AEP AMERICAN ELECTRIC POWER

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AEP Comprehensive Dental Plan (DPPO Option)

Summary Plan Description for Active Employees, Retirees and Surviving Dependents

Issued 2016

AEP System Comprehensive Dental Plan

The American Electric Power System Comprehensive Dental Plan is administered by Aetna. The Dental Plan is designed to provide you and your eligible dependents with high quality, cost-effective dental care. The plan offers a wide range of preventive care, basic and major restorative care, and orthodontic coverage for you and your covered dependents.

What's Here:

IMPORTANT NOTICE

This is a summary of the American Electric Power Comprehensive Dental Plan as in effect on January 1, 2016. This description of the American Electric Power Comprehensive Dental Plan is not intended as an employment contract or a guarantee of current or future employment. The Company reserves the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time, at its discretion, with or without advance notice to participants, for any reason, subject to applicable law. The Company further reserves the right to change the amount of required participant contributions for coverage at any time, with or without advance notice to participants.

This Summary Plan Description is an overview of the Plan documents as they apply to the benefits described herein. In the event of a conflict between this Summary and any Plan documents, the applicable Plan documents (excluding this Summary Plan Description) shall govern. For fully insured benefits, any discrepancy will be governed by the insurance certificates or policies.

Your Dental Options at a Glance

Dental Preferred Provider Organization (DPPO)

The DPPO option, administered by Aetna, lets you choose between receiving in-network and out-of-network care each time you need dental work. You will generally pay less for your dental care when you use an Aetna in-network dental provider because in-network dentists have agreed to lower, negotiated fees for their services.

Covered DPPO Expenses*	
Annual deductible (applies to basic and restorative expenses only)	$50/individual $150/family
Preventive care	100% (no deductible)
Basic restorative care	80% after deductible
Major restorative care	50% after deductible
Orthodontia care (eligible children under age 19)	50% of eligible expenses (no deductible)
Lifetime orthodontia maximum	$1,500/lifetime per covered child under age 19
Annual maximum benefit (excludes orthodontia)	$1,500/year per covered person

*****Up to Aetna's network discounted rates or Aetna's recognized charges if a non-network provider is used.

Dental Maintenance Organization (DMO)

The DMO option, administered by Aetna, offers you a broad range of dental services based on a Dental Benefits Summary. The Dental Benefits Summary, which is a separate booklet available from the AEP Benefits Center that shows the patient copay that applies to each covered dental procedure. You are responsible for the applicable copay at the time the services are performed. You agree to receive care solely from a primary care dentist (PCD) associated with the DMO network, and in return, you will have:

- No deductibles or annual maximum.
- No copayment for covered preventive services.
- Low, fixed copayments on other dental services.
- No claim forms to file.

DPPO/DMO Comparison Chart

Features	DPPO	DMO
Cost Sharing Arrangement	Coinsurance – you pay a percentage of covered expenses	Copay – you pay a set dollar amount at the time of service.
Primary Care Dentist Election	Not required	Yes, you must elect a PCD at the time you enroll, either online at www.aetna.com or by calling 1-800-243-1809
Annual Deductible – the amount you pay before your plan pays.	Individual: $50 Family: $150	No Deductible
Annual Maximum – the maximum amount your plan will pay out in a Plan Year.	$1,500 per covered person	No Limit
Orthodontics Eligibility	Children under age 19	Adults and children
Orthodontics Out-of-Pocket Maximum	No Limit	$2,400 per covered person
Orthodontics Lifetime Maximum	$1,500	No Limit
Out-of-Network Benefits	Visit any licensed dentist to receive benefits. You will typically pay lower out-of- pocket costs if you choose a dentist who participates in the Aetna DPPO network.	Out-of-network coverage is not available in Arizona, Texas, North Carolina, New Jersey, and California. Contact Aetna at 1-800-243-1809 for state-required benefits
Referrals – the primary care dentist directs you to seek dental care from another dental professional.	None required	Referrals are required, except when you visit an orthodontist in the DMO network.
Procedures NOT covered by the plan	You are responsible for the cost of procedures not covered by your plan. Note: Participating DPPO dentists offer discounts on procedures not covered by the plan.	You are responsible for the cost of procedures not covered by the plan.

Please refer to the separate AEP Comprehensive Dental Plan (DMO Option) Summary Plan Description for Active Employees and Retirees for additional information about the DMO option. You may also obtain more information about your eligibility for the DMO, how the DMO works, and what the DMO covers if you would contact Aetna at 1-800-243-1809.

Eligibility

Active Employees

You are eligible to enroll yourself and your eligible dependents in the AEP Comprehensive Dental Plan on your first day of work if you are classified by AEP as:

- A full-time active employee of a Participating AEP System Company scheduled to work an average of at least 40 hours per week; or
- A part-time active employee of a Participating AEP System Company scheduled to work an average of at least 20 hours per week.

You are not eligible to participate if you are:

- Not an employee of a Participating AEP System Company; or
- Classified by AEP as a contractor, a temporary employee, a leased employee, or as an employee under a collective bargaining agreement not covered under the plan.

Retirees

You remain eligible to elect dental coverage for yourself and your eligible dependents if you were last hired or rehired by an AEP Participating System Company on or before December 31, 2013 and you are at least age 55 with 10 or more years of service with a Participating AEP Company and elected to enroll in retiree dental coverage at retirement. If you do not remain covered by retiree dental coverage at retirement, you will not be eligible to enroll in dental coverage at a later date.

In addition, if you are rehired by a Participating AEP System Company on or after January 1, 2014, you may remain eligible to elect dental coverage for yourself and your eligible dependents upon your later retirement if you were eligible to elect such benefits in connection with your pre-2014 employment with AEP and maintained that coverage until your rehire date.

In determining whether a Retiree has met the service requirement, any service provided as a temporary employee, independent contractor, leased employee or otherwise had services based upon a fee or contract, will not be taken into account. You also will be excluded from eligibility if your benefits were the subject of a collective bargaining agreement that does not provide for retiree coverage under this Plan.

Surviving Spouse and Dependent Eligibility

Survivors of Active Employees (not retiree benefit eligible)

Surviving spouses of active employees who were not retiree benefit eligible on the date of death can elect to continue dental coverage until the earlier of age 65 or remarriage, if the surviving spouse was enrolled in the dental plan at the time of the employee's death.

Surviving dependent children of an active employee who was not retiree benefit eligible on the date of death can elect to continue dental coverage until they reach the limiting age (see the "Dependent Eligibility" section), if the surviving dependent was enrolled in the dental plan at the time of the employee's death.

Survivors of Active Employees (retiree benefit eligible)

Surviving spouses of active employees who were retiree benefit eligible on the date of death can elect dental coverage until remarriage, if the surviving spouse was enrolled in the dental plan at the time of the employee's death. Surviving dependents of active employees who were retiree benefit eligible on the date of death can elect dental coverage until the limiting age (see the "Dependent Eligibility" section), if the surviving dependent was enrolled in dental coverage at the time of the employee's death.

Survivors of Retirees

Surviving spouses of retirees can elect dental coverage until remarriage, if the surviving spouse was enrolled in the dental plan at the time of the retiree's death. Surviving dependents of retirees can elect dental coverage until the limiting age (see the "Dependent Eligibility" section), if the surviving dependent was enrolled in dental coverage at the time of the retiree's death.

Once a survivor waives or terminates participation in the dental plan, he or she cannot re-elect it.

Domestic Partners are not eligible for survivor dental benefits. However, AEP will offer COBRA-like coverage to eligible Alternative Family Members. Refer to the "Continuing Dental Coverage through COBRA" section for additional information.

Participating AEP Companies

Eligibility to participate in the plan depends, in part, on employment with a Participating AEP System Company. The list of Participating AEP System Companies includes the following as of January 1, 2016, but their inclusion may change for various reasons, including an amendment to the plan, or disposition of AEP's interest in the Company:

- American Electric Power Service Corporation
- AEP Energy Services, Inc.
- AEP Energy Partners, Inc.
- AEP Generating Company
- AEP Generation Resources Inc.
- AEP Onsite Partners, LLC
- AEP Pro Serv, Inc.
- AEP Texas Central Company
- AEP Texas North Company
- Appalachian Power Company
- CSW Energy, Inc.
- Dolet Hills Lignite Company, LLC
- Indiana Michigan Power Company
- Kentucky Power Company
- Kingsport Power Company
- Ohio Power Company
- Public Service Company of Oklahoma
- River Transportation Division I&MP
- Southwestern Electric Power Company
- Wheeling Power Company

This list is not complete. If you want more information on whether and when a particular AEP System Company participated in the plan, please call the AEP Benefits Center toll-free at 1-888-237-2363.

Dependent Eligibility

The AEP Comprehensive Dental Plan allows Employees and Retirees covered by the Plan to purchase coverage for their eligible dependents. Survivors of active employees or Retirees generally cannot enroll any of their own dependents who were not covered by the dental plan at the time of the Employee's or Retiree's death.

Eligible dependents include the Employee's or Retiree's:

Spouse: As defined by state law where you live, including common law marriages. However, a same-sex spouse relationship created under applicable law will be respected regardless of whether the state in which you live recognizes it.

Domestic Partner: AEP no longer allows the addition of domestic partners to coverage under the Plan. Only those same-sex domestic partners enrolled prior to October 28, 2015, are permitted to remain covered, but only through December 31, 2016. Coverage after December 31, 2016 will be limited to those who are legally married.

