pay period to cover your price tag, the *company* will deduct what you owe (arrears) from your future paychecks on a post-tax basis. You will be billed for any amount in arrears for more than three consecutive pay periods.

Situations Affecting Bought Vacation Hours

If you do not use all the vacation hours you bought by the last pay period of the year, you will receive payment for any remaining unused bought vacation hours on the last payday of the year. You will receive information in November regarding the year-end payment process for remaining bought vacation hours. See the **Events Affecting Your Benefits** section for other situations that may affect your coverage.

How Vacation Cash Out Works

Payment For Cashed Out Vacation

You cash out vacation in eight-hour increments. The amount paid for cashed out vacation is your hourly *base pay* on the *company's* record keeping system as of September 1 of the prior plan year (the calendar year for which you cashed out vacation) multiplied by eight.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Vacation payments are subject to income tax. You will receive payment for the number of hours you cashed out in a paycheck in January of the respective vacation year.

The number of hours you cashed out will be shown as Vacation Hours "Cashed Out" on your paycheck stub in January and will reduce your available vacation for the year.

Appeals

If your bought elective vacation hours are paid out at year-end when you believe they should not have been, you may appeal the decision. See **Claims and Appeals** in the Other Important Information section in this handbook for details about documentation and the appeals process.

For More Information

You can get information about holidays and vacation by contacting the HR Service Center at PAX 23456 or (800) 500-4723 and choose the option for the Employee Information Center.

Other Time Off

Overview

The *company* recognizes that we all need time away from work to fulfill commitments - to our families and our communities. As a result, the *company* makes available a range of benefits designed to meet individual needs. These "Other Time Off" benefits include:

- Paid time off, including voting, jury duty, and death in your immediate family
- Leaves of absence, including *military leave*, personal leave, and family and medical leave
- Other unpaid time off for employees in California to spend time at their child's school or to attend their child's school function

Paid Time Off

Overview and Important Features

In addition to paid holidays and vacation, the *company* provides eligible employees paid time off, within certain limits, for the following reasons:

- Voting
- Jury Duty
- Testifying As A Subpoenaed Witness
- Death in the Immediate Family
- Funeral of a Fellow Employee

In order to receive pay for time off in most of these situations, you must have your supervisor's approval ahead of time. Other limitations and requirements for each type of time off are listed in the sections below.

Voting

Upon advance notification to management, *full-time*, *part-time* and *part-time plus* employees will be given time off to vote in elections. Payment for such time off is limited to two hours per election.

Jury Duty

Full-time, *part-time* and *part-time plus* employees who have been summoned are eligible for paid time off to serve jury duty. For more information, see Human Resources Policy #507 under Edison Policy & Procedure Central available on Portal.

Testifying As A Subpoenaed Witness

Full-time, *part-time* and *part-time plus* employees may be eligible to receive paid time off to serve as a subpoenaed witness.

Upon notification to management, you will be given paid time off to serve as a subpoenaed witness when you are requested by the *company* in a *company*-related matter, or when subpoenaed by a governmental body.

If you are subpoenaed to testify on a non-*company* matter or by a non-governmental body, you are not paid for this time off. You may, however, use your vacation or floating holiday time for these purposes.

Death in the Immediate Family

Full-time, *part-time* and *part-time plus* employees with six months or more of *company* service are eligible for paid time off due to the death of an immediate family member.

Full-time Employees

The *company* provides paid time off for eligible employees to arrange and attend the funeral of an immediate family member. The approved amount of paid time off is determined by your local business unit and is made on an individual basis. Maximum paid time off for this purpose is 24 hours per incident.

Part-time and *Part-time Plus* Employees

The *company* provides paid time off for you to arrange and attend the funeral of an immediate family member only if you are scheduled to work during the time needed to arrange and attend the funeral. The approved

amount of paid time off is determined by your local business unit and is made on an individual basis. Maximum paid time off for this purpose is 24 hours per incident.

Immediate Family Members

For the purposes of paid time off for death in the family, your immediate family includes your:

- *Spouse* or *domestic partner*
- *Child,* step-child, and child of your *domestic partner*
- Parent and step-parent
- Parents of your *spouse* or *domestic partner*
- Brother and step-brother
- Sister and step-sister
- Grandparent (but not your *spouse's* or *domestic partner's* grandparent)
- Grandchild

Funeral of a Fellow Employee

Full-time, *part-time* and *part-time plus* employees with six months or more of *company* service may be eligible for paid time off to attend the funeral of a fellow employee of the *company*.

Full-time Employees

The approved amount of paid time off is determined by your local business unit and is made on an individual basis.

Part-time and *Part-time Plus* Employees

The *company* provides paid time off for this purpose only if you are scheduled to work during the time needed to attend the funeral. Also, you will receive pay only for time off during your normally scheduled work hours. The approved amount of paid time off is determined by your local business unit and is made on an individual basis.

Leaves Of Absence And Other Unpaid Time Off

Overview and Important Features

Leaves of absence are extended periods of time during which you are unable to come to work. Your supervisor's approval is required for most types of unpaid time off. For military or medical leave in the case of an emergency, your supervisor must be informed as soon as possible. Time limits and circumstances under which a leave of absence may be taken vary by type of leave.

Under certain circumstances, the *company* permits employees to take unpaid time off for brief periods of time. Employees in California, for example, may be granted time off under the California Education Code and the California Family School Partnership Act. Approval for unpaid time off for other reasons is determined by your local business unit and is made on an individual basis.

Military Leave of Absence

Full-time, part-time, part-time plus and *temporary* employees who serve in the military are eligible for a *Military Leave of Absence*. For more information, see Human Resources Policy #503 under Edison Policy & Procedure Central available on Portal.

Personal Leave of Absence

A Personal Leave of Absence is *company*-approved time away from work, without pay, for a period of more than 30 consecutive calendar days. For more information, see Human Resources Policy #501 under Edison Policy & Procedure Central available on Portal.

Family and Medical Leave

Full-time, part-time, part-time plus and *temporary* employees may be eligible for leave due to their own serious health conditions (including pregnancy related disability), to care for a family member with a serious health condition, or to bond with a child following birth, adoption, or foster care placement. For more information, see Human Resources Policy #502 under Edison Policy & Procedure Central available on Portal.

California Education Code

Any employee (*full-time, part-time, part-time plus, temporary*) working in California who is a parent, guardian, or grandparent with custody of a child in kindergarten through grade 12 may take time off from work under the California Education Code.

How Time Off under the California Education Code Works

Upon advance notification to management, eligible employees may be given time off to appear at their child's school when the child has been suspended. Attendance at school is limited to the class(es) from which the child was suspended in addition to a meeting with the school administrator. Suspension of a child attending day care is not covered.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Time taken off under the California Education Code is unpaid. Employees may be paid for this time if they use vacation or floating holiday time.

California Family School Partnership Act

Any employee (*full-time, part-time, part-time plus, temporary*) working in California who is a parent, guardian, or grandparent with custody of a child in kindergarten through grade 12 or attending a licensed child day care facility may take time off from work under the California Family School Partnership Act.

How Time Off under the California Family School Partnership Act Works

With advance notice to management, employees may use up to eight hours in a calendar month (not to exceed 40 hours per calendar year) to attend the school activities of their children. Time may be taken in hourly increments. All activities sponsored by the school are covered, such as school plays, graduation, parent-teacher conferences, athletic events, and special commemorative days like Parents' Day. Non-school sponsored activities such as organized youth sports programs or boys and girls club functions are not covered.

If both parents work for the *company*, they may take time off simultaneously to attend school activities.

Time taken off under the California Family School Partnership Act is unpaid. Employees may be paid for this time if they use vacation or floating holiday time.

For More Information

If you have questions about time off benefits and policies, you should contact the Employee Information Center at PAX 23456, (626) 302-3456, or (800) 500-4723. You may e-mail the Employee Information Center at infocntr@sce.com

Other Programs

An Overview of Other Programs

The *company* recognizes the challenges we all face in balancing work and family responsibilities in today's fast-paced environment. As a result, the *company* is pleased to make available to eligible employees, retirees, and their families a wide range of benefits and programs designed to meet individual concerns.

These "Other Programs" may include Long-Term Care insurance, tuition assistance for approved educational expenses, the availability of outside resources to help with a variety of dependent care and personal issues, and discounts on entertainment attractions for the enjoyment of employees and retirees. The programs available to you depend on which *company* you work for and, in some cases, where you live.

Rideshare Program

The Rideshare Program provides employees with options for commuting to and from work. Employees may voluntarily participate in the option that best meets their work schedules and personal needs.

If you would like more information on the Rideshare Program, call PAX 23456, (626) 302-3456, or (800) 500-4723 and select the option for the Employee Information Center, or e-mail your request to infocntr@sce.com. Information is also available on Portal.

Credit Union

The SCE Federal Credit Union helps you and your family members accumulate personal savings, establish credit, and obtain loans. As a non-profit organization, the Credit Union returns any gains or earnings to members in the form of lower interest rates and higher yields on savings. The Credit Union has served the *company's* employees, retirees, and family members since 1952, but it operates completely independent of the *company*.

If you would like an application or more information, call the Credit Union at:

- PAX 48765
- (626) 960-6888, or
- (800) 866-6474

You may also visit the Credit Union's Web site at www.scefcu.org.

Educational Reimbursement Program

The Educational Reimbursement Program encourages and assists employees in their development and enhances the *company's* performance through an educationally advanced workforce.

If you would like more information on the Educational Reimbursement Program, call PAX 23456, (626) 302-3456, or (800) 500-4723, and select the option for the Employee Information Center. You can also access the Employee Information Center via e-mail at infocntr@sce.com.

Information is also available on Portal.

Electric Service Discount/Reimbursement

Southern California Edison Company (SCE) provides a discount on domestic electric service to eligible employees and retirees of SCE who reside within SCE's service territory. Employees whose work assignment precludes them from living in SCE's service territory may be eligible to receive a comparable reimbursement for

their electric service. The employee discount is subject to the DE Tariff Schedule approved by the California Public Utilities Commission.

If you would like more information on the Electric Service Discount or Reimbursement, call PAX 23456, (626) 302-3456, or (800) 500-4723 and select the option for the Employee Information Center, or send your request by e-mail to infocntr@sce.com.

Employee Activities by Recreation Connection

Employee Activities by Recreation Connection offers employees and retirees discounts on entertainment attractions, *company* logo merchandise, and certain services.

For more information about Employee Activities by Recreation Connection, please call PAX 28841 or (626) 302-8841. You may also access the Recreation Connection at www.recreationconnection.com/edison.