To qualify, you and your domestic partner must certify and declare that you met the criteria below. You and your domestic partner:

- Must be the same gender.
- Must not be related by blood.
- Must be at least 18 years of age or older.
- Must be jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Your partner need not contribute equally or

jointly to the cost of these expenses as long as you both agree that you both are responsible for the cost.
- Must have been living with you in the same residence for at least six consecutive months with the intent to continue doing so indefinitely.
- Must be in a serious and committed relationship.
- Must not be legally married to you or anyone else, in a partnership with another individual, or have had another partner within the prior six months. The determination of whether you are legally married will be determined based upon the law of the state in which you reside or where the marriage takes place.
- Must be legally competent – that is, legally and mentally capable of entering into a legally enforceable contract.
- Must have Affidavit of Domestic Partnership on file at the AEP Benefits Center.

Note: If you terminate your domestic partner relationship, or your domestic partner ceases to satisfy the criteria above for an eligible domestic partner, you must notify the AEP Benefits Center to discontinue your domestic partner from coverage. Failure to do so in a timely manner will not prevent their loss of coverage retroactively but will result in their loss of eligibility to elect COBRA continuation coverage.

You may cover your domestic partner whether or not he or she qualifies as your tax dependent. If your domestic partner is not a tax dependent, you will incur imputed income on that benefit coverage.

Children: To qualify for coverage, your dependent child(ren) must be under age 26 and fall into one of the following categories:
- Your natural child or the natural child of your spouse or eligible domestic partner;
- A child legally adopted by you, your spouse or eligible domestic partner or placed with you, your spouse or eligible domestic partner for adoption;
- Your foster child;
- A child who resides in your household for whom you, your spouse or your eligible domestic partner are the court-appointed guardian; or
- A child for whom you are required to provide coverage as a result of a Qualified Medical Child Support Order (QMSCO).
- Any other child you claim as a dependent on your federal income tax return, provided that neither natural parent of the child lives with the child and you are acting as the child's guardian.

Disabled Dependents: To qualify for coverage beyond the child limiting age, your disabled child(ren) must meet the criteria listed under the "Children" section above, plus:
- Disability must have occurred prior to attaining age 26.
- Remain continuously covered under the plan.

You must submit proof that the child reaching age 26 is disabled and incapable of self-support within 31 days after he or she reaches age 26. If you are enrolling the child for the first time after the child has already reached age 26, you must submit proof that the child has been disabled and incapable of self-support since age 26 within 31 days after enrolling the child. The claims administrator has the right to require, at reasonable intervals, proof that the child continues to be disabled and incapable of self-support. If you fail to submit any required proof or if you refuse to permit a medical examination of the child, he or she will not be considered disabled and, therefore, not eligible for coverage.

If Both You and Your Eligible Dependent have AEP Benefits

If both you and your spouse/domestic partner or eligible dependent are eligible for the dental plan as an AEP employee or retiree:

- You may each enroll in the plan as an employee or retiree, as appropriate; or
- One of you may enroll as an employee or retiree and the other as a dependent spouse, domestic partner or child. Neither of you may be covered as both an employee or retiree and as a dependent.
- Neither of you or your spouse or domestic partner can cover the same eligible dependent children.

Tax Considerations When Covering Your Dependents

A number of benefits that AEP offers to its employees receive special tax treatment. For the most part, the special tax provisions allow employees to pay their share of the cost of certain benefits on a before-tax basis and AEP to pay its share of the cost without having to include those payments in the employees' taxable wages.

AEP makes dental coverage available to dependents that may not satisfy the requirements to be treated as dependents for tax purposes, and the employee's contributions for covering those dependents would be paid on an after-tax basis and AEP's share of the cost of covering them would be taxable wages for the employee. If you want more information on the requirements to be treated as a dependent for tax purposes, please call the AEP Benefits Center toll-free at 1-888-237-2363.

When you enroll one or more dependents, you will be required to declare whether or not they are considered your federal income tax dependent under Sections 152 and 106 of the Internal Revenue Code for group health coverage purposes.

State Eligibility Laws and ERISA

States sometimes pass laws that require benefit plans to provide coverage and/or benefits to individuals who otherwise are not eligible. For example:

- A state might require an employer to provide coverage to an ex-spouse or to a child who is over age 26 and is not otherwise eligible for medical coverage under the Plan; or
- A particular state law may mandate coverage for a particular condition or medication that is not ordinarily covered by AEP's group health coverage.

While an insurer (e.g., under a fully insured benefit option like the Dental DMO) is generally required to comply with a particular state law, self-insured plans are exempt from many state mandates. So, if you are enrolled in one of AEP's self-insured benefit options, you should know that a state mandate does **not** apply to these benefits as a result of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA contains a preemption provision that supersedes most state laws that "relate to an employee benefit plan."

Enrolling for Coverage

How and When to Make Enrollment Elections and Changes

You can enroll for coverage after you meet the eligibility requirements.

As a New Employee

As a newly eligible employee of a Participating AEP System Company, you will receive information and instructions about how to enroll for your benefits. You must indicate your dental election either online or by phone to the AEP Benefits Center within 31 days of your date of hire. If you do not enroll within 31 days, you will not be covered by the Plan.

Social Security Numbers Generally Required for Enrollment
Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), the Centers for Medicare & Medicaid Services ("CMS") generally require Social Security numbers (or Tax Identification number for non-USA citizens) for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements.

For a newborn child, the newborn may be enrolled under your coverage without a Social Security number (provided you do so within 90 days of the birth). However, you should apply for the child's Social Security number as soon as possible and provide it to the AEP Benefits Center.

Annual Enrollment for Employees

Each year, during a designated Annual Enrollment period, you will be given the opportunity to enroll in or drop coverage, change your coverage elections, or change the dependents you cover. Your Annual Enrollment materials will provide the options available to you and your share of the premium cost, if any, for the coverages you elect. Your materials will also include what actions you must take to continue certain coverages and will explain any applicable default coverage that you will be deemed to have elected if you do not make the required elections by the specified deadline. The elections you make will take effect on January 1 and stay in effect through December 31, unless you have a qualifying change in status that permits you to make a mid-year election change. See the "Making Changes During the Year" section.

As a New Retiree

Your coverage in effect as an active employee will automatically continue into retirement. You will continue being enrolled in the same option under the plan, covering the same eligible dependents. If you wish to change plan options, drop coverage or add/remove dependents at the time of your retirement, you must do so by contacting the AEP Benefits Center within 31 days of your retirement. You may NOT change options under the AEP Dental Plan due to your retirement event.

If you are not enrolled in an AEP dental plan option at the time of your retirement, you will continue to not be enrolled until you contact the AEP Benefits Center within 31 days of your retirement.

This is a one-time election. If you choose not to enroll in dental benefits or waive coverage as a new retiree, you cannot enroll in dental coverage at any time in the future.

As a New Surviving Dependent

As a new AEP surviving spouse or dependent, if all contributions are paid up to date at the time of the Employee's or Retiree's death, you will automatically be enrolled in the same dental plan option you had as of the date of death. You may NOT change dental plan options. If you do not wish to continue coverage as a surviving spouse or dependent, you must contact the AEP Benefits Center within 31 days of the Employee's or Retiree's death. If you choose not to enroll in dental coverage as a surviving spouse or dependent, you will not be able to enroll at a later date, regardless of any changes in employment or family status.

This is a one-time election. If you waive coverage as a new surviving spouse or surviving dependent, you cannot enroll in dental coverage at any time in the future.

Annual Enrollment for Retirees and Surviving Dependents

Each year, during a designated Annual Enrollment period, Retirees and then participating Surviving Dependents will be given the opportunity to drop coverage or change coverage elections. Retirees may change the dependents they cover, Surviving Dependents only would have the opportunity to drop any eligible dependents that they cover. Your Annual Enrollment materials will provide the options available to you and your share of the premium cost, if any, for the coverages you elect. Your materials will also include what actions you must take to continue certain coverages and will explain any applicable default coverage that you will be deemed to have elected if you do not make the required elections by the specified deadline. The elections you make will take effect on January 1 and stay in effect through December 31, unless you have a qualifying change in status that permits you to make a mid-year election change. See the "Making Changes During the Year" section.

Making Changes During the Year

In general, after you enroll in benefits, you may not change or cancel your election choices during the year. However, certain qualifying changes in status may warrant benefit changes if they are due to and consistent with the qualifying change in status that affects your eligibility for the coverage. If you experience a qualifying change in status, you can make certain mid-year changes to your dental coverage elections. Examples of these qualifying life events and what you need to do relative to your dental coverage are listed in the "Life Events and Your Coverage" section.

Covering Your Family

When you enroll yourself in dental coverage, you decide if you want to enroll your eligible dependents. Refer to the "Eligibility" section for a definition of eligible dependents. You can choose one of the following coverage levels:

- Participant only;
- Participant + Spouse or Domestic Partner (not applicable to surviving dependents);
- Participant + Child(ren) and/or Domestic Partner's Child(ren) (A surviving spouse or dependent child may enroll the other surviving dependent children); or
- Participant + Family (not applicable to surviving dependents).

You must be enrolled in dental coverage to enroll your eligible dependents. Coverage is provided only for those eligible dependents the Employee, Retiree or Surviving Dependent has actually enrolled. You should contact the AEP Benefits Center to confirm those enrolled or to add or remove dependents from your coverage at permissible times.

Waiving Coverage

You may also waive coverage under the AEP Comprehensive Dental Plan. If you elect to waive coverage for yourself, you automatically waive coverage for your eligible dependents. If you are a Retiree or Surviving Dependent, if you waive coverage, you cannot enroll at a later date.

Qualified Medical Child Support Order (QMCSO)

In some cases, you may be required by a court or administrative order to cover a dependent under the AEP Comprehensive Dental Plan. Federal law requires group health plans to comply with orders from state courts and administrative agencies that meet the requirements to be considered Qualified Medical Child Support Orders (QMCSOs). A QMCSO may require you to add your child as a dependent for dental benefits in some situations, typically a divorce.

You must be enrolled in dental coverage to add a dependent pursuant to a QMCSO. When you receive a QMCSO, you should contact the AEP Benefits Center toll-free at 1-888-237-2363 to request a change in

coverage. You will also need to forward a copy of the court or administrative order to the AEP Benefits Center. Once you or your dependent furnishes a court or administrative order to the AEP Benefit Center, you and each affected child will be informed of receipt of the order and will be provided a copy of the procedures for determining if the order is a QMCSO. Subsequently, the interested parties will be notified of the determination. You may also obtain a copy of the QMCSO administrative procedures, free of charge, by contacting the AEP Benefits Center**.**

Cost of Coverage

Each year, AEP evaluates plan costs and may adjust your cost of coverage for the next year. Your cost may be affected by factors that AEP considers appropriate, such as the availability of other coverage to covered dependents, the time and circumstances applicable to an Employee or Retiree at the time of disability, retirement or death and wellness incentive programs that AEP may implement from time to time. The applicable cost for the upcoming year is made available by the time the Annual Enrollment period for that year begins.

Employees

As an active employee, you and AEP share the cost of your dental coverage. Your monthly cost for dental coverage is automatically deducted from 24 paychecks per year. For any period that your paycheck is not sufficient to cover your cost, you will have to make payment as directed at that time.

The amount you contribute toward the cost of your benefits generally is determined by:

- The options you choose.
- The number of dependents you cover.

Your contributions generally will be paid through before-tax payroll deductions; however, some benefits or other circumstances may require contributions to be paid with after-tax dollars.

Retirees and Surviving Dependents

If you are covered as a Retiree or Surviving Dependent, you pay the full cost of your dental coverage on an after-tax basis. If you are covered as a Retiree, you may be able to elect payment of your contribution from a monthly annuity being paid to you by the AEP System Retirement Plan (including the portion consisting of the former Central and South West Corporation Retirement Plan). Otherwise, you will receive a monthly billing statement for your dental contributions. Failure to remit payments in a timely manner will result in loss of coverage.

When Coverage Begins

Employees

For New Hires — If you timely enroll as an eligible employee, your coverage begins on your date of hire. Coverage for your dependents begins the same day that your coverage begins.

For New Retirees — If you timely enroll as a Retiree (or, if your coverage automatically continued, failed to waive coverage), your retiree coverage begins the first of the month following your retirement date.

For Newly Surviving Dependents — If you fail to waive coverage as a surviving dependent, your coverage continues the first of the month following the date of the Employee's or Retiree's death.

During Annual Enrollment — If you make changes to your AEP Comprehensive Dental Plan election during the Annual Enrollment period, coverage for you and your enrolled dependents begins on January 1 of the following year and continues through December 31.

If You Make Changes During the Year — You must notify the AEP Benefits Center, toll-free, at 1-888-237-2363 within 31 days of a qualifying change in status event (or within 90 days of a birth or adoption),except as otherwise specified. To be qualified, the change that you make to your coverage must be due to and consistent with the event and affect your eligibility for coverage. You also may be required to provide proof of the qualifying status changes. If you make changes to your coverage because of a qualifying status change, the change in your coverage generally will become effective as of the date of your qualifying event.

Refer to the "Life Events and Your Coverage" section for a list of some possible qualifying events and actions you must take if any of these events in your life occur.

Dental Preferred Provider Organization

How the DPPO Works

The Dental Preferred Provider Organization (DPPO) option has networks of participating dentists and other dental providers who have agreed to a negotiated fee arrangement for covered dental services with Aetna. In-network providers give you the maximum benefit available under this option. These providers agree to charge lower fees for their services; therefore you generally pay less out of your own pocket when you visit in-network dentists.

However, you can still choose to receive dental care from a non-participating dental provider and still receive benefits. If you visit an out-of-network dentist, you may be charged more than the recognized charge for a service or supply. You are responsible for any charges exceeding the recognized charge, in addition to your deductible and co-insurance.

Availability of Providers
Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any network provider may terminate the provider contract or limit the number of patients accepted in a practice.

The DPPO option pays out-of-network benefits based on recognized charges. Refer to the Glossary section of this booklet for a definition of recognized charges.

The plan does not cover any charges over the recognized charges. Billed charges which exceed the recognized charge are not considered eligible expenses.

The plan's co-insurance level is the same no matter what dentist you use, but your out-of-pocket costs may be lower when you visit a participating network dentist.

To obtain a list of network providers, contact Aetna Member Services at 1-800-243-1809 or access the Aetna website at **www.aetna.com**.

What the DPPO Option Covers

To be covered by the DPPO option, a dental expense must be dentally necessary and the services must be performed by or under the direction of a qualified and licensed dentist. Charges for services that are specifically excluded will not be covered. Charges for covered items must be within Aetna's recognized charges guidelines.

For basic and major restorative services, participants must first meet their annual deductible of $50 per person or $150 per family before the plan begins paying benefits.

The plan will pay a maximum of $1,500 per covered person each calendar year, excluding orthodontia. There is a separate $1,500 lifetime maximum for orthodontia treatment for each covered dependent child under age 19.

Not all of your expenses will be covered by the AEP Comprehensive Dental Plan. If you are an active employee, some of the excluded expenses may be reimbursed tax-free if you have an available balance in a Health Care Flexible Spending Account. To learn more about how the Health Care Flexible Spending Account made available by AEP works, refer to the Health Care Flexible Spending Account section in the American Electric Power Flexible Spending Account Summary Plan Description booklet.

DPPO Provisions	Eligible Dental Expenses
Annual deductible (applies to basic and restorative expenses only)	$50/individual $150/family
Preventive care	100% of eligible expenses (no deductible)
Basic restorative care	80% after deductible
Major restorative care	50% after deductible
Orthodontia care (eligible dependent children under age 19)	50% of eligible expenses (no deductible)
Lifetime orthodontia maximum	$1,500/lifetime per covered person
Annual maximum benefit (excludes orthodontia)	$1,500/year per covered person

Pretreatment Reviews

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $300. Ask your dentist to write down a full description of the treatment you need, using either an Aetna claim form or an ADA approved claim form. Then, before actually treating you, your dentist should send the form to Aetna.

Aetna may request supporting X-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement outlining the benefits payable by the plan. You and your dentist can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result.

To receive a pretreatment review, follow these steps:

- Your dentist will describe the planned services by ADA code and charge(s) on the claim form and send the form, pertinent X-rays and other diagnostic materials to Aetna.
- Aetna will review the planned treatment, determine the benefits payable, and notify you and your dentist of the benefit determination by returning the explanation of benefits (EOB) form.
- When the treatment is complete, the form must be signed and dated by your dentist and returned to Aetna for payment of the covered services.

Preventive Care

Visits and X-Rays

- Office visit during regular office hours, for oral examination.
  - Two routine comprehensive or problem focused examinations (limited to 2 visits per calendar year, combined frequency).
- Prophylaxis (cleaning) (limited to 2 treatments per calendar year).
- Topical application of fluoride, (limited to one course of treatment per calendar year and to children under age 19).
- Sealants, per tooth (limited to one application every 5 calendar years for 1st and 2nd permanent molars only and to children under age 19).
- Bitewing X-rays or vertical bitewing X-rays (limited to 1 set per calendar year).
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 5 years).
- Periapical X-rays (single film up to age 13).
- Intra-oral, occlusal view, maxillary or mandibular.
- Upper or lower jaw, extra-oral.
- Emergency palliative treatment, per visit.

Space Maintainers

- For dependents to age 19 and only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)
  - Fixed (unilateral or bilateral).
  - Removable (unilateral or bilateral).

Basic Restorative Care

Visits and X-Rays

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater).

X-Ray and Pathology

- Biopsy and histopathologic examination of oral tissue.

Oral Surgery

- Extractions.
  - Erupted tooth or exposed root.
  - Coronal remnants.

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration).
- Root planning and scaling, per quadrant (limited to 4 separate quadrants every 2 years).
- Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years).

- Periodontal maintenance procedures following active therapy (limited to 4 per year).
- Full mouth debridement.

Endodontics
- Pulp capping.
- Pulpotomy.

Restorative Dentistry
- Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
- Amalgam restorations.
- Resin-based composite restorations (other than for molars).
- Pins.
  - Pin retention—per tooth, in addition to amalgam or resin restoration.
- Crowns (when tooth cannot be restored with a filling material).
  - Prefabricated stainless steel.
  - Prefabricated resin crown (excluding temporary crowns).
- Recementation.
  - Inlay.
  - Crown.
  - Bridge.

Prosthodontics
- Office reline.
- Laboratory reline.
- Special tissue conditioning, per denture.
- Rebase, per denture.
  - Adjustment to denture more than 6 months after installation.
- Full and partial denture repairs.
- Broken dentures, no teeth involved.
- Repair cast framework.
- Replacing missing or broken teeth, each tooth.
- Adding teeth to existing partial denture.
  - Each tooth.
  - Each clasp.
- Repairs: crowns and bridges.

General anesthesia and intravenous sedation (only when medically necessary and only when provided in conjunction with a covered surgical procedure).

Major Restorative Care

Oral Surgery
- Surgical removal of impacted teeth.
  - Removal of tooth (soft tissue).
  - Removal of tooth (partially bony).
  - Removal of tooth (completely bony).

Extractions
- Surgical removal of erupted tooth/root tip.