Resources for Living

The *company* offers worklife benefits through Resources for Living which provide you and your household members with the valuable and timely knowledge needed to manage daily life. Resources for Living offers assistance with dependent care including child care, adult/elder care, prenatal planning, adoption preparation, summer care, emergency care, school profiling, college planning, and temporary or specialized care for dependents of all ages. Resources for Living also provides assistance with personal issues including pet services, health and wellness resources, and convenience services, such as entertainment and travel/vacation planning.

In addition, Resources for Living provides a variety of consultation services including:

- Financial services and consultation
- Legal information and consultation
- Identity theft program

Resources for Living counselors are available 24 hours a day, 365 days a year. If you would like more information about worklife services, contact Resources for Living by phone or Internet:

- (800) 443-4474 (or (858) 571-1698 if outside the United States)
- (800) 873-1322 for hearing impaired
- www.HorizonCareLink.com Logon: edison, password: eap

Long-Term Care (LTC) Insurance Plan

The group Long-Term Care Insurance Plan is provided directly by Prudential Insurance Company of America (Prudential). The plan pays benefits when a covered person cannot perform certain activities of daily living because of illness, injury, or the aging process. Medical insurance and Medicare cover only a small portion of long-term care expenses.

Custodial care services like Nursing Home Care, Assisted Living Facilities, and Home Health Care services are examples of some of the benefits provided under the Long-Term Care Insurance Plan.

The *company* does not administer the plan. It allows Prudential to offer this coverage to employees, retirees, and eligible family members at group rates, and allows payroll deductions for you and your spouse's coverage. The Long-Term Care Insurance Plan is not available in all states.

If you would like more information about the Long-Term Care Insurance Plan, call Prudential at (800) 732-0416, 5:00 a.m. to 5:00 p.m., Pacific time, Monday through Friday.

To enroll, log on to www.prudential.com/gltcweb/sce

Other Important Information

Overview

This section of your handbook provides general administrative information about the *company's* benefit plans. It includes:

- A review of various situations that could affect your participation in the following benefit plans and programs, which are described in this handbook
  - 401(k) Savings Plan
  - Comprehensive Disability Plan
  - Dental Plan
  - Dependent Care Reimbursement Account
  - Employee Assistance Program
  - *Flex*
  - Health Care Reimbursement Account
  - Life and Accident Insurance Plans
  - Long Term Disability Plan
  - Medical Plan
  - Retirement Plan
  - Vacation Buying Plan and Vacation Cash Out Option
  - Vision Plan
- Directions on how to file a claim for benefits and, in the event your claim for benefits is denied, how to file an appeal
- Information the *company* is required to provide you under the Employee Retirement Income Security Act of 1974 (ERISA) describing your rights and protections as a plan participant
- Details about the *company's* rights and responsibilities as a benefit plan sponsor

Situations That May Affect Your Plan Participation

A variety of life events, government regulations and employment-related circumstances may affect your participation in the *company's* benefit plans. While the examples described below and in the Events Affecting Your Benefits section cover most situations, there may be some circumstances that are not discussed in this

handbook. If you need information about how a specific situation might affect your participation and the payment of benefits to you and/or your beneficiaries, contact the *EIX Benefits Connection* by phone or online at:

- (866) 693-4947
- www.eixbenefits.com

You may also access the *EIX Benefits Connection* online by logging on to the Edison International Portal and clicking on *EIX Benefits Connection*.

Company Changes to Your Benefit Elections

The *company* has the right to change the benefit elections of certain employees as required to keep the plans in accord with federal and state laws. While such changes are most likely to apply to higher-paid employees, they could affect other employees. You will be notified if the *company* is required to make changes to your benefit elections.

Changes in Your Name or Address

You must promptly notify the *company* of any change in your name or address by contacting the *EIX Benefits Connection* by phone or online at:

- (866) 693-4947
- www.eixbenefits.com

If you don't notify the *company* in a timely manner, you may not receive important benefits information, enrollment materials, or benefit payments. Any *company* or plan communication, statement or notice addressed to you at your latest name and/or mailing address on file with the *company* is binding on you.

Changes in Your Employment Status

Your health care, life insurance, accident insurance, disability benefits and other health and welfare plan coverage may be delayed, changed or stopped if your employment status changes or if you leave the *company*. Participation in the Retirement Plan and 401(k) Savings Plan may also be affected. See the individual benefit plan summaries in this handbook for options available to you if your eligibility ends. The Continued Health Care Coverage section of this handbook provides details about options for continuing your health care coverage if you or your dependents become ineligible.

Late Notification of Claim

If you or your beneficiary do not notify the respective plan's claim administrator of a pending claim on a timely basis, payment may be delayed or may not be paid at all. It is important to follow each plan's procedures for filing benefit claims. See **Claims and Appeals** in this summary for additional information.

Plan Participant's Competency

Every person receiving or claiming benefits under the plans shall be presumed to be mentally competent and of age until the date on which the plan receives written, legal notice that the person is incompetent or a minor and that a guardian or other person legally vested with the care of this person or estate has been appointed. Any payment made to a qualified appointee shall completely discharge the plan's liability for making such payment.

Not a Contract of Employment

Nothing in this handbook or in the benefit plan documents states or implies that participation in the plans is a guarantee of continued employment with the *company*. Unless you are covered by the express terms of a written agreement stating otherwise, you are employed at the will of the *company*. The *company's* rights regarding disciplinary action and termination of any employee are in no manner changed by any provision of any plan, regardless of the effect such action may have upon the employee's benefits under the plans.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Collective Bargaining Agreements

The plans described in this handbook may be maintained pursuant to one or more collective bargaining agreements. Copies of these agreements are available for examination by participants and beneficiaries and may be obtained upon written request to:

Labor Relations Department
Southern California Edison Company
P.O. Box 800
Rosemead, CA 91770

Employees represented by the following unions have rights as a result of the collective bargaining process:

- *IBEW*, Locals 15, 47 and 459
- *SOFA*, Local 246A
- *UWUA*, Local 246

Plan Funding

Some of the benefits are funded completely by the *company*; others are funded by the *company* and plan participants; and some are funded solely by plan participants. The respective benefits committees administer the plans for the exclusive benefit of plan participants and beneficiaries. *Company* and participant contributions are used for the exclusive benefit of plan participants and beneficiaries or to pay plan expenses not otherwise paid by the *company*. The following chart shows the funding method and the responsible party(ies) for plan administrative expenses.

PLAN FUNDING			
Plan	**Funding Method**	**Trustee**	**Responsibility for Administrative Expenses**
Health Care Reimbursement Account (HCRA)	Participants pay for HCRA through pre-tax payroll deductions.	Not applicable	Southern California Edison Company
Dependent Care Reimbursement Account (DCRA)	Participants pay for DCRA through pre-tax payroll deductions.	Not applicable	Southern California Edison Company
Medical Plan	Contributions are based on pre-established monthly rates and projected claims experience and other costs. Participants pay a share of these contributions through pre-tax payroll deductions. The *company's* share is paid out of its operating income. For Southern California Edison Company (and its subsidiaries), a portion of these *companies'* share of the cost for providing benefits under these plans after retirement	For Health Care Benefits Account: Mellon Trust of New England, National Association 135 Santilli Highway Everett, MA 02149 For VEBAs: Northern Trust Company 50 South LaSalle Chicago, IL 60675	Southern California Edison Company

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	may also be funded through the Health Care Benefits Account of the Southern California Edison Company Retirement Plan and various Voluntary Employees' Beneficiary Associations (VEBAs) including: • The VEBA of the Non-represented Employees of Southern California Edison Company • The 1999 VEBA of the Non-represented Employees of Southern California Edison Company • The VEBA of the Represented Employees of Southern California Edison Company		
Dental Plan	Each month the cost of the actual claims, plus an administrative fee, are paid to the respective plans. Participants pay a share of these costs through pre-tax payroll deductions. The *company's* share is paid out of its operating income. For Southern California Edison Company (and its subsidiaries), a portion of these *companies'* share of the cost for providing benefits under these plans after retirement may also be funded through	For Health Care Benefits Account: Mellon Trust of New England, National Association 135 Santilli Highway Everett, MA 02149 For VEBAs: Northern Trust Company 50 South LaSalle Chicago, IL 60675	Southern California Edison Company

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	the Health Care Benefits Account of the Southern California Edison Company Retirement Plan and various Voluntary Employees' Beneficiary Associations (VEBAs) including: • The VEBA of the Non-represented Employees of Southern California Edison Company • The 1999 VEBA of the Non-represented Employees of Southern California Edison Company • The VEBA of the Represented Employees of Southern California Edison Company		
Vision Plan	The *company* pays the full cost of the Vision Plan.* Each month the cost of actual claims, plus an administrative fee, are paid out of the *company's* operating income. For Southern California Edison Company (and its subsidiaries), a portion of these *companies'* share of the cost for providing benefits under this plan after retirement may also be funded through the Health Care Benefits Account of the Southern California Edison Company Retirement Plan	For Health Care Benefits Account: Mellon Trust of New England, National Association 135 Santilli Highway Everett, MA 02149 For VEBAs: Northern Trust Company 50 South LaSalle Chicago, IL 60675	Southern California Edison Company

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	and various Voluntary Employees' Beneficiary Associations (VEBAs) including: • The VEBA of the Non-represented Employees of Southern California Edison Company • The 1999 VEBA of the Non-represented Employees of Southern California Edison Company • The VEBA of the Represented Employees of Southern California Edison Company * Certain categories of participants also contribute through pre-tax payroll deductions. See the Vision Plan summary for more information.		
Employee Life Insurance	Funding is through insurance policies with Aetna U.S. Healthcare and the Prudential Life Insurance Company and is based on claims experience. The *company* and plan participants contribute. The *company's* share is paid out of its operating income. For Southern California Edison Company (and its subsidiaries), a portion of these *companies'* share of the costs for providing benefits under this plan after retirement	For VEBAs: Northern Trust Company 50 South LaSalle Chicago, IL 60675	Southern California Edison Company

	may be funded through the Life Insurance Voluntary Employees' Beneficiary Association (VEBA) of Southern California Edison Company.		
Dependent Life Insurance	Funding is by plan participants through an insurance policy with the Prudential Life Insurance Company and is based on claims experience.	Not applicable	Southern California Edison Company
Accidental Death & Dismemberment Insurance (AD&D)	Funding is through an insurance policy with CIGNA Group Insurance and is based on claims experience. The *company* and plan participants contribute. The *company's* share is paid out of its operating income.	Not applicable	Southern California Edison Company
Business Travel Accident Insurance	Funding is through an insurance policy with CIGNA Group Insurance and is based on claims experience. The *company* pays the cost of this plan out of its operating income.	Not applicable	Southern California Edison Company
Employee Assistance Program (EAP)	The *company* pays the cost of the EAP out of its operating income. For Southern California Edison Company (and its subsidiaries), a portion of these *companies'* share of the cost for providing benefits under this plan after retirement may also be funded through the Health Care Benefits Account of the Southern California Edison Company	For Health Care Benefits Account: Mellon Trust of New England, National Association 135 Santilli Highway Everett, MA 02149 For VEBAs: Northern Trust Company 50 South LaSalle	Southern California Edison Company

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	Retirement Plan and various Voluntary Employees' Beneficiary Associations (VEBAs) including: • The VEBA of the Non-represented Employees of Southern California Edison Company • The 1999 VEBA of the Non-represented Employees of Southern California Edison Company • The VEBA of the Represented Employees of Southern California Edison Company	Chicago, IL 60675	
Comprehensive Disability Plan	Participants contribute an amount equal to the contributions required by the California State Disability Insurance program. The *company* contributes any additional amount required out of its operating income. Participant contributions are held in the Southern California Edison Employee Welfare Plan Trust II.	Dr. Susan Heller, Corporate Medical Director George Tabata, Assistant Treasurer Robin Drummond, Manager of Cash Management Southern California Edison Company 8631 Rush Street Rosemead, CA 91770	Southern California Edison Company
Long Term Disability Plan (LTD)	Funding is actuarially determined. Participants pay a share of these costs through pre-tax payroll deductions. The *company's* share is paid out of its operating income.	Northern Trust Company 50 South LaSalle Chicago, IL 60675	Southern California Edison Company

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	For Southern California Edison Company (and its subsidiaries), a portion of these *companies'* share of the cost for providing benefits under this plan may also be funded through the Long Term Disability Voluntary Employees' Beneficiary Association (VEBA) of Southern California Edison Company.		
401(k) Savings Plan	Participants contribute a percentage of pay through pre-tax and/or post-tax (Roth contributions) payroll deductions, and the *company* makes matching contributions for eligible employees from its operating income. Forfeitures from the plan are used to reduce future *company* contributions. All plan assets are held in a trust.	State Street Global Advisors Retirement Investment Services 200 Newport Avenue North Quincy, MA 02171	Southern California Edison Company
Retirement Plan	Funding is actuarially determined and is paid by the *company* out of its operating income. Forfeitures from the plan are used to reduce future *company* contributions. All plan assets are held in a trust.	Mellon Trust of New England, National Association 135 Santilli Highway Everett, MA 02149	Southern California Edison Company
Vacation Buying Plan	Participants pay for vacation they purchase through pre-tax payroll deductions.	Not applicable	Southern California Edison Company

Plan Administration

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The Southern California Edison Company Benefits Committee serves as plan administrator to each of the plans and has the full and final power and discretionary authority to determine eligibility to participate in the plans, to determine covered benefits, and to interpret, construe and apply the terms and provisions of the plans. The Committee may designate one or more persons to carry out those responsibilities. Any discretionary acts taken by or on behalf of the plan administrator shall be uniform in nature and apply to all participants similarly situated without discrimination under ERISA or the Internal Revenue Code. Likewise, all rules and decisions made by or on behalf of the plan administrator shall be uniformly applied to all participants in similar circumstances.

The Committee has delegated the determination of covered benefits for medical, dental, vision, employee assistance, and insurance provided for life, accidental death and dismemberment, and business travel to the claims administrators identified under the Contact for Filing Claims chart in the Claims and Appeals section below. The claims administrators have the full discretionary authority to interpret, construe and apply the terms of the plans, to decide questions related to the payment of benefits, and to make any related findings of fact.

The decisions of the Committee and the claims administrators shall be final and binding to the full extent permitted by law.

Plan Confidentiality

Any information provided by a participant or physician to the *company* or the plans' Benefits Committee shall be treated as confidential and not be disclosed without the participant's consent, except as may be permitted by law.

Reliance on Plan

The terms of each plan control. A participant or beneficiary may not rely on any oral or written statement, received from any source, which contradicts the terms of the plans as set forth in the official plan documents. Where conflicts exist, the terms set forth in the plan documents will govern.

Plan Continuation

The *company* expects to continue the plans and programs described in this handbook indefinitely, but reserves the right to change, suspend, amend, or terminate any provision or plan or all plans at any time.

Contributions, premium rates, *deductibles*, *out of pocket* maximums, benefit levels, benefits covered, and all other plan features can be affected. Such changes may affect any or all participants and beneficiaries, including active, inactive and retired employees. The *company* is not obligated to continue its contributions or to maintain the plans or any of their provisions for any given length of time. If a benefit plan is terminated or materially changed for any reason, you will be promptly notified if you are affected by the termination or the change.

Changes affecting the benefits provided to union-represented employees are generally subject to bargaining agreement provisions.

Claims and Appeals

How to File a Claim

Requests for plan benefits should be directed to the party identified in the chart below as the Contact for Filing Claims under that plan. Except for Urgent Care Claims (as described below), claims must be made in writing. For some of the health care plans, you do not need to file a claim in order to receive plan benefits if you use a provider within the plan's network. Refer to the individual plan summary for more information on the claim procedures of a particular plan. Unless otherwise stated in a respective plan summary, you must file your claim

within a reasonable time (not exceeding 120 days) after you become aware, or reasonably should have become aware, of the existence of facts on which the claim could be based.

Time Period for Deciding Claim

The chart below describes the maximum period of time within which an initial decision on a claim will be made after the claim is received. The administrator may extend the decision period for an additional number of days, as indicated in the chart, if the administrator determines that an extension of time for processing the claim is required due to special circumstances, or in the case of the health and disability plans, for matters beyond the plan's control. In such cases, the administrator will notify you of its need for an extension, the reason for the extension, and when they expect to make a decision on your claim. If the extension is needed because they need additional information from you to decide the claim, the administrator will notify you of the information needed, and you will have at least 45 days to provide that information. The time period permitted for the administrator to decide your claim will be suspended pending the administrator's receipt of the additional information requested from you. Once you respond to that notice, the plan will have the benefit of the extension of time for deciding your claim.

Claims for Group Health Plans

With respect to the health plans, the time period for determining a claim will depend upon whether the claim is a "Pre-Service Claim," an "Urgent Care Claim," or an "Other Claim," as described below.

- Pre-Service Claims: A claim is a "Pre-Service Claim" if:
  - You are requesting prior authorization for a health care item or service because you are required to do so under the plan as a condition of receiving that benefit;
  - You are requesting prior authorization for a health care item or service because you are required to do so under the plan as a condition of receiving a larger benefit; or
  - You are requesting prior approval under a utilization review program.

Pre-Service Claims will be determined within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan, subject to one 15 day extension for matters beyond the control of the plan. You should indicate in your claim any medical circumstances that may require a faster decision.

If you communicate a Pre-Service Claim to a person or organizational unit customarily responsible for handling the *company's* benefit matters, and you communicate the name of the claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, but otherwise fail to follow the plan's procedures for filing a Pre-Service Claim, you will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notice will be provided to you as soon as possible, but not later than five days (24 hours in the case of a failure to file a claim involving an Urgent Care Claim) following the failure. Notification may be oral, unless you request written notification.

- Urgent Care Claims: A claim is an "Urgent Care Claim" if:
  - The claim is a Pre-Service Claim; and
  - The claims administrator, or a *physician* with knowledge of the patient's medical condition, determines that application of the regular time periods for deciding Pre-Service Claims will seriously jeopardize the patient's life or health, or their ability to regain maximum function, or subject them to severe pain that cannot be adequately managed without the requested care or treatment.

  Urgent Care Claims will be determined as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the plan's receipt of the claim. You should indicate in your claim any medical exigencies that might require a faster decision. You will be notified within 24 hours if your claim is incomplete.

  Exception: If the claim is a request to extend an ongoing course of treatment (i.e., the plan previously approved a certain number of treatments or treatment for a certain period of time) that involves Urgent Care, then instead of the regular time period for deciding Urgent Care Claims, the claim will be decided within 24 hours, provided the request is received at least 24 hours before the treatment expires. Otherwise, the regular time period for deciding Urgent Care Claims will apply.
- Other Claims: The time period for "Other Claims" will apply to all claims that are not Pre-Service Claims or Urgent Care Claims. For example, if your claim is for reimbursement or payment of the cost of medical care already provided, the time period for "Other Claims" would apply.

Plan Name	Contact for Filing Claims	Decision Time Limit
Southern California Edison Company Retirement Plan	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947	90 days
Edison International Retirement Plan for Bargaining Unit Employees of EME Homer City Generation, LP	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947	90 days (up to 180 days with extension) For disability retirement: 45 days (up to 75 days with one extension; or up to 105 days with two extensions)
Edison International Retirement Plan for Bargaining Unit Employees of Midwest Generation, LLC	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947	90 days (up to 180 days with extension) For disability retirement: 45 days (up to 75 days with one extension; or up to 105 days with two extensions)
Edison 401(k) Savings Plan	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947	90 days If claim involves a disability determination: 45 days (up to 75 days with one extension; or up to 90 days with two extensions)
Edison International Welfare Benefit Plan Claims for plan eligibility (Claims procedures for benefits under individual plan components are described below)	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947	90 days (Up to 180 days with extension)
Blue Shield of California PPO and EPO	Prior authorization: (800) 343-1691 Prior authorization for radiological services in California (888) 642-2583 Claims submission: Blue Shield of California P.O. Box 272540 Chico, CA 95927-2540	15 days for PreService Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Express Scripts and CuraScript	Express Scripts - (C2N) Express Scripts, Inc. Member Reimbursements P.O. Box 66583 St. Louis, MO 63166 (800) 955-1181	15 days for PreService Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Health Net HMO and PPO	Health Net Commercial Claims P.O. Box 14702 Lexington, KY 40512 (888) 893-1572	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Health Net Seniority Plus Medicare Advantage HMO	Health Net Medicare Claims P.O. Box 14703 Lexington, KY 40512 (800) 275-4737	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

		with extension)
Kaiser Permanente California and Kaiser Senior Advantage Medicare Advantage HMO	Kaiser Permanente Insurance Company c/o Harrington Health 3701 Boardman-Canfield Rd., Bldg. B Canfield, OH 44406-7005 (800) 533-1833 – So. Calif. (800) 663-1771 – No. Calif. Kaiser Senior Advantage Kaiser Permanente Regional Member Services 393 Walnut Street Pasadena, CA 91188 (800) 443-0815	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
UnitedHealthcare HMO and UnitedHealthcare Medicare Advantage HMO	UnitedHealthcare Claims Department P.O. Box 30968 Salt Lake City, UT 84130-0968 (800) 624-8822 - HMO (866) 622-8055 – Medicare Advantage	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
UHC Senior Supplement and UHC Senior Supplement 3500	UnitedHealthcare Claims Department P.O. Box 30972 Salt Lake City, Utah 84130-0972 (800) 851-3802	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Highmark PPOBlue	Highmark Blue Cross Blue Shield Member Services 120 Fifth Avenue Fifth Avenue Place P. O. Box 1210 Pittsburgh, PA 15222-3099 (800) 241-5704	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Highmark Keystone Blue HMO	Keystone Health Plan West, Inc. Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222-3099 (800) 547-9378	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Delta Dental	Benefits Services Delta Dental Plan P.O. Box 997330 Sacramento, CA 95899-7330 (800) 765-6003 (888) 335-8227	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Anthem Blue Cross of California Dental Net	Blue Cross of California P.O. Box 9201 Oxnard, CA 93031-9201 (800) 627-0004	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
SafeGuard Dental	Member Services SafeGuard Health Plans, Inc.	15 days for Pre-Service Claims (up to 30 days with extension);