Other Surgical Procedures

- Alveoplasty, in conjunction with extractions - per quadrant.
- Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces — per quadrant.
- Alveoplasty, not in conjunction with extraction - per quadrant.
- Sialolithotomy: removal of salivary calculus.
- Closure of salivary fistula.
- Excision of hyperplastic tissue.
- Removal of exostosis.
- Transplantation of tooth or tooth bud.
- Closure of oral fistula of maxillary sinus.
- Sequestrectomy.
- Crown exposure to aid eruption.
- Removal of foreign body from soft tissue.
- Frenectomy.
- Suture of soft tissue injury.
- Odontogenic cysts and neoplasms.
  - Incision and drainage of abscess.
  - Removal of odontogenic cyst or tumor.

Periodontics

- Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years (combined frequency with gingivectomy and gingeval flap procedures).
- Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years (combined frequency with gingivectomy and gingeval flap procedures).
- Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years) (combined frequency with osseous surgery and gingeval flap procedures).
- Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years (combined frequency with osseous surgery and gingeval flap procedures).
- Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years) (combined frequency with osseous surgery and gingivectomy).
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years) (combined frequency with osseous surgery and gingivectomy).
- Localized delivery of antimicrobial agents.
- Soft tissue graft procedures.
- Clinical crown lengthening, hard tissue.

Endodontics

- Root canal therapy including necessary X-rays.
- Molar.
- Anterior.
- Bicuspid.
- Apexification/recalcification.
- Apicoectomy.

Restorative

- Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5 years – see “Replacement Rule”).
- Inlays/onlays.

- Labial Veneers.
  - Laminate – chairside.
  - Resin laminate – laboratory.
  - Porcelain laminate – laboratory.
- Crowns.
  - Resin.
  - Resin with noble metal.
  - Resin with base metal.
  - Porcelain/ceramic substrate.
  - Porcelain with noble metal.
  - Porcelain with base metal.
  - Base metal (full cast).
  - Noble metal (full cast).
  - 3/4 cast metallic or porcelain/ceramic.
- Post and core.
- Core build up including any pins.

Prosthodontics

- First installation of dentures and bridges is covered only if needed to replace teeth which were not abutments to a denture or bridge less than 5 years old (see "Tooth Missing but not Replaced Rule").
- Replacement of existing bridges or dentures is limited to 1 every 5 years (see "Replacement Rule").
- Bridge Abutments.
- Pontics.
  - Base metal (full cast).
  - Noble metal (full cast).
  - Porcelain with noble metal.
  - Porcelain with base metal.
  - Resin with noble metal.
  - Resin with base metal.
- Removable Bridge (unilateral).
  - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics.
- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
  - Complete upper denture.
  - Complete lower denture.
- Partial upper or lower, resin base (including any conventional clasps, rests and teeth).
- Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth).
- Stress breakers.
- Interim partial denture (stayplate), anterior only.
- Implants.
- Non-surgical Temporomandibular (Jaw) Joint Disorder (TMJ) services.

Orthodontic Care

Orthodontia is only covered when the treatment is for your eligible dependent child(ren) under age 19. The plan pays 50% of either the negotiated discounted amount or the recognized charges up to a lifetime maximum benefit of $1,500 per covered child. The amount you pay depends on the dentist you choose:

- When you use a network dentist, you will pay up to 50% of the negotiated fee, plus any amount which exceeds the eligible orthodontic benefit.

- When you use a non-network dentist, you pay 50% of the eligible expenses up to the lifetime benefit maximum, plus you will be responsible for all charges in excess of the recognized charges. Coverage includes examinations, X-rays, laboratory tests, and other necessary treatments and appliances. If orthodontic treatment began before your dependent child(ren) were covered by this plan, the plan will begin paying for covered dental expenses on the date that your dependent child(ren) became covered.

The plan covers the following orthodontic services and supplies:
- Interceptive orthodontic treatment.
- Limited orthodontic treatment.
- Comprehensive orthodontic treatment of adolescent dentition.
- Comprehensive orthodontic treatment of adult dentition.
- Post treatment stabilization.
- Removable appliance therapy to control harmful habits.
- Fixed appliance therapy to control harmful habits.

The plan does NOT cover the following orthodontic services and supplies:
- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

To remain eligible for coverage of orthodontic treatments that extend into the next Plan Year, you must continue to cover your child(ren) under the AEP Comprehensive Dental Plan.

Additional Covered DPPO Expenses

If you have AEP medical coverage and have at least one of the following conditions:
- Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes;

Then, the following additional dental expenses will be considered covered expenses:
- One additional prophylaxis (cleaning) per year;
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year); and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy).

Alternative Treatment

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment; and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges), implants and implant prosthetics and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant or implant prosthetics or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

What the DPPO Option Does NOT Cover

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The DPPO option covers only those services and supplies that are medically necessary and included in the "What the DPPO Option Covers section."

These dental exclusions are in addition to the exclusions that apply to health coverage.

- Dental work that began before you were covered by the plan:
  - An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan;
  - A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan; or
  - Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan.
- Any instruction for diet, plaque control and oral hygiene.
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the "What the DPPO Option Covers" section. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays and onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.
- Braces, mouth guards, and other devices to protect, replace or, except as provided for orthodontic treatment covered in the "What the DPPO Option Covers" section, reposition teeth and removal of implants.
- Dental services and supplies that are covered in whole or in part:
  - Under any other part of this plan; or

  - Under any other plan of group benefits provided by the Participating AEP Companies.
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
- Except as covered in the "What the DPPO Option Covers" section, treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
- Orthodontic treatment except as covered in the "What the DPPO Option Covers" section.
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).
- Prescribed drugs; pre-medication; or analgesia.
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Surgical removal of impacted wisdom teeth only for orthodontic reasons.
- Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
  - Scaling of teeth;
  - Cleaning of teeth; and
  - Topical application of fluoride.
- Experimental or investigational drugs, devices, treatments or procedures, except as described in the "What the DPPO Option Covers" section.
- Payment for that portion of the charge for which Medicare or another party is the primary payer.
- Miscellaneous charges for services or supplies including:
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.
- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
- Routine dental exams and other preventive services and supplies, except as specifically provided in the "What the DPPO Option Covers" section.
- Services rendered before the effective date or after the termination of coverage.
- Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement

may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

To be covered by the plan, a dental expense must be medically necessary and the services must be performed by or under the direction of a qualified and licensed dentist. Charges for services that are specifically excluded will not be covered. Charges for covered items must be within the recognized charges guidelines.

Not all of your expenses will be covered by the AEP Comprehensive Dental Plan. If you are an active employee, some of the excluded expenses can be reimbursed tax-free by your participation in the Health Care Flexible Spending Account. To learn more about how the Health Care Flexible Spending Account works refer to the Health Care Flexible Spending Account in the Flexible Spending Account Summary Plan Description booklet.

Filing a DPPO Claim

When you use network providers, your provider will file claims for you. If you use a non-network provider, you may be required to file a claim. You may request a claim form from the AEP Benefits Center or from Aetna by calling 1-800-243-1809 or by logging into Aetna Navigator the Aetna website at **www.aetna.com**.

To file a claim, you (or your provider) must complete a claim form which includes elements such as:

- Member identification number,
- Patient identification number,
- Dates of service, and
- Complete and accurate breakdown of services.

Attach all receipts to the claim form and mail it to the address shown on the form:

Aetna Dental
P. O. Box 14094
Lexington, KY 40512-4094

Claims must be filed within one year of the date the expense is incurred, or it will not be eligible for reimbursement under the plan.

Remember — any treatment expected to cost $300 or more should receive a pretreatment review by Aetna.

If your claim is denied, you will receive a written notice from the claims administrator no later than 30 days after the claim is received, as long as all needed information was provided with the claim. Sometimes additional time is necessary to process a claim due to circumstances beyond the control of the plan. If an extension is necessary, the claims administrator will notify you in writing within the 30-day period of the reasons for the extension and the date by which it expects to render a decision. The extension generally will be no longer than 15 days, unless additional information is needed.

If the extension is necessary because you failed to provide all needed information, the notice of extension will describe the additional information required. You will have 45 days to provide the additional

information. If all the additional information is received within 45 days, the claims administrator will notify you of the claim decision within 15 days after the information is received. If you do not provide the needed information within the 45-day period, the claims administrator will deny the claim. Any notification of an adverse benefit determination will include:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific plan provisions on which the adverse benefit determination is based.
- A description of the plan's appeal procedures applicable to your claim and of your right to bring a civil action under federal law following the denial of all available appeals.
- A statement disclosing any internal rule, guideline, protocol, or similar criterion relied on in denying the claim (or a statement that such information will be provided free of charge upon request), if applicable.

If you have questions or concerns about a benefit determination, you may informally contact Aetna Customer Services before requesting a formal appeal. If the Aetna Customer Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your questions in writing. Remember, however, that if you are not satisfied with a benefit determination, you may appeal it immediately as described in the "How to File a Dental Plan Appeal" section, without first informally contacting Aetna Customer Services.

Coordinating AEP DPPO Option Benefits with Another Benefit Plan

The AEP Comprehensive Dental Plan includes a maintenance of benefits (MOB) provision that applies to coordinate benefits when you or your covered dependents have dental care coverage under more than one plan.

Under the maintenance of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans."

The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan.

When you or your covered family member is also covered under another dental plan, the following benefit determination rules govern the order which each Plan will pay a claim for benefits.

1) Any plan that does not have a coordination of benefits provision is automatically the primary plan.
2) A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
    a) Secondary to the plan covering the person as a dependent; and
    b) Primary to the plan covering the person as other than a dependent.

The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

    a) Covers the person as other than a dependent; and
    b) Is secondary to Medicare.

3) Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4) In the case of a dependent child whose parents are divorced or separated:
   a) If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   b) If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
   c) If there is not such a court decree: If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
   d) If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.
   e) If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:
- Laid-off or retired employee; or
- The dependent of such person shall be determined after the benefits of any other plan which covers such person as:
  – An employee who is not laid-off or retired; or
  – Dependent of such person.

If the other plan does not have a provision:
- Regarding laid-off or retired employees; and
- As a result, each plan determines its benefits after the other, then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:
- Regarding right of continuation pursuant to federal or state law; and
- As a result, each plan determines its benefits after the other, then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all “other plans” for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules. For this

purpose, if Aetna administers claims for both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments. When the DPPO option under this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

When the DPPO option is secondary, it will pay only the difference between the benefits paid by the primary plan and what would have been paid had the DPPO option been primary.

For example: Your spouse has coverage through his or her company's dental plan and is also covered as a dependent under the AEP DPPO option in this Plan. Assume:

- Total allowable expense is $1,000.
- Deductible has been met.
- Spouse's plan pays 80%.

	Primary Plan (Spouse's plan)	Secondary Plan (AEP DPPO)
Dental Bill	$1,000	$1,000
Plan Co-insurance	80%	80%
Plan pays (if the primary plan)	$800	$800

In this case, since the primary plan pays the same as what the AEP DPPO would have paid if the AEP DPPO was primary, the AEP plan would pay $0 ($800-$800).

If, on the other hand, your spouse's plan pays at 70% ($700), the AEP DPPO would pay the difference — an additional $100 ($800-$700).

The term “another benefit plan” refers to:

- Employer-sponsored plans, regardless of whether they are fully insured or self-funded.
- Group coverage sponsored and subsidized by a school or other educational institution.
- Government or tax supported programs, including Medicare and Medicaid.
- Property or homeowner’s insurance.
- No fault motor vehicle coverage.

Dental Plan Claim Determinations

Post-Service Claims

Claims that do not need urgent attention (see the next following section on Urgent Care Claims), generally will be handled as a post-service claim under the DPPO option. Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the claim is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Urgent Care Claims

If the Plan's application of the time periods for making its determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, Aetna will treat that claim as an urgent care claim and make notification of its determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48 hour period given the physician to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Concurrent Care Claim Extension

If a claimant has been approved for an ongoing course of treatment that is to be provided over a period of time or number of treatments, but the claimant has made a request for an extension of time or an increase to the number of treatments, those decisions will be treated as "concurrent care claims" and handled under the procedures described here. Aetna will make notification of a concurrent care claim determination involving an extension or increase for emergency or urgent care as soon as possible after the request is received but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. With respect to all other care, Aetna will make notification of its determination within 15 calendar days following a request for a concurrent care claim extension.

Concurrent Care Claim Reduction or Termination

If Aetna would decide to reduce or terminate a previously approved course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments, Aetna will make notification of its determination with enough time for you to file an appeal and obtain a determination on review of that before the benefit is reduced or terminated.

Dental Plan Complaints

If you are dissatisfied with the service you receive in connection with the processing of a claim with the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Claims Appeal Process

How to File a Dental Appeal

If Aetna gives notice of an adverse benefit determination in connection with your claim (whether a pre-service, urgent or concurrent care claim), you may submit an appeal. The DPPO option provides for two levels of appeal.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your level one appeal. Your appeal may be submitted verbally or in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

The notice of an adverse benefit determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number on your ID card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing verbal or written consent to Aetna.

Level One Appeal

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination. The review of the level one appeal will afford no deference to the initial benefit determination.

If your claim was denied based on a medical judgment (such as whether a service or supply is experimental or dentally necessary), Aetna will consult with a dental professional with appropriate training and experience. The dental care professional consulted for the level one appeal will not be the professional (if any) consulted during the prior determination or a subordinate of such professional.

Urgent Care Claims

Urgent Care Claims may include concurrent care claim reduction or termination. Aetna shall issue a decision within 36 hours of receipt of the request for an appeal.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

If you receive an adverse benefit determination on your level one appeal, the notification will include:

- The specific reasons for the adverse benefit determination.
- Reference to the specific plan provisions on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim.
- A description of the level two appeal procedures offered by the plan and statement of your right to bring civil action under federal law following the denial of all your available appeals.
- A statement disclosing any internal rule, guideline, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request), if applicable.

Level Two Appeal

If Aetna upholds an adverse benefit determination at the level one appeal, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

A level two appeal of an adverse benefit determination of an urgent care claim or a Post-Service Claim shall be provided by Aetna personnel not involved in making any prior adverse benefit determination in connection with your claim. The review of the level two appeal will afford no deference to the prior benefit determinations.

If your claim was denied based on a medical judgment (such as whether a service or supply is experimental or dentally necessary), Aetna will consult with a dental professional with appropriate training and experience. The dental care professional consulted for the level two appeal will not be the professional (if any) consulted during any prior determination or a subordinate of such professional.

Urgent Care Claims

Urgent Care Claims may include concurrent care claim reduction or termination. Aetna shall issue a decision within 36 hours of receipt of the request for a level two appeal.

Post-Service Claims

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.

Denial notifications of level two appeals will include the same applicable information for adverse determinations as listed on a level one appeal. Aetna and its representatives who handle claims determinations, level one appeals and level two appeals have full discretionary authority to interpret the provision of the plan in making their decisions.

You must use and exhaust the AEP Comprehensive Dental Plan's administrative claims and appeal procedure before bringing a suit in either state or federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner may also cause you to lose your right to sue regarding an adverse benefit determination.

Right of Recovery

The amount of your plan benefits will be adjusted if:

- You have misstated any information in your application for plan coverage (including any statement of health) or in your application for benefits;
- You do not report required information while receiving Company-provided benefits; or
- Any error is made in calculating your benefits.

If a benefit is overpaid or duplicated, you are expected to repay the plan within 60 days. If you do not, the plan may reduce or refuse future benefits, as allowed by law, until the overpayment is repaid. The plan may also take any additional action that is permitted by law.

No interest will be charged on the amount of any overpayment or duplication of benefits and, unless required by law, no interest will be paid on any underpayment of benefits or on any benefit payments that have been delayed for any reason.

When Coverage Ends

Under most circumstances, your AEP coverage ends on the last day of the month in which:

- You stop paying required contributions;
- You terminate employment;
- You are no longer eligible;
- The plan ends; or
- You die.

Coverage for your eligible dependents ends on the last of the month in which your coverage ends, or in which they are no longer eligible.

Continuing Coverage as an AEP Retiree

If you are age 55 or older with at least 10 years of service when your employment with AEP ends, you alternatively may be able to continue coverage for yourself as an AEP "retiree" and for your eligible dependents. Please refer to the "Eligibility" section for more information.

Continuing Coverage as a Surviving Dependent

If you are covered as a dependent spouse or child of an Employee or Retiree at the time of the Employee's or Retiree's death, your coverage may be continued as a "Surviving Dependent. Please refer to the "Eligibility" section for more information about the availability and additional circumstances that may cause that coverage to terminate.

Continuing Dental Coverage under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act, a federal law known as "COBRA," employers with 20 or more employees that sponsor group health plans generally are required to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA in connection with the group health benefits maintained by the Participating AEP Companies (generally referred to in this notice as the "Company"). The group health benefits maintained by the Company include the American Electric Power System Comprehensive Dental Plan (referred to as the "Plan"). You and your spouse should take the time to read this notice carefully.

Qualified Beneficiaries

Status as a qualified COBRA beneficiary gives an individual special rights under COBRA. Persons covered by the plan will be considered COBRA qualified beneficiaries only if they fit into one of the following categories:

- Retiree;
- Employee or former employee;
- Spouse or former spouse of the retiree, employee, or former employee; or
- Dependent child(ren) of the retiree, employee, or former employee.

Therefore, you, your spouse and dependent children who are covered by the Plan at the time of the "qualifying event" generally will be considered "qualified COBRA beneficiaries" with respect to the Plan. Any child born or placed for adoption during the COBRA continuation period will also be treated as a qualified beneficiary if you have dependent coverage under the Plan at the time. Please remember that to enroll a newborn infant or a child placed with you for adoption (or even any other child or other dependents acquired through marriage) in the Plan, you must follow the enrollment procedures that are described in the Plan. A child is considered "placed for adoption" when the adoptive parent assumes and retains the legally enforceable obligation for the partial or total support of the child. This obligation generally arises when the proper court or proper agency issues an order to that effect.

Although COBRA laws do not establish health benefit continuation rights for other categories of eligible dependent children or Alternative Family Members (such as domestic partners), AEP offers COBRA-like coverage to them under the AEP Comprehensive Dental Plan.

COBRA Qualifying Events

Employee. You have a right to choose this continuation coverage if you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part) or, if you are a retiree, because of a filing under Title 11 of the Federal Bankruptcy Code with respect to your employer (with regard to this qualifying event, the loss of coverage may include the substantial elimination of your coverage within one year before or after the filing).

Spouse or Domestic Partner. The spouse or domestic partner of an employee (or a retiree for reason 6) covered by the Plan, has the right to choose continuation coverage for himself or herself if he or she lost coverage under that plan for ANY of the following six (6) reasons:

1. Your death;
2. A surviving spouse's remarriage within 36 months of your death;
3. The termination of your employment (for reasons other than gross misconduct) or reduction in your hours;
4. Your divorce, legal separation or termination of domestic partnership;
5. You become eligible for benefits under Medicare Part A, Part B, or both; or
6. A filing under Title 11 of the Federal Bankruptcy Code with respect to the employer. With regard to this qualifying event, the loss of coverage may include the substantial elimination of coverage within one year before or after the filing.

Dependent Child. Your dependent child, if covered by the Plan, has the right to continuation coverage under the Plan if coverage is lost for any of the following six (6) reasons:

1. Your death;
2. The termination of your employment (for reasons other than gross misconduct) or reduction in your hours;
3. Your divorce, legal separation or termination of domestic partnership;
4. You become eligible for benefits under Medicare Part A, Part B, or both;
5. Your dependent ceases to be a "dependent child" under the Plan; or
6. A filing under Title 11 of the Federal Bankruptcy Code with respect to the employer. With regard to this qualifying event, the loss of coverage may include the substantial elimination of coverage within one year before or after the filing.

For qualifying event purposes, coverage will be considered lost if a person ceases to be covered under the same terms and conditions as in effect immediately before the applicable qualifying event. Any increase in the premium or contribution that you must pay (or that your spouse or dependent child must pay) for coverage under a plan that results from the occurrence of a qualifying event is considered a loss of coverage. The loss of coverage need not occur immediately after the qualifying event, so long as the event occurs before the end of the maximum coverage period (discussed under the heading "Duration of Continuation Coverage").

The taking of leave under the Family and Medical Leave Act (FMLA) is not considered a qualifying event under COBRA. A qualifying event may occur under COBRA, however, on the last day of your FMLA leave.

Obligation to Notify the Company of Certain Qualifying Events

Under COBRA, you or your family member has the responsibility to inform the Company of a divorce or legal separation, or of a child losing dependent status under the Plan. This notice must be provided to the AEP Benefits Center within 60 days of the qualifying event. If the AEP Benefits Center is not provided such notice within that time, there will be no continuation coverage available with respect to that qualifying event.

You or your covered family member also has the responsibility to inform the Company of a Social Security determination that you or your covered family member was disabled either at the time of your termination or reduction in hours, or within 60 days thereafter. This notice must be provided to the AEP Benefits Center in writing during the initial 18 months of continuation coverage and within 60 days of the Social Security determination. If the AEP Benefits Center is not provided such notice within that time, the 11-month extension of the maximum continuation coverage period will not be available.

Also, if a child is born to you or placed for adoption with you during the period that you have elected continuation coverage, that child may also be added to your coverage assuming that you timely notify the AEP Benefits Center of the addition of the child and timely pay any additional premium that becomes payable as a result of the addition. Please refer to the section entitled "Dependent Eligibility" to determine how and when you may add a child to your coverage.

The Company has the responsibility to notify the Plan of your death, termination of employment or reduction in hours, or if you become eligible for Medicare. Therefore, you should immediately notify the AEP Benefits Center if you or another covered individual becomes eligible for Medicare.

The Company also relies on you to notify the Plan of the death of a covered individual or if a covered individual becomes eligible for Medicare. Therefore, please immediately notify the AEP Benefits Center if any of these persons dies or becomes eligible for Medicare and of the death of a covered individual.

Notice of Election. When the AEP Benefits Center is notified that one of the applicable qualifying events has occurred, the AEP Benefits Center will in turn notify the qualified beneficiary of the right to choose continuation coverage. This COBRA Notification letter will be mailed to you and/or the other qualified beneficiaries at the last known address; therefore, it is imperative that you and your dependents keep the AEP Benefits Center informed of any address change.

Under COBRA, you and each qualified beneficiary have 60 days from the latter of the date you would lose coverage because of one of the qualifying events previously described, or the date you are notified of your rights to continue coverage, to inform the Company that you want continuation coverage. As mentioned, to inform the Company of your decision, please contact the AEP Benefits Center toll-free at 1-888-237-2363. If you do not choose continuation coverage with respect to the Plan, your coverage under the Plan will end.

If you choose continuation of coverage under the Plan, the Company is required to give you coverage which is identical to the coverage provided under the Plan to similarly situated employees or family members, as such coverage may change from time to time. You and each of your other qualified beneficiaries are eligible to continue only those Plan coverages that were in effect immediately before the qualifying event. No evidence of insurability is required for election of COBRA continuation coverage. Of course, you must pay the required contributions for the continuation coverage in a timely manner. (See the section on "Conditions on Continuation Coverage.")

Duration of Continuation Coverage. COBRA requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18-months, unless the Social Security Administration determines that you or a member of your family were disabled at the time of the termination or reduction of hours (or within 60 days thereafter), and you inform the AEP Benefits Center in writing within 60 days of that determination and before the end of the 18-month period, in which case your coverage and the coverage of your family members may be extended to as many as 29 months. You may be requested to provide additional documentation in order to qualify for this 11-month extension.

If, during the initial 18 months of continuation coverage, another qualifying event takes place that also entitles you to coverage, coverage may be extended. In no case may the total amount of continued coverage be more than 36 months. If a second event occurs, it is the qualified beneficiary's obligation to notify the AEP Benefits Center of the second qualifying even within 60 days of that event and within the original 18-month period.

There is a special rule that applies if you become eligible for Medicare within the 18 months prior to termination of employment or reduction in hours. Under that circumstance, although your spouse and/or dependent children effectively lose coverage because of your termination of employment or reduction in hours, they will be entitled to maintain continuation coverage for a period that does not expire before 36 months have passed since you became entitled to Medicare.

If you are a retiree or a spouse or dependent child of a retiree, special rules apply to determine your maximum period of COBRA continuation coverage.

COBRA generally requires that a plan offer conversion health plan coverage to a qualified beneficiary who uses continuation coverage for the maximum coverage period, but only if conversion coverage is otherwise generally available under the Plan. Because the DPPO option offers no such conversion coverage, none will be made available following the expiration of continuation coverage for any qualified beneficiary. DMO option participants may be eligible to convert to an individual health plan without providing proof of good health.

COBRA also provides that continuation coverage may be cut short for ANY of the following reasons:

1. The Company no longer provides group health coverage to any of its employees;
2. The contribution for continuation coverage is not paid in a timely fashion;
3. You, your spouse or dependent will lose COBRA continuation coverage upon becoming covered under another group health plan that does not include a preexisting conditions clause that applies (note that the Health Insurance Portability and Accountability Act of 1996 limits the circumstances in which plans can apply preexisting conditions clauses);
4. You, your spouse or dependent will lose COBRA continuation coverage upon becoming entitled to benefits under Medicare (Part A, Part B or both); or
5. For cause, such as fraudulent claim submission, on the same basis that coverage could terminate for other similarly situated participants in the Plan.

Therefore, you must immediately notify the AEP Benefits Center if you, your spouse or any of your covered dependents become eligible for benefits under Medicare.

Furthermore, if continuation coverage is extended beyond 18 months because of disability, continuation coverage will be cut short after the latter of the expiration of the initial 18-month continuation period or the date that the qualifying beneficiary is determined to be no longer disabled. You are required to notify the AEP Benefits Center within 60 days of the date of any final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. If you fail to timely notify the AEP Benefits Center, the Plan reserves the right to recover from you its costs associated with recovering the excess benefits provided to you.

Conditions on Continuation Coverage. You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you will have to timely pay all of the contributions for your continuation coverage as outlined under the law. The contribution for your continuation coverage generally is equal to no more than the full cost of the coverage plus a 2% charge to cover the cost of plan administration. If you or your dependents are entitled to up to 29 months of continuation coverage due to disability, the premium increases to as much as 150% of the full cost beginning with the 19th month of continuation coverage. The AEP Benefits Center can provide you with current cost information.

You must pay for the coverage in monthly installments. Your first payment must be in full and received no later than 45 days after the date you elect continuation coverage. For payment after that first payment, you will have a grace period of at least 30 days to pay the premiums. As a general matter, coverage will be suspended for any period that premiums have not been paid. However, coverage will be reinstated upon the receipt of timely payment (taking into account the grace period for that payment).

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her group health benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the contributions and the Employee is only required to pay his or her share of the contributions without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

The AEP Benefits Center

You may contact the AEP Benefits Center in order to provide any notice required under these procedures as follows:

AEP Benefits Center
PO Box 622
Des Moines IA 50306-0622
Phone number: 1-888-237-2363
www.ibenefitcenter.com/aep

Life Events and Your Coverage

In general, once you enroll in dental plan benefits, you cannot make changes to your elections until the next Annual Enrollment period. However, certain events in your life — such as a marriage, divorce or birth of a child -- may warrant mid-year changes that are due to and consistent with the event.

Remember — if you do not make your change within 31 days of the event (or as otherwise specified below in certain circumstances), you may not change your elections until the next Annual Enrollment period.

You Begin Working at AEP

As a new employee of a Participating Company, you must indicate your dental plan election within 31 days of your hire date. If you do not enroll within 31 days, you will not have coverage. Unless you experience a qualifying change in family or employment status, you will not be able to make changes to your benefit elections until the next Annual Enrollment period.

Coverage begins on your first day of work, if you enroll within 31 days of your date of hire.

You Get Married

Your marriage is considered a qualifying change in family status which allows you to adjust your participation in the dental plan. You must contact the AEP Benefits Center in order to make benefit changes when you marry. All changes must be made within 31 days of the date of your marriage. A copy of the certified marriage certificate will be requested by the AEP Benefits Center in order to enroll your new spouse. A marriage event does NOT allow you to change your dental plan option.

Coverage is effective on the date of your marriage if you enroll yourself, your spouse and/or your eligible dependents within 31 days of the date of your marriage.

Your Marriage Ends

It's important to keep the AEP Benefits Center informed of loss of dependent eligibility due to the end of your marriage. The AEP Benefits Center can help you make appropriate benefits changes. If you have spouse or family dental coverage, coverage for your former spouse (and any stepchildren) ends on the last day of the month in which your marriage ends.