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	P.O. Box 3594 Laguna Hills, CA 92654 (800) 880-1800	72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Blue Care Dental HMO	Dental Network of America Two TransAm Plaza Drive Oakbrook Terrace, IL 60181 (800) 323-7201	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
HumanaDental PPO	HumanaDental Claims Office P.O. Box 14611 Lexington, KY 40512-4611 (800) 233-4013	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
VSP	VSP 3333 Quality Drive Rancho Cordova, CA 95670 VSP Member Services: (800) 877-7195 Non-VSP Member Provider Claims should be sent to: VSP Attn: Out-of Network Provider Claims P.O. Box 997105 Sacramento, CA 95899-7105	15 days for Pre-Service Claims (up to 30 days with extension); 72 hours for Urgent Care Claims (up to 120 hours with extension); or 30 days for Other Claims (up to 45 days with extension)
Preventive Health Account (PHA)	YSA P.O. Box 785040 Orlando, FL 32878-5040 Fax: (888) 211-9900	30 days (up to 45 days with extension)
Employee Assistance Program	Horizon Health 7676 Hazard Center Drive San Diego, CA 92108 (800) 443-4474	90 days (up to 180 days with extension)
Health Care Reimbursement Account Plan (HCRA)	Reimbursement Center P.O. Box 25172 Lehigh Valley, PA 18002-5172	30 days (up to 45 days with extension)
Dependent Care Reimbursement Account Plan (DCRA)	Reimbursement Center P.O. Box 25172 Lehigh Valley, PA 18002-5172	90 days (up to 180 days with extension)
***Company*-provided Employee Life Insurance and Paid-Up Life Insurance**	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542 For premium waived life insurance for disabled employees as of 12/31/01 and for Paid-Up Life Insurance benefits as of 12/31/01: Aetna U.S. Healthcare Life Operations/Claims RT 32 151 Farmington Avenue	90 days (up to 180 days with extension)

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	Hartford, CT 06156-3007 (800) 523-5065	
Supplemental Employee Life Insurance	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542 (800) 524-0542	90 days (up to 180 days with extension)
Dependent Life Insurance	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542 (800) 524-0542	90 days (up to 180 days with extension)
Accidental Death & Dismemberment Insurance	CIGNA Group Insurance Gateway New Plaza 1600 West Carson Street Pittsburgh, PA 15219	90 days (up to 180 days with extension)
Business Travel Accident Insurance	CIGNA Group Insurance Gateway New Plaza 1600 West Carson Street Pittsburgh, PA 15219	90 days (up to 180 days with extension)

Southern California Edison Company Comprehensive Disability Plan	During the first three consecutive scheduled work days of absence and thereafter, employees are responsible for contacting their manager/supervisor based on the call-in procedures required by the employee's respective business unit. For all absences after the third full consecutive scheduled work day of absence, you must call: Sedgwick, CMS (866) 925-6789 Mailing address: P.O. Box 14435 Lexington, KY 40512-4435	45 days (up to 75 days with one extension; up to 105 days with two extensions.)

Edison International Involuntary Severance Plan	Employee Information Center P.O. Box 800 Rosemead, CA 91770 PAX 23456 (626) 302-3456 (800) 500-4723	90 days (up to 180 days with extension)

Southern California Edison Company Long Term Disability Plan	Sedgwick, CMS P.O. Box 14435 Lexington, KY 40512-4435 (866) 925-6789	45 days (up to 75 days with one extension; up to 105 days with two extensions.)

Flex **Claims for plan eligibility**	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947	90 days (up to 180 days with extension)

Vacation Buying Plan	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947	90 days (up to 180 days with extension)

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Determination of Claim

Generally, you will only be notified if your benefit claim is denied. However, if your claim is an Urgent Care Claim or a Pre-Service Claim for health care benefits, you will be notified whether your claim is denied or granted.

If your benefit claim is denied, in whole or in part, you will be provided the reason for the denial with reference to specific plan provisions, a description of additional information you may need to submit (if applicable), and information as to the steps to seek a review or appeal of the denied claim. If you were denied benefits under a group health plan, you will be advised of any internal rule, guideline, or other criterion relied upon in denying your claim (or an offer will be made to provide such information free of charge upon request). If you were denied benefits under a group health plan based on medical necessity or a similar exclusion or limit, you will be advised of the scientific or clinical judgment for the decision (or an offer will be made to provide such explanation free of charge upon request).

You should be aware that the claims administrators have the right to request repayment if they overpay a claim for any reason.

Appeal of a Denied Benefit

You have the right to appeal a denied benefit claim. To file an appeal, submit a letter within the specific benefit plan's time limit for appeals (see charts below for time limits and where to mail your letter) that includes all of the following:

- A statement of your position on the claim
- Relevant facts supporting your claim
- Any documentation that supports your claim
- Any other information you feel is necessary to explain your claim

You will be provided, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

All information submitted in connection with your appeal will be considered whether or not it was submitted or reviewed in connection with the initial determination of your claim.

Certain benefit plans require a request for review to be submitted before an appeal can be filed (see **Summary of Review and Appeal Procedures** chart below for the specific benefit plans). If you wish to request a review of a denied claim, submit a letter within the plan's time limit for reviews that includes all the information indicated above. Your request will be reviewed and an investigation conducted. If your request for review results in denial, in whole or in part, you will receive a written notice including the reason for the denial, clear references to the plan provisions on which the determination was made, a description of additional information which may be necessary to perfect your claim, and an explanation of the appeal procedure. You may file an appeal of the denied review following the procedures described above in this section.

Urgent Care Claims

In the case of an Urgent Care Claim, you may submit your appeal orally or in writing. Also, you and the plan may communicate any information related to your claim by phone, facsimile or other available method to expedite the review process.

Health or Disability Claims

If your appeal is for benefits under one of the *company's* health or disability plans, no deference will be given to the initial denial of your claim (or if there are two levels of appeal, to the denial at the initial level of appeal). Your claim will be reviewed by a fiduciary of the plan who is neither the individual who initially denied your claim (nor the individual who denied it at the initial level of appeal), nor a subordinate of that person. If the decision is based on a medical judgment, such as whether a particular treatment is medically necessary, the fiduciary will consult with a health care professional with experience and training in the field of medicine involved in the judgment, who is neither the individual, nor a subordinate of the individual, consulted in connection with a prior determination of your claim.

Time Period for Deciding Appeal

Once received by the plan, your appeal will be reviewed and a determination generally made within the time limits indicated in the charts below. For certain plans, the review period may be extended if the administrator determines that special circumstances require an extension of time to process the appeal. However, if your

appeal is for benefits under any *company* health plan, the decision period will not be extended by the plan, without your agreement.

If Your Appeal is Denied

If your appeal is denied, you will be notified in writing of the reason for the denial with reference to specific plan provisions on which the determination was based.

If your appeal was for benefits under one of the *company's* health or disability plans, the notice will also include:

- A description of any internal rule, guideline or protocol relied upon in making the determination (or notice that such rule, guideline or protocol was relied upon and an offer to provide a copy the rule, guideline or protocol free of charge upon request), and
- If the determination was based on medical necessity or *experimental* treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination (or an offer to provide such explanation free of charge upon request).

The determination on the appeal will be final and is not subject to further appeal under the plan.

Statute of Limitations

If your appeal is denied, in whole or in part, you may bring a civil action in federal court under section 502(a) of ERISA. However, no action may be brought against the plan administrator, the *company*, or any of their agents until you have exhausted the claim and appeal procedures described in this handbook. Your civil action must be filed no later than 180 days after the final decision has been rendered by the Benefits Committee or claims administrator on the appeal of your claim for benefits under the terms of the respective plans. This period shall not be extended unless the Committee or claims administrator specifically determines otherwise. **See Agent for Service of Legal Process** in this summary for more information.

Summary of Appeal Procedures

The plans listed in the table below have an appeal procedure, but not a review procedure. For a listing of plans that require both a review of the denied claim and, if necessary, a subsequent appeal, see below the **Summary of Review and Appeal Procedures** section.

Plan Name	Contact for Filing an Appeal	Time Limit to File Appeal	Decision Time Limit
Flex Appeals for plan eligibility	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800 Rosemead, CA 91770	Within 60 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Health Care Reimbursement Account (HCRA)	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800 Rosemead, CA 91770	Within 180 days of receipt of denial notice	60 days
Dependent Care Reimbursement Account (DCRA)	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800 Rosemead, CA 91770	Within 60 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Preventive Health Account (PHA)	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800 Rosemead, CA 91770	Within 180 days of receipt of denial notice	60 days
Employee Assistance Program	Resources for Living 7676 Hazard Center Drive San Diego, CA 92108	Within 60 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Edison International Welfare Benefit Plan Appeals for plan eligibility	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800 Rosemead, CA 91770	Within 60 days of receipt of denial notice	60 days; up to 120 days under special circumstances

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Express Scripts and CuraScript	Express Scripts, Inc. Pharmacy Appeals C2N Mail Route BL0390 6625 West 78th Street Bloomington, MN 55439	Within 180 days of receipt of denial notice	72 hours for Urgent Care Claims; 30 days for Pre-Service Claims; or 60 days for Other Claims
UnitedHealthcare HMO	UnitedHealthcare Appeals & Grievances Department P.O. Box 6107 Mail Stop CA124-0160 Cypress, CA 90630-9972 (800) 624-8822	Within 180 days of receipt of denial notice	72 hours for Urgent Care Claims; 30 days for Pre-Service Claims; or 60 days for Other Claims
UnitedHealthcare Medicare Advantage HMO	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106; Mail Stop CY 124-0157 Cypress, CA 90630-9972 (866) 622-8055	Within 180 days of receipt of denial notice	72 hours for Urgent Care Claims; 30 days for Pre-Service Claims; or 60 days for Other Claims
UHC Senior Supplement 3500 and UHC Senior Supplement	UnitedHealthcare Appeals Department P.O. Box 400046 San Antonio, TX 78229 Facsimile: (888) 615-6584	Within 180 days of receipt of denial notice	72 hours for Urgent Care Claims; 30 days for Pre-Service Claims; or 60 days for Other Claims
Anthem Blue Cross of California Dental Net	Blue Cross of California Dental Customer Service P.O. Box 9201 Oxnard, CA 93031-9201	Within 180 days of receipt of the denial notice	72 hours for Urgent Care Claims; 30 days for Pre-Service Claims; or 60 days for Other Claims
Delta Dental	Delta Dental Plan of California P.O. Box 997330 Sacramento, CA 95899-7330	Within 180 days of receipt of denial notice	72 hours for Urgent Care Claims; 30 days for Pre-Service Claims; or 60 days for Other Claims
Company-provided (premium waived) Life Insurance for disabled employees as of December 31, 2001, and Paid-Up Employee Life Insurance benefit as of December 31, 2001	Aetna U.S. Healthcare Life Operations/Claims RT 32 151 Farmington Avenue Hartford, CT 06156-3007 (800) 523-5065	Within 60 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Company-provided Employee Life Insurance	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542	Within 180 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Supplemental Employee Life Insurance	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517	Within 180 days of receipt of denial notice	60 days; up to 120 days under special circumstances

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	Philadelphia, PA 19176 (800) 524-0542		
Dependent Life Insurance	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542	Within 180 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Accidental Death & Dismemberment Insurance	CIGNA Group Insurance Gateway New Plaza 1600 West Carson Street Pittsburgh, PA 15219	Within 60 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Business Travel Accident Insurance	CIGNA Group Insurance Gateway New Plaza 1600 West Carson Street Pittsburgh, PA 15219	Within 60 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Comprehensive Disability Plan (CDP) for employees working outside California	Sedgwick CMS Appeals Unit P.O. Box 14446 Lexington, KY 40512-9951 (800) 939-4911	Within 180 days of receipt of denial notice	45 days; up to 90 days under special circumstances
Comprehensive Disability Plan (CDP) for employees working in California	Sedgwick CMS Appeals Unit P.O. Box 14446 Lexington, KY 40512-9951 (800) 939-4911 and/or State of California Employment Development Department 800 Capital Mall, Room 500 Sacramento, CA 95814 (916) 445-9212	Within 180 days of receipt of denial notice Within 20 days of receipt of the denial notice	45 days; up to 90 days under special circumstances
Long Term Disability Plan (LTD)	Sedgwick CMS Appeals Unit P.O. Box 14446 Lexington, KY 40512-9951 (800) 939-4911	Within 180 days of receipt of denial notice	45 days; up to 90 days under special circumstances
Edison 401(k) Savings Plan	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800 Rosemead, CA 91770	Within 90 days of receipt of denial notice If the claim required a disability determination, within 180 days of receipt of the denial notice	60 days; up to 120 days under special circumstances (*SOFA*- and *UWUA*-represented employees: no extension permitted for special circumstances) If claim required a disability determination 45 days (up to 90 days under special circumstances) (*SOFA*- and *UWUA*-represented employees: up to 60 days under special circumstances)
SCE Retirement Plan	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800 Rosemead, CA 91770	Within 60 days of receipt of denial notice	60 days; up to 120 days under special circumstances
Edison International Involuntary Severance Plan	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800	Within 60 days of receipt of	60 days; up to 120 days under special circumstances

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	Rosemead, CA 91770	denial notice	
Vacation Buying Plan	Chairman, Benefits Committee Southern California Edison Company P.O. Box 800 Rosemead, CA 91770	Within 60 days of receipt of denial notice	60 days; 120 days under special circumstances

Summary of Review and Appeal Procedures

Some benefit plans require a review of denied claims before you may file an appeal. If the claim is still denied after the review, you may then appeal the denied claim. Those benefit plans that require this two-step process are listed in the chart below. For a list of plans with only an appeal procedure, see the **Summary of Appeal Procedures** section.

Plan Name	Contact for Requesting a Review or Filing an Appeal	Time Limit to File Review Request	Review Decision Time Limit	Time Limit to File Appeal	Decision Time Limit
Blue Shield of California PPO and EPO	Review: Contact Customer Service: (800) 898-7807 Blue Shield of California Customer Service Department P.O. Box 272540 Chico, CA 95927-2540 Appeal: Contact Member Services: (800) 898-7807	Within 180 days of receipt of the denial notice	Urgent Care: 72 hours Pre-Service: 15 days Other Claims: 30 days	Within 60 days of receipt of the review decision	Pre-Service: 15 days Other Claims: 30 days
Health Net HMO	Health Net Commercial Claims P.O. Box 14702 Lexington, KY 40512 (888) 893-1572	Not applicable	Urgent Care: 72 hours Pre-Service: 15 days Other Claims: 30 days	Within 356 days following the date of the incident that caused the appeal	Pre-Service: 15 days Other Claims: 30 days
Health Net PPO	Health Net Commercial Claims P.O. Box 14702 Lexington, KY 40512 (888) 893-1572	Within 180 days of receipt of the denial notice	Urgent Care: 72 hours Pre-Service: 15 days Other Claims: 30 days	Within 60 days of receipt of the review decision	Pre-Service: 15 days Other Claims: 30 days
Health Net Seniority Plus Medicare Advantage HMO	Health Net Medicare Claims P.O. Box 14703 Lexington, KY 40512 (800) 275-4737	Not applicable	Urgent Care: 24 hours Pre-Service: 15 days Other Claims:	Within 60 days of receipt of the review decision	Pre-Service: 15 days Other Claims: 30 days (additional 14 days if additional information is required)

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

			30 days		
Kaiser Permanente California Medical	Kaiser Permanente Insurance Company c/o Harrington Health 3701 Boardman-Canfield Rd., Bldg. B Canfield, OH 44406-7005 (800) 533-1833 – So. Calif. (800) 663-1771 – No. Calif.	Within 180 days of receipt of the denial notice	Urgent Care: 72 hours Pre-Service: 15 days Other Claims: 30 days	Within 60 days of receipt of the review decision	Pre-Service: 15 days Other Claims: 30 days
SafeGuard Dental	Review: SafeGuard Health Plans, Inc. 95 Enterprise Aliso Viejo, CA 92656-2601 Appeal: Member Services SafeGuard Health Plans, Inc. Quality Management P.O. Box 3532 Laguna Hills, CA 92654-3532	Within 180 days of receipt of the denial notice	Urgent Care: 72 hours Pre-Service: 15 days Other Claims: 30 days	Within 60 days of receipt of the review decision	Pre-Service: 15 days Other Claims: 30 days
Blue Care Dental HMO	Dental Network of America Two TransAm Plaza Drive Oakbrook Terrace, IL 60181	Within 180 days of receipt of the denial notice	Urgent Care: 72 hours Pre-Service: 15 days Other Claims: 30 days	Within 60 days of receipt of the review decision	Pre-Service: 15 days Other Claims: 30 days
Humana Dental PPO	HumanaDental Claims Office P.O. Box 14638 Lexington, KY 40512-4638	Within 180 days of receipt of the denial notice	Urgent Care: 72 hours Pre-Service: 15 days Other Claims: 30 days	Within 60 days of receipt of the review decision	Pre-Service: 15 days Other Claims: 30 days
Vision Plan	VSP Claims & Grievances 3333 Quality Drive Rancho Cordova, CA 95670	Within 180 days of receipt of the denial notice	Urgent Care: 72 hours Pre-Service: 15 days Other Claims: 30 days	Within 60 days of receipt of the review decision	Pre-Service: 15 days Other Claims: 30 days

Conflicts Between Claimants

If the Benefits Committee or its designee learns of conflicting claims for a benefit made by more than one claimant, the benefit may be withheld until the conflict has been resolved by one of the following:

- Agreement between the claimants
- A final judicial determination as to who is entitled to benefits
- Any other procedure reasonably calculated to protect the plan from paying benefits more than once

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If there is conflict between claimants and also a dispute between any claimant and the plans regarding benefit payment, the Secretary of the Benefits Committee may process the request for benefits under normal appeal procedures before resolving the conflict between claimants.

Agent for Service of Legal Process

Legal process with respect to your plan benefits may be served upon:

Southern California Edison Company
Law Department
2244 Walnut Grove Avenue
Rosemead, CA 91770

When serving process, please state the following on the envelope:

"After receipt of the service, for the attention of the Secretary of the Benefits Committee"

Service of legal process may also be made upon the plan trustee and/or claims administrators. However, you must fully exhaust the plan's administrative remedies for reviews and appeals prior to initiating any legal action. Further, no legal action may be brought against the benefit plans, the plan administrators, the *company*, or any of their agents, more than 180 days after the final decision has been rendered by the Benefits Committee or claims administrator on the appeal of your claim for benefits under the terms of the respective plans. This period shall not be extended unless the Committee or claims administrator specifically determines otherwise.

Except as expressly provided by ERISA or a successor law, only the plan, the plan administrator and/or the claims administrator shall be necessary parties to any court proceeding involving a plan. Any final judgment entered in any such proceeding shall be conclusive upon the plan, plan administrator, claims administrator, participants and all other persons. In the event any provision of a plan is found to be invalid, that finding shall not affect the other provisions of the plan. The plan will continue to operate as if that invalid provision had never been inserted into the plan.

The plans are governed and construed in accordance with federal laws, including ERISA, and in accordance with applicable state laws where such laws are not in conflict with the aforementioned federal laws.

Your ERISA Rights

As a participant in the benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits
  - Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites, all plan documents governing the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual reports (Form 5500 series) filed by the plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
  - Obtain, upon written request to the plan administrator, copies of documents governing the operations of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
  - Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of the Summary Annual Report.
  - Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

- Continue Group Health Plan Coverage
  - Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
  - Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in you coverage.
- Prudent Actions by Plan Fiduciaries
  - In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plans, called “fiduciaries” of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.
- Enforce Your Rights
  - If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
  - Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
- Assistance with Your Questions
  - If you have any questions about your benefit plans, you should contact the Employee Information Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Restrictions Against Assignment of Benefits

Except for the limited exceptions noted in this section, under no circumstances may you or your beneficiary assign your benefit or rights, in whole or in part, under plans that are governed by ERISA, nor may your benefit or rights under these plans be liable for or subject to any obligation (with the exception of unpaid federal income tax) or liability you assume at any time. In other words, your benefits are exempt from attachment, garnishment, or other legal process for your debts or the debts of your beneficiaries. This does not preclude the plan administrator from disbursing funds to a legally appointed guardian, executor, administrator or personal

representative of a participant or beneficiary. Notwithstanding the above, you or your beneficiary may assign payment for healthcare benefits directly to your health care providers.