- You are required to notify the AEP Benefits Center to remove the names of former dependents from your dental plan.
- Your former spouse and any stepchildren may continue the group coverage for 36 months through COBRA.
- If you have eligible children, you may wish to retain Participant + Child(ren) dental coverage even if you do not have custody of your child(ren). If you drop dependent coverage, you may not resume coverage for these dependents until the next Annual Enrollment period.
- If you were covered under your spouse's dental plan, you have 31 days from the date your marriage ends to apply for AEP dental coverage in your own name.

An event ending your marriage event does NOT allow you to change your dental plan option.

Your Domestic Partnership Ends

You must notify the AEP Benefits Center of the loss of dependent eligibility due to termination of a domestic partnership. The AEP Benefits Center can help you make changes to your dental coverage. You will need to supply a "Declaration of Termination of Domestic Partnership" form to the AEP Benefits Center in order to change your dental coverage.

- If you have domestic partner or family dental coverage, coverage for your former domestic partner (and any children of your domestic partner) ends on the last day of the month of the end of your partnership.
- You are required to notify the AEP Benefits Center to remove the names of former dependents from your dental coverage.
- Your former domestic partner (and any children of your domestic partner) may continue the group coverage for up to 36 months, based on the manner the Company is currently offering COBRA continuation coverage.
- If you were covered under your domestic partner's dental coverage, you have 31 days from the date of the end of the partnership to apply for AEP dental coverage.

The termination of your domestic partnership does NOT allow you to change your dental plan option.

You Are Unable to Work Due to an Illness or Injury

If you are unable to work due to illness or injury while covered under the AEP Comprehensive Dental Plan, your coverage and obligation to make contributions continue while you are receiving sick pay and for as long thereafter as you are receiving benefits under AEP's Long-term Disability (LTD) plan.

You Die

In the event you die, your survivors must contact the AEP Benefits Center to:

- Make decisions about whether to continue dental coverage for themselves if they were enrolled in dental coverage at the time of your death.

If you die while employed at AEP, your eligible surviving dependents can continue dental plan coverage if all required contributions are paid up to date. Please refer to the "Eligibility" section for additional information about who is eligible to be covered as a surviving dependent and for how long.

If a surviving dependent enrolls in the AEP Comprehensive Dental Plan but later disenrolls from the plan, he or she may not elect to re-enroll later.

Your survivors will need to submit a copy of your Death Certificate to the AEP Benefits Center prior to enrollment in coverage.

Your survivors must enroll within 31 days of your death, or such longer period as may be required by COBRA.

Your survivors will need to submit a copy of your Death Certificate to the AEP Benefits Center prior to enrollment in coverage.

Your death does NOT allow your surviving dependents to change the dental plan option in which they were enrolled

A Covered Family Member Dies

The death of a family member who is eligible for AEP benefits is considered a qualifying change in family status which allows you to adjust your participation in the dental plan. Remember that any changes must be made within 31 days of the death.

Review your dental coverage, and contact the AEP Benefits Center to adjust your coverage level, as appropriate, for the surviving family members The death of a covered dependent does NOT allow you to change your dental plan option..

Your Child Loses Dependent Status

Your child loses eligibility to be covered as your dependent at the end of the month in which he or she turns age 26.

If your child is disabled when coverage would otherwise end, you may be able to keep him or her covered under your plan. Consult the AEP Benefits Center for requirements to continue coverage during the child's disability.

Dental coverage also ends for your dependent on the last day of the month in which he or she no longer meets any other requirement to be considered an eligible dependent. The child may continue coverage through COBRA.

Birth, Adoption, Placement for Adoption or Legal Guardianship

Your newborn child will be eligible for coverage on the date of birth. If a child is placed with you for adoption, he or she will be eligible for coverage on the date of the placement for adoption as long as the child satisfies the eligibility requirements of this plan.

To enroll a newborn or other dependent child in dental coverage, you must notify the AEP Benefits Center within 90 days of the birth, adoption, or the date the child was legally placed in your care in anticipation of adoption. You must provide the dependent's Social Security number or tax-identification number for non-USA citizens, within six months of adding a dependent. The AEP Benefits Center will request a copy of the birth certificate to validate their eligibility.

Change in Your Spouse's/Domestic Partner's Employment

If your spouse's/domestic partner's coverage is affected by a change in his or her employment or benefits eligibility with his or her current employer, you may be eligible to begin, change, or discontinue coverage under the AEP Comprehensive Dental Plan to the extent that would be consistent with the events affecting your spouse/domestic partner. You may not change your dental plan option if you are already enrolled in the AEP Dental Plan.

You must contact the AEP Benefits Center within 31 days of your spouse's/domestic partner's loss/gain of coverage.

You Begin a Family Medical Leave of Absence (FMLA)

If you are on an approved Family Medical Leave of Absence (FMLA), your benefits may be affected. You may be on a paid or unpaid leave of absence under FMLA.

Under a paid FMLA absence, your dental coverage continues as normal and your dental plan contributions continue to be taken from your first and second paychecks of the month.

If your FMLA is unpaid, you have the following options:

- Revoke Coverages during the Leave. In order to take advantage of this option, then within 31 days after your leave begins, you must notify the AEP Benefits Center of the specific coverages that you want to discontinue during the period of your unpaid FMLA leave. You will be entitled to reinstate the discontinued coverages upon your return to work following your leave.
- Continue Your Coverages by Making Payments. Unless you notify the AEP Benefits Center otherwise, it will be assumed that this is the option that you select. Under this option, you would pay for your coverage by the first of each month during the leave. When the leave ends, your salary reduction election that had been in effect at the beginning of your leave will be given effect for the duration of the calendar year unless you would make an election change upon returning from the leave, as permitted under the terms of our plan (e.g., for changes in status). If you would stop making contributions for your coverage during the leave, AEP will continue your coverage, and AEP will recoup your missed payments upon your return.

COBRA eligibility does not begin until your FMLA leave ends.

You Begin an Unpaid Leave of Absence (non-FMLA)

In certain situations, you may need to take more time off from work than your available vacation time allows. In such cases, you may be eligible for an unpaid leave of absence.

- Your dental contributions from your paycheck stop when your unpaid leave begins.
- Coverage ends at the end of the month in which your unpaid Leave of Absence begins. You will be offered the option to continue dental coverage through COBRA.

You Begin a Paid Military Leave of Absence

Serving on active duty in the Armed Forces of our country can have an effect on your AEP benefits. Generally, all benefit coverage levels will continue for up to 24 months at the level in effect immediately before your paid military leave begins. You have the option to maintain some or all of your benefits during your paid military leave.

If you elect to continue your dental coverage, your contribution continues at the active employee rate for as long as you receive pay differential, for up to 24 months and your contributions will be withheld from your paycheck. If you don't have enough net pay to take all of your deductions, you will be billed on a monthly basis. If you elect to discontinue dental coverage during your paid military leave of absence, your coverage will end at the end of the month in which your paid military leave began.

If you go onto an unpaid Military Leave of Absence, see "Continuation of Coverage During Military Leave (USERRA)," and "You Begin an Unpaid Leave of Absence (non-FMLA)" for information regarding your dental coverage.

You Terminate Employment Before Qualifying for AEP Retiree Benefits

If your employment with a Participating Company terminates for any reason prior to both reaching age 55 and at least 10 years of service, your dental coverage ends on the last day of the month in which your employment ends.

You and your dependents may be eligible to continue dental coverage through COBRA. Under COBRA you pay the full cost of that coverage, plus an administrative charge.

You Terminate Employment After Becoming Retiree Benefits Eligible

If you are age 55 or older with at least 10 years of service when your employment with a Participating AEP system company ends, you may be considered an AEP "retiree."

See the "Enrolling for Coverage" section.

If you elect retiree dental coverage, premiums will either be deducted from your monthly pension check or you will be billed monthly for your premiums.

You are Rehired at AEP

As a rehired employee of a Participating Company, you must indicate your dental care election within 31 days of your rehire date. If you do not enroll within 31 days, you will not have dental coverage. Unless you experience a qualifying change in family or employment status, you will not be able to make changes to your benefit elections until the next Annual Enrollment period.

You and your eligible dependents are covered from your first day of work, if you enroll within 31 days of your rehire date.

You Return from an Unpaid Leave of Absence

After returning from an approved leave of absence, you may resume participation in benefits that you may have stopped during your leave or benefits that you may have elected under COBRA.

You may continue, add, or discontinue dental coverage for yourself and your eligible dependents, within 31 days of your return from leave. If you resume participation in the dental plan when you return from your unpaid leave, your contributions will begin coming out of your paycheck again.

You Return After Retirement

If you return to work with a Participating AEP Company after retirement and are only returning for a temporary length of time (less than 1 year), you may be eligible to be considered a "rehired retiree" or you can also return to work for AEP as a regular full-time or part-time employee. If you return as a "rehired retiree", you retain your retiree dental coverage at the applicable retiree contribution rate while you work. Your dental contributions will be deducted from your paycheck.

Coverage or Employer Contributions Lost Under Another Dental Plan

A Special Enrollment Period is available to you (if you are an eligible Employee or Retiree) and your eligible Dependents who:

- lost eligibility under a prior dental plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact;
- exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior dental plan; or
- lost Employer contributions towards the cost of the other coverage; or

Notice of a requested change must be made to the AEP Benefits Center within 31 days of the event (or within 90 days of a birth or adoption). You also may be required to provide proof of the qualifying status change(s).