Even though you may not assign your benefits, they will be paid or provided in accordance with any valid Qualified Domestic Relations Order (QDRO) or Qualified Medical Child Support Order (QMCSO) received by the plan administrator.

With regard to life insurance benefits, if you and the *company* consent in writing, you may transfer as a gift, or by viatical assignment, all ownership, both present and future, in your Supplemental Employee Life Insurance. This assignment must be an absolute and irrevocable assignment, and will not be binding on the insurer unless it meets the conditions and requirements specified by the plan.

ERISA Plan Administrative Information

This section provides information about all of the benefit plans that the *company* offers – including plans that may not apply to you. Refer to the **Eligibility** section to see which benefit plans you are eligible for.

Official Plan Name and Type of Plan	Plan Sponsor and I.D. Number	Plan I.D. No.	Effective Date	End of Plan Year	Plan Administrator and I.D. Number	Day-to-Day Administration and Claims
Southern California Edison Company Retirement Plan Defined benefit and cash balance retirement plan	Southern California Edison Company 95-1240335	001	01/01/58	12/31	Benefits Committee 95-3225971	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947
Edison International Retirement Plan for Bargaining Unit Employees of EME Homer City Generation, LP Defined benefit retirement plan	Edison International 95-4137452	001	03/18/99	12/31	Employee Benefits Committee 95-4784855	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947
Edison International Retirement Plan for Bargaining Unit Employees of Midwest Generation, LLC Defined benefit retirement plan	Edison International 95-4137452	002	12/15/99	12/31	Employee Benefits Committee 95-4784855	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947
Edison 401(k) Savings Plan Defined contribution plan,401(k) plan, 404(c) plan, profit sharing plan, ESOP	Southern California Edison Company 95-1240335	002	01/01/64	12/31	Benefits Committee 95-3225971	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Edison International Welfare Benefit Plan (Medical coverage) Group health plan providing for medical care benefits options as listed below	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	
• Blue Shield of California PPO and EPO	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Blue Shield of California P.O.Box 272540 Chico CA 95927-2540 (800) 898-7807
• Express Scripts and CuraScript	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Express Scripts-(C2N) Express Scripts, Inc. Member Reimbursements P.O. Box 66583 St. Louis, MO 63166 (800) 955-1181
• Health Net HMO and PPO	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	General Correspondence:: Health Net Member Services Correspondence Department P. O. Box 9103 Van Nuys, CA 91409-9103 Claims: Health Net Commercial Claims P.O. Box 14702 Lexington, KY 40512 (888) 893-1572
• Health Net Seniority Plus Medicare Advantage HMO	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	General Correspondence: Health Net Seniority Plus Member Services Department P. 0. Box 10198 Van Nuys, CA 91410-0198 Claims: Health Net Medicare Claims P.O. Box 14703 Lexington, KY 40512 (800) 275-4737
• Kaiser Permanente California and Kaiser Senior Advantage Medicare Advantage HMO	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Kaiser Permanente Insurance Company c/o Harrington Health 3701 Boardman-Canfield Rd., Bldg. B Canfield, OH 44406-7005 (800) 533-1833 – So. Calif. (800) 663-1771 – No. Calif.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

						Kaiser Senior Advantage Kaiser Permanente Regional Member Services 393 Walnut Street Pasadena, CA 91188 (800) 443-0815
• UnitedHealthcare HMO and UnitedHealthcare Medicare Advantage HMO	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	UnitedHealthcare Claims Department P.O. Box 30968 Salt Lake City, UT 84130-0968 (800) 624-8822 HMO (866) 622-8055 Medicare Advantage
• UHC Senior Supplement 3500 and UHC Senior Supplement	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	UnitedHealthcare Claims Department P.O. Box 30972 Salt Lake City, UT 84130-0972 (800) 851-3802
• Highmark PPOBlue	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Highmark Blue Cross Blue Shield Member Services 120 Fifth Avenue Fifth Avenue Place P. O. Box 1210 Pittsburgh, PA 15222-3099 (800) 241-5704
• Highmark Keystone Blue HMO	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Keystone Health Plan West, Inc. Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222-3099 (800) 547-9378

Edison International Welfare Benefit Plan (Dental coverage) Group dental plan providing for dental care benefits options as listed below	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	
• Delta Dental	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Benefits Services Delta Dental Plan of California P.O. Box 997330 Sacramento, CA 95899-7330 (800) 765-6003 (888) 335-8227
• Anthem Blue Cross of California Dental Net	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Blue Cross of California P.O. Box 4127 Woodland Hills, CA 91365-4127 (800) 627-0004

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

• SafeGuard Dental	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Member Services SafeGuard Health Plans, Inc. P.O. Box 3594 Laguna Hills, CA 92654 (800) 880-1800
• Blue Care Dental HMO	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Dental Network of America Two TransAm Plaza Drive Oakbrook Terrace, IL 60181 (800) 323-7201
• HumanaDental PPO	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	HumanaDental Claims Office P.O. Box 14611 Lexington, KY 40512 (800) 233-4013
Edison International Welfare Benefit Plan (Vision coverage) Welfare plan providing for vision care benefits	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	VSP 3333 Quality Drive Rancho Cordova, CA 95670 VSP Member Services: (800) 877-7195
Edison International Welfare Benefit Plan (Employee Assistance Program) Behavioral health plan providing assistance for assessment and counseling services	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	Resources for Living 7676 Hazard Center Drive San Diego, CA 92108 (800) 443-4474
Edison International Welfare Benefit Plan (Health Care Reimbursement Account) Flexible benefits plan providing for eligible health care reimbursement	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947
Edison International Welfare Benefit Plan (Dependent Care Reimbursement Account) Flexible benefits plan	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	EIX Benefits Connection P.O. Box 199428 Dallas, TX 75219-9428 (866) 693-4947

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

providing for eligible dependent care reimbursement						

Edison International Welfare Benefit Plan (Life, Accidental Death & Dismemberment, and Business Travel-related Accidental Death & Dismemberment Insurance coverage) Group life insurance plan providing life and accidental death and dismemberment insurance benefits listed below	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	
• *Company*-provided Employee Life Insurance and Paid-Up Life Insurance	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542 For premium waived life insurance for disabled employees as of 12/31/01 and for Paid-Up Life Insurance benefits as of 12/31/01: Aetna U.S. Healthcare Life Operations/Claims RT 32 151 Farmington Avenue Hartford, CT 06156-3007 (800) 523-5065
• Supplemental Employee Life Insurance	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542
• Dependent Life Insurance	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	The Prudential Insurance Company of America Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176 (800) 524-0542
• Accidental Death & Dismemberment Insurance	Southern California Edison Company 95-1240335	501	05/01/33	12/31	Benefits Committee 95-3225971	CIGNA Group Insurance Gateway New Plaza 1600 West Carson Street Pittsburgh, PA 15219
• Business Travel Accident Insurance	Southern California Edison Company	501	05/01/33	12/31	Benefits Committee	CIGNA Group Insurance Gateway New Plaza 1600 West Carson

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

	95-1240335				95-3225971	Street Pittsburgh, PA 15219

Southern California Edison Company Comprehensive Disability Plan Group disability plan providing short-term disability benefits	Southern California Edison Company 95-1240335	504	07/01/58	12/31	Benefits Committee 95-3225971	Sedgwick CMS P.O. Box 14435 Lexington, KY 40512-4435 (800) 939-4911

Edison International Involuntary Severance Plan Severance plan	Southern California Edison Company 95-1240335	525	08/11/93	12/31	Benefits Committee 95-3225971	Employee Information Center P.O. Box 800 Rosemead, CA 91770 PAX 23456 (626) 302-3456 (800) 500-4723

Southern California Edison Company Long Term Disability Plan Group disability plan providing long term disability benefits	Southern California Edison Company 95-1240335	527	05/01/80	12/31	Benefits Committee 95-3225971	Sedgwick CMS P.O. Box 14435 Lexington, KY 40512-4435 (800) 939-4911

For More Information

If you have questions about the information contained in this handbook, contact the *EIX Benefits Connection* by phone or online at:

- (866) 693-4947
- www.eixbenefits.com

You may also access the *EIX Benefits Connection* online by logging on to the Edison International Portal and clicking on *EIX Benefits Connection*.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Glossary of Terms

Glossary of Terms revised December 19, 2012.

A | B | C | D | E | F | H | I | L | M | O | P | Q | R | S | T | U | Y

A variety of specific terms are used to describe the benefits available to you under your various *company*-provided benefit plans and other employee programs. These include *Flex*, health care plans, Reimbursement Accounts, Disability benefit plans, Life and Accident Insurance plans, Vacation Buying, the 401(k) Savings Plan and the Retirement Plan.

As you read through the summaries in this handbook, you'll find these specific terms *italicized* – a signal that the word has a precise meaning in the context of your benefit plan. Some of those terms are fairly common – or at least would seem to be fairly common, such as *company* and *base pay*. Some may be less familiar to you. In either case, it's important that you understand precisely what each term means in the context of your benefit plans.

Unless they are otherwise defined in the specific sections of your benefit plans, italicized terms are defined in this section. The definition of specific terms **not** italicized in this section can be found in the section describing the specific benefit. You'll also find references to terms – one example is the term emergency – where the definition can vary depending on the individual benefit plan or health care company involved.

This section includes terms for all of the benefit plans that the *company* offers -- including plans that may not apply to you. Refer to the **Eligibility** section to see which benefit plans you are eligible for.

Actively at Work

Actively at work means present on the job and performing the work you were hired to do. You are also considered to be *actively at work* for certain approved absences — *company*-paid holidays, vacation days, jury duty and absence due to death in your family.

Annualized Base Pay

Your *annualized base pay* is a factor that determines the coverage available to you under Employee Life Insurance, Accidental Death and Dismemberment Insurance, and Business Travel Accident Insurance.

- If you are a *full-time* employee, your *annualized base pay* is your monthly *base pay* multiplied by 12.
- If you are a *part-time* or *part-time plus* employee, your *annualized base pay* is your hourly rate of pay converted to a monthly full-time rate and multiplied by 12.

Annualized base pay is rounded to the next higher $1,000, unless your *annualized base pay* is already a multiple of $1,000. For example, if multiplying your monthly *base pay* x 12 comes to $50,075, your *annualized base pay* is rounded up to $51,000.

Base Pay

Base pay is your regular salary or wages represented as an hourly or monthly rate. *Base pay* includes your 401(k) Savings Plan contributions and any pre-tax dollars you contribute to pay for *Flex* benefits. It does not include temporary upgrade earnings, overtime pay, shift differentials, bonuses, subsistence pay, back pay, commissions, and all extraordinary compensation and allowances.

For purposes of the Edison 401(k) Savings Plan and the Southern California Edison Company Retirement Plan, *base pay* is capped at $255,000 (as adjusted by the IRS for cost of living increases) and any pay in excess of this cap is ignored.

For purposes of the Long Term Disability (LTD) Plan, *base pay* is the base rate of pay on your last day worked before the first date of your disability.

Child/Children

Child and *children* refer specifically to:

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- Your natural or lawfully adopted children or children placed for adoption with you
- Your stepchildren or foster children who qualify as your dependents for income tax purposes under IRS rules
- Any other children who live with you in a normal parent-child relationship and who qualify as your dependents for income tax purposes under IRS rules

Also included, for purposes of the Medical, Dental, Vision and EAP plans, is any child dependent on you for medical support pursuant to a Qualified Medical Child Support Order.

Code

The Internal Revenue Code of 1986, as amended from time to time.

Company(ies)

For each benefit plan sponsored by Edison International or Southern California Edison Company, *company* refers collectively to each employer participating in such benefit plan. *Company* also refers to your specific employer. Only Edison International and its affiliated *companies* may be a *company* under the terms of the benefit plans.

Contingent Workers

These are individuals (other than *leased* employees) who are not classified by the *company*, at its discretion, as common law employees in the *company's* Human Resources personnel system. This includes, but is not limited to, individuals classified by the *company* as independent contractors, non-employee consultants, and individuals employed by a temporary staffing agency who are on assignment at the *company*. Service as a *contingent worker* does not count for any purpose under the *company's* benefit plans. A *contingent worker* is an *excluded person*.

Covered Expenses

For medical treatment, *covered expenses* are those for *medically necessary* treatment, service, equipment or supplies as rendered or provided to a participant in the Medical Plan, and that are listed as covered by the plan in the relevant sections of this handbook.

The *covered expense* is limited to: (a) the contract fee for preferred providers, (b) the *reasonable and customary (R&C)* fee, or, if less, (c) the actual fee charged.

For dental treatment, *covered expenses* are those for *medically necessary* treatment or services rendered to a participant in the Dental Plan, and that are identified as covered by the plan in the Dental Plan summary. *Covered expenses* shall not exceed *usual, customary and reasonable (UCR)* fees.

Custodial Care

This refers to care primarily provided to assist a patient in meeting the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision of medications that are ordinarily self-administered. It is not care that requires skilled nursing services on a continuing basis.

Deductible

This is the initial portion of *covered expenses*, determined annually, that you must pay *out-of-pocket* before further *covered expenses* will be paid by the Medical, Dental, or Vision Plans. Medical and dental care options that have *deductibles* normally have an individual *deductible* and a family *deductible*. Some medical and dental care options, such as HMOs, have no *deductibles*.

Deduction Periods

Deduction Periods are pay periods during which *Flex* benefit plan payments are deducted from your paychecks. These are the same pay periods in which *company* contributions are added to eligible employees' paychecks. If you participate in *Flex* for a full calendar year and you are on a biweekly payroll cycle, there are 24 *deduction periods* in a year. (There are 26 pay periods in a year, but two of these do not count as *deduction periods*.) If you participate for less than a full calendar year, there will be proportionately fewer *deduction periods*.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

If you are on an unpaid leave of absence, a retiree, a survivor of an employee or a retiree, or an individual eligible for extended health care coverage due to severance or under COBRA that requires you to pay for that coverage, you make your contributions either:

- By direct payment to the outside administrator designated by the *company*
- By deductions taken from your monthly Retirement Plan benefit check if authorized by you

Domestic Partner

A *domestic partner* means a person with whom you have entered into a committed relationship with, and you and the individual must:

- Expect the relationship to be long-term
- Be financially responsible for each other to third parties, and be responsible to each other for the direction and management of your shared primary residence
- Not be married to another individual, or have another *domestic partner*
- Not be blood relatives to each other
- Both be age 18 or older, and
- Have shared a primary residence for, and have a committed relationship of mutual caring that has existed at least twelve months (the 12-month requirement does not apply if your partner is your *registered domestic partner* or *same-sex spouse*)

In addition, you must complete the benefit plan's Declaration of Domestic Partnership by calling the *EIX Benefits Connection* at (866) 693-4947.

For purposes of this handbook, references to *domestic partners* shall encompass the domestic partnerships described above as well as *registered domestic partners* and *same-sex spouses,* with the following exceptions:

Domestic partners who are not recognized as registered or certified domestic partners by a state which offers the ability to register or certify a domestic partnership are treated differently than *registered domestic partners* and *same-sex spouses* for the following purposes:

- State tax purposes (for certain states);
- Retirement Plan;
- 401(k) Savings Plan
- Time off work -- In situations where you are taking time off from work involving your *domestic partner* or your *domestic partner's child* or parent, the rules in the sections of this handbook identified below shall only apply to d*omestic partners* who are *registered domestic partners* (as certified by California's Secretary of State) or *same-sex spouses* (excluding civil unions):
    - Death in the Immediate Family
    - Comprehensive Disability Plan:
        - Paid Family Leave
        - Illness in Your Immediate Family
        - Leave under California's Sick Leave Statute (AB 109/Kin Care)
        - Family and medical leave under the California Family Rights Act

Durable Medical Equipment

Equipment designed for repeated use that is *medically necessary* to treat an illness or injury, to improve the functioning of a malformed body part, or to prevent further deterioration of a medical condition. Examples of *durable medical equipment* are wheelchairs, crutches, and hospital beds. Equipment may be rented or purchased, as determined by your Medical Plan option.

EIX Benefits Connection

The *EIX Benefits Connection* provides you direct access to information about your Edison health care benefits, 401(k) Savings Plan benefits, Southern California Edison Company Retirement Plan benefits, and your annual enrollment options. You can access up-to-date account information, make changes, and get information about the plans for which you are eligible.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

The *EIX Benefits Connection* is generally available 24 hours a day, 7 days a week. You may call (866) 693-4947 or visit the website at **www.eixbenefits.com.** Representatives are available Monday through Friday from 7:30 a.m. to 5:30 p.m., Pacific Time, but may not be available on certain holidays.

Emergency/Emergencies:

Each option offered through the Medical Plan has its own definition of *emergency*. Generally, a medical *emergency* manifests itself by acute, severe symptoms that, if not treated with immediate medical attention, could reasonably be expected to place the patient's health in jeopardy or cause serious impairment of bodily function. See the Medical Plan summary for specific definitions of *emergency*.

With respect to Dental Plan coverage, *emergency* services are those required to alleviate severe pain or bleeding and/or to immediately diagnose and treat an unforeseen condition. *Emergency* services are not for continuing any treatment plan currently in process, unless it has been authorized by the administrator of your Dental Plan option. Final determination as to whether services were rendered in connection with an *emergency* rest solely with the Dental Plan administrator.

Excluded Person

The following individuals shall not be eligible to participate in any benefit plan or program of the *company* unless eligibility is specifically provided for in such benefit plan(s) or program(s):

Individuals whose collective bargaining or other agreement with the *company* does not provide for such benefit coverage

Temporary employees

Nonresident aliens who receive no earned income (within the meaning of Section 911(d)(2) of the *Code*) from the *company* which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the *Code*)

Leased employees; and

Individuals who are not classified by the *company*, in its discretion, as employees under Section 3121(d) of the *Code*. This includes (but is not limited to) individuals classified by the *company*, in its discretion, as independent contractors, non-employee consultants, *contingent workers*, employees of a person or an entity other than the *company* and individuals whose basic compensation for services on behalf of the *company* is not paid directly by the *company*.

Experimental/Investigational/Investigative

These terms refer to any procedure, treatment, therapy, drug, service, biological product, facility, equipment, device or supply (collectively, "Services") not recognized by generally accepted professional medical or dental standards as safe and effective for use in the treatment of the patient's illness, injury or condition. This includes Services that are not approved by the federal government prior to use. If government approval has been obtained, only the uses and indications for which the Service was licensed will be a covered expense. These terms also include Services that have been authorized for use in testing, clinical trials, or other studies, but are not yet recognized to be within accepted professional medical or dental standards.

The fact that a *physician* or other medical professional or expert may prescribe, order, recommend, recognize or approve any Service does not in itself make the service non-experimental within the meaning of this section. The determination that a Service is *experimental* shall be made by, and in the sole and absolute discretion of, the administrator of your Medical, Dental or Vision plan option, as the case may be.

Flex

Flex is the term used to describe the *company's* flexible benefit programs, which provide tax advantages and an array of benefit choices and levels of coverage. Most of the benefit plans offered under the *company's* flexible benefit programs (*Flex*) are governed by Section 125 of the *Code* and its relevant regulations. Some benefit plans under *Flex* are not available on a pre-tax basis and, therefore, are not covered under Code Section 125.

***Full-Time* Employees**

These are employees who are classified as "full-time" in the *company's* Human Resources personnel system. This also includes employees who are on inactive status due to disability, or who are on a *company*-approved leave of absence, but were classified as "full-time" before the disability or leave of absence.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

Notwithstanding the above, *full-time* employee excludes any person who is identified in the definition of *excluded person*.

Hour(s) of Service

An *hour of service* is an hour for which you are paid (or entitled to payment) by the *company* for your work, and for your *company*-approved paid absences, such as vacation. An *hour of service* is also credited for each hour of an absence without pay for authorized absences not in excess of 30 consecutive calendar days, or during periods of absence for *Military Leave* provided you return to employment with the *company* within the time period specified by law. For those employees whose actual hours worked are not recorded, if you work at least one hour in a calendar month, you will be credited with 190 *hours of service* for the month.

Hours of service do not include any absences:

- Resulting from a non-industrial accident or illness (i) prior to the completion of six months of active and continuous service with the *company* or (ii) following the exhaustion of your sick time allowance credits under the Comprehensive Disability Plan
- Before July 1, 1968 due to industrial accidents or illnesses
- After benefits from the Comprehensive Disability Plan are exhausted, if the absence began before July 1, 1973, unless the employee was entitled to receive benefits under the Long Term Disability Plan.

For *part-time* employees, only service occurring after January 1, 1976 is recognized for purpose of Southern California Edison Company Retirement Plan benefit accrual.

For *temporary* employees, only service occurring after January 1, 1995 is recognized for purpose of Southern California Edison Company Retirement Plan benefit accrual.

For purposes of avoiding a break in service, up to 501 *hours of service* will be credited in a calendar year for absences due to maternity or paternity reasons (i.e., absences due to your pregnancy, the birth of your child, the placement of a child with you for purpose of adoption, or to care for your child immediately following the birth or placement), and for a family leave under the Family and Medical Leave Act.

IBEW

This term denotes employees of the *company* represented by the following International Brotherhood of Electrical Workers locals:

- Local 15, Midwest Generation, LLC
- Local 47, Southern California Edison Company
- Local 459, EME Homer City Generation LP

The benefits and programs described in this handbook applicable to *IBEW*-represented employees are subject to the collective bargaining process.

Leased Employee

This term refers to individuals who are "leased employees" as defined in Section 414(n)(2) of the *Code* with respect to the *company*. Service as a *leased* employee is never taken into account under the Southern California Edison Company Retirement Plan for benefit accrual purposes. However, such service can count toward vesting in the Southern California Edison Company Retirement Plan and the Edison 401(k) Savings Plan. A leased employee is an *excluded person*.

Medically Necessary

This refers to any procedure, service, treatment, therapy, drug, biological product, facility, equipment, device, supply or confinement (collectively, “Services”) performed or prescribed by a *physician* practicing within the scope of his license and determined to be:

- Consistent with the individual’s symptoms, diagnosis, treatment or where applicable, the prevention of the injury or illness
- Effective and appropriate treatment for the specific illness or injury
- Provided in a timely manner at the most appropriate and efficient level that can be performed safely
- Within generally accepted medical or dental standards

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.

- Not primarily for your convenience or the convenience of the *physician* or any other person
- Care that is neither educational in nature or *experimental*

For Dental Plan purposes, this refers to Services (as defined above) determined by the plan to be:

- Appropriate and necessary for the diagnosis or treatment of the dental condition
- Within the standards of good dental practice within the organized dental community
- Not primarily for your convenience, or for the convenience of your dentist, *physician*, or any other person

Medically necessary, as it applies to Vision coverage, refers to Services or eyewear necessary due to cataract surgery, visual acuity problems that cannot be corrected with glasses, certain conditions of anisometropia, and keratoconus.

The fact that a *physician* or dentist may prescribe order, recommend or approve a Service does not, in and of itself, make that Service *medically necessary.*

The determination of *medically necessary* shall be made by, and in the sole and absolute discretion of, the administrator of your Medical, Dental or Vision plan option, as the case may be.

Military Leave of Absence/Military Leave

A leave of absence granted to employees who leave their job to perform military training for, or active duty in, the armed forces of the United States for the period specified under, and in accordance with, the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Out-of-Pocket

This is the amount of money a participant or family must pay for *covered expenses* in a health care plan.

***Part-Time* Employees**

These are employees classified as “part-time” in the *company’s* Human Resources personnel system. Notwithstanding the above, any person who is an *excluded person* is not a *part-time* employee.

The *part-time* classification generally limits the number of hours an employee may be scheduled to work in a calendar year to 1,456 hours for represented employees.

***Part-Time Plus* Employees**

These are employees classified for benefit and pay practice purposes as “part-time plus” in the *company’s* Human Resources personnel system. Notwithstanding the above, any person who is an *excluded person* is not a *part-time plus* employee.

Part-time plus employees must be regularly scheduled to work at least an average of 16 hours per calendar week, but less than 40 hours per calendar week.

Except where specified otherwise in Your Benefits Handbook, the benefit and pay practice descriptions in Your Benefits Handbook for *part-time* employees also apply to *part-time plus* employees.

Permanently and Totally Disabled

For purposes of Employee Life Insurance, an employee is *permanently and totally disabled* if the insurance company that provides the group policy determines the employee to be permanently unable to work at any job for which he or she is, or may reasonably become, qualified by education, training, or experience and is not engaged in any other gainful occupation. The definition of *permanently and totally disabled* also covers the entire and irrecoverable loss of the:

- Sight of both eyes
- Use of both hands, of both feet, or of one hand and one foot by severance

For purposes of the 401(k) Savings Plan, an employee is considered to be *permanently and totally disabled* if the Benefits Committee, based on findings of the *company’s* Corporate Medical Director or his or her representative, believes the employee to be permanently unable to work at any reasonable job within the

company solely because of an illness or accidental bodily injury. A reasonable job is one for which the employee is, or may reasonably become, qualified by education, training, or experience.

Physician

A doctor of medicine (M.D.) or osteopathy (D.O.) who is legally qualified and licensed to practice medicine or perform surgery and is operating within the scope of that license at the time and place services are rendered. In addition, a licensed practitioner shall be considered a *physician* if:

- There is a law that applies to the benefit plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a *physician*; and
- The services performed by the practitioner are within the scope of that license at the time and place services are rendered

Medical providers that can certify claims for Comprehensive Disability Plan (CDP) or Paid Family Leave (PFL) include:

- Licensed medical or osteopathic doctors
- Authorized medical officer of a U.S. Government facility
- Chiropractor
- Podiatrist
- Optometrist
- Dentist
- Psychologist
- Licensed midwife, nurse-midwife, or nurse-practitioner for normal pregnancy or childbirth
- Accredited religious practitioner

For Long Term Disability (LTD) Plan purposes, this term refers to anyone meeting the requirements in the preceding description. In addition, for LTD purposes only, the term *physician* shall also include, if at any time during a period of total disability you are disabled primarily because of a mental, psychoneurotic, or personality disorder, a licensed psychologist who has, by reason of training and/or experience, a specialized competency in the field sufficient to render the necessary evaluation and treatment of mental illness.

Health care providers who may provide certification of a serious health condition under the Family and Medical Leave Act (FMLA) include:

- Doctors of medicine or osteopathy authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices;
- Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist) authorized to practice in the State and performing within the scope of their practice under State law;
- Nurse practitioners, nurse-midwives, and clinical social workers authorized to practice under State law and performing within the scope of their practice as defined under State law;
- Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts;
- Any health provider recognized by the employer (*company*) or the employer's (*company's*) group health plan's benefits manager; and
- A health care provider listed above who practices in a country other than the United States and who is authorized to practice under the laws of that country

Qualified Life Event(s)

Qualified life events are events that allow you to change your coverage for *Flex* benefits during the calendar year. For details on the types of changes allowed and the rules that apply to these changes, refer to the **Events Affecting Your Benefits** section in this handbook.

Reasonable and Customary (R&C)

For Medical Plan purposes, a fee is *reasonable and customary (R&C)* if it is the fee which meets both of the following requirements:

- It is the fee that a *physician* or other practitioner legally qualified to provide the covered service(s) most frequently charges for similar services, supplies or treatment to patients in like circumstances such as age, sex and medical condition (including unusual circumstances or medical conditions requiring additional time, skill and experience)
- The fee falls within the 90th percentile of fees charged by most *physicians* or other practitioners with similar training and experience legally qualified to provide the covered service(s) or similar service, supplies and treatment in the locality in which the covered service(s) is incurred

All charges above the *reasonable and customary* amount are your responsibility.

Registered Domestic Partner

A *registered domestic partner* means a person who is not your *spouse* or *same-sex spouse*, but who is recognized as your registered or certified domestic partner by a state which offers the ability to register or certify a domestic partnership. Confirmation may be required of the existence of a registered or certified domestic partnership. Except for exceptions set forth in the definition of *domestic partner*, *registered domestic partners* are considered *domestic partners* for purposes of this handbook and references to *domestic partners* shall include *registered domestic partners*.

Same-Sex Spouse

A *same-sex spouse* means a person of the same gender as you who either (i) is recognized as being legally married to you under the laws of the state or country in which the marriage was legally created, or (ii) is a person who has joined with you in a civil union that is recognized as creating all of the rights of marriage under the laws of the state or country in which the civil union was legally created. Confirmation may be required of the existence of a same-sex marriage or civil union. Except as used above in this definition of *same-sex spouse*, any use of the terms "married" and "unmarried" in this handbook refers to whether the individual has a husband or wife (of the opposite gender) to whom they are legally married. Except for exceptions set forth in the definition of *domestic partner*, *same-sex spouses* are considered *domestic partners* for purposes of this handbook and references to *domestic partners* shall include *same-sex spouses*.

SOFA

This term denotes Southern California Edison Company employees represented by the San Onofre Firefighters Association of the Utility Workers Union of America, Local 246A. The benefits and programs described in this handbook applicable to *SOFA*-represented employees are subject to the collective bargaining process.

Spouse

A *spouse* means your husband or wife (of the opposite gender from you) who is legally married to you. Confirmation of marital status may be required.

***Temporary* Employees**

Interns and union-represented employees who are classified as *temporary* in the *company's* Human Resources personnel system. A *temporary* employee is an *excluded person*.

Usual, Customary and Reasonable (UCR)

With respect to the Dental Plan, *usual, customary and reasonable (UCR)* means:

- Usual – A usual fee is the amount a provider regularly charges and receives for a given service. If the provider charges more than one fee for a given service, the usual fee for that service is the lowest fee the provider regularly charges or offers to patients
- Customary – A fee is customary when it is within the range of usual fees charged and received for a particular service by providers of similar training in the same geographic area that the plan administrator determines is statistically relevant
- Reasonable – A fee is reasonable if it is usual and customary, or if the plan administrator agrees that a fee that falls above customary is justified by a superior level of care or by the extraordinary circumstances of the case in question

All charges above the *usual, customary and reasonable* amount are your responsibility.

UWUA

This term denotes Southern California Edison Company employees represented by Local 246 of the Utility Workers Union of America, AFL-CIO. The benefits and programs described in this handbook applicable to *UWUA*-represented employees are subject to the collective bargaining process.

Year(s) of Service

Effective June 1, 2006, unless otherwise specified below, a *year of service* is a calendar year in which you earn at least 1,000 *hours of service*.

For purposes of calculating benefit accruals under the Southern California Edison Company Retirement Plan, a *year of service* is a "computation period" in which you earn at least 2,000 *hours of service*. Beginning January 1, 1996, a computation period is a calendar year. Prior to January 1, 1996, a computation period was your anniversary year – a 12-consecutive month period beginning on your date of hire and each anniversary thereafter. If you earn between 1,000 and 2,000 *hours of service* during a computation period, you will be credited with a partial *year of service*.

Note: Unless otherwise stated in a specific section, the summaries contained in this handbook apply to non-represented employees of Southern California Edison Company and describe the features of the plans/programs as of January 1, 2013.