Newly Eligible Because of Change In AEP Employment Status

If your AEP employment status would change from one not eligible to participate (such as if you had been classified as a contractor, temporary employee, or leased employee) to one that is, you may be able to enroll in the dental plan within 31 days of the change in employment status. Notice of a requested change must be made to the AEP Benefits Center within 31 days of the change in your status.

Your Legal Rights

Participants in the AEP Comprehensive Dental Plan 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 Plans and Benefits

Examine, without charge, at the plan administrator's office and other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. 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 operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The plan administrator may charge a reasonable fee for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant a copy of this summary annual report.

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.

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 plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 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 up to $110 a day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the plan administrator. If you have a claim for benefits which is ignored

or denied, in whole or in part, you may file suit in Federal or state 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 a 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 plans, you should contact the plan administrator. 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, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 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.

Plan Documents

This AEP Comprehensive Dental Plan Summary Plan Description (SPD) provides a summary of the dental benefits available to eligible employees. In some instances, full details of the plan are contained in the official plan documents and/or insurance contracts. If a provision described in this SPD differs from the provision of the applicable plan document and/or insurance contract, the plan document and/or insurance contract prevails.

Transfer of Benefits

Your dental plan benefits belong to you and, in certain cases, to members of your family. Your benefits may not be sold, assigned, transferred, pledged, or garnished. In addition, a Qualified Medical Child Support Order (QMCSO) may require you to provide coverage for a dependent under your dental plan.

In the event that you or your beneficiary is unable to attend to legal or financial affairs, benefits may be paid to a guardian, relative or other third party appointed on your behalf. If benefits are paid to a third party in good faith, benefits will not be paid again.

Plan Amendment or Termination

The Company reserves the right to change or end the AEP Comprehensive Dental Plan, in whole or in part, at any time and for any reason, which could result in modification or termination of benefits to employees, retirees or other participants. The Company's decision to amend, replace, or terminate a plan may be due to changes in federal law or state laws governing welfare benefits, the requirements of the Internal Revenue Service, ERISA or any other reason. If the Company does make a change or decides to end the plan, it may decide to set up a different plan providing similar or identical benefits. The Company has the right to change the amount of participant contributions to these plans.

If the AEP Comprehensive Dental Plan is terminated, you will not receive any further benefits under the plan other than payment for losses or expenses incurred before the plan was terminated.

Administrative Information

This section provides details about the way the AEP Comprehensive Dental Plan is administered, the way claims are processed and related topics. If you have questions about your dental benefits that are not answered below, please contact the AEP Benefits Center toll-free at 1-888-237-2363.

Plan Name: American Electric Power System Comprehensive Dental Plan

Type of Plan: Welfare benefit group health plan that provides dental benefits

Type of Administration: The Dental Maintenance Organization (DMO) option is insured through a contract with Aetna. Aetna sets the premiums, administers claims and is solely responsible for providing benefits.

The Dental Preferred Provider Organization (DPPO) option is self-insured by AEP through contributions made solely by the Company and Plan participants. Benefits are paid either directly by the Company or through trusts administered by the Company. AEP contracts with Aetna to administer claims under the plan DPPO option (i.e., process claims, pay providers), but AEP bears the risk associated with offering DPPO benefits.

Plan Sponsor and Administrator: The Plan sponsored by American Electric Power Service Corporation (AEP) and AEP is also the plan administrator. AEP's address is:

American Electric Power Service Corporation (AEP)
1 Riverside Plaza
Columbus, OH 43215
(614) 716-1000

The plan administrator has the authority to control, administer and manage the operation of all plans. The rights to carry out responsibilities and use maximum discretionary authority permitted by law are assigned to the plan administrator and any representative it chooses for self-insured options, and to the claims administrator appointed by insurer for insured options. These rights and responsibilities include the following:

- Interpret, construe and administer the plans,
- Make determinations regarding plan participation, enrollment and eligibility for benefits,
- Evaluate and determine the validity of benefit claims, and
- Resolve any and all claims and disputes regarding the rights and entitlements of individuals to participate in the plans and to receive benefits and payments pursuant to the plans.

The decisions of these parties are final and binding.

Plan Numbers: Plans are identified by the United States Department of Labor by reference to two numbers: the Plan Sponsor's Employer Identification Number (EIN) and the Plan Number. The EIN for AEP is 13-4922641.Three-Digit Plan Identification Number: 503.

Plan Year: January 1 through December 31.

Agent for Service of Legal Process: Legal process may be served on the plan administrator at the address listed under section titled "Plan Sponsor and Administrator."

Glossary

Accident
This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Policy. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Alternative Family Member
Your Domestic Partner and any dependent children of your domestic partner who satisfy the requirements for eligibility under this Plan as defined in the Section entitled "Dependent Eligibility."

Coinsurance
Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" and varies by the type of expense.

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various copayments, and these copayment amounts or percentages are specified in the Certificate of Coverage or Schedule of Benefits.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Deductible
The part of your covered expenses you pay before the plan starts to pay benefits.

Deductible Carryover
As it pertains to the DMO, this allows you to apply any covered expense incurred during the last three months of a calendar year that is applied toward this year's deductible to also apply toward the following year's deductible.

Dental Emergency
Any dental condition that occurs unexpectedly, requires immediate diagnosis and treatment in order to stabilize the condition and is characterized by symptoms such as severe pain and bleeding.

Dental Provider
This is any dentist; group; organization; dental facility; or other institution or person legally qualified to furnish dental services or supplies.

Dental Maintenance Organization (DMO)
A legal entity that accepts responsibility and financial risk for providing specified services to a defined population during a defined period of time at a fixed price. An organized system of dental care delivery that provides comprehensive care to enrollees through designated providers.

Dentist
A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Directory
A listing of all DMO network providers serving the class of employees to which you belong. The DMO policyholder will give you a copy of this directory. Network provider information is available through Aetna's online provider directory, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this directory.

Experimental or Investigational
A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

Hospital
An institution that:
- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of physicians;
- Provides twenty-four (24) hour-a-day R.N. service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury
An accidental bodily injury that is the sole and direct result of:
- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Jaw Joint Disorder
- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofascial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Lifetime Maximum
This is the most the plan will pay for covered expenses incurred by any one covered person during their lifetime. Medically Necessary or Medical Necessity Health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:
- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, other health care or dental provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Negotiated Charge
The maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.

Network Provider
A dental provider who has contracted to furnish services or supplies for a negotiated charge; but only if the provider is, with Aetna's consent, included in the directory as a network provider for:
- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)
Health care service or supply that is:
- Furnished by a network provider; or
- Furnished or arranged by your PCD.

Non-Occupational Illness
A non-occupational illness is an illness that does not:
- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- Is covered under any type of workers’ compensation law; and
- Is not covered for that illness under such law.

Non-Occupational Injury
A non-occupational illness is an accidental bodily injury that does not:
- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Occupational Illness or Occupational Injury
An illness or injury that:
- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full-time basis; or
- Result in any way from an illness or injury that does.

Occurrence
This means a period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person:
- Receives no medical treatment; services; or supplies; for a disease or injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or injury.

Orthodontic Treatment
This is any:
- Medical service or supply; or
- Dental service or supply;

furnished to prevent, diagnose, or to correct a misalignment of the:
- Teeth;
- Bite; or
- Jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Out-of-Network Provider
A dental provider who has not contracted with Aetna, an affiliate, or a third party vendor to furnish services or supplies for this plan at a negotiated charge.

Out-of-Network Service(s) and Supply(ies)
For the DMO this is a Health care service or supply that is:
- Furnished by an out-of network provider; or
- Not furnished or arranged by your **PCD**.

Physician
A duly licensed member of a medical profession who:
- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate. This also includes a health professional who:
  - Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
  - Provides medical services which are within the scope of his or her license or certificate;
  - Under applicable insurance law is considered a "physician" for purposes of this coverage;
  - Has the medical training and clinical expertise suitable to treat your condition;

- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify
A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Preferred Provider Organization (PPO)
A formal agreement between a purchaser of a dental benefit program and a defined group of dentists for the delivery of dental services to a specific patient population, as an adjunct to a traditional plan, using discount fees for cost savings.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Dentist (PCD)
This is the network provider who:
- Is selected by a person from the list of **Primary Care Dentists** in the **directory**;
- Supervises, coordinates and provides dental services to a person;
- Initiates **referral**s for **specialist dentist** care and maintains continuity of patient care; and
- Is shown on **Aetna**'s records as the person's **primary care dentist**.

If you do not choose a **PCD**, **Aetna** will have the right to make a selection for you. You will be notified of the selection.

Reasonable Fees
The fee charged by a dentist for a specific dental procedure that has been modified by the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances, and therefore may differ from the dentist's "usual" fee or the benefit administrator's recognized charge.

Recognized Charge
Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of:
- The provider's usual charge for furnishing it;

- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
- The charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished.

In determining the recognized charge for a service or supply that is:
- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of providers in the geographic area;

Aetna may take into account factors, such as:
- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The recognized charge in other geographic areas.

In some circumstances, **Aetna** may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply. In these instances, in spite of the methodology described above, the **recognized charge** is the rate established in such agreement.

As used above, the term "geographic area" means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three-digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

Referral
This is a written or electronic authorization made by your **primary care physician** (PCP) or **primary care dentist** (PCD) to direct you to a **network provider**, for **medically necessary** services or supplies covered under the plan.

Referral Care
Covered services given to you by a **specialist dentist** who is a **network provider** after **referral** by your **primary care dentist** and providing that **Aetna** approves coverage for the treatment.

R.N.
A registered nurse.

Skilled Nursing Facility
An institution that meets all of the following requirements:
- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:

  - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorders**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by**:**
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or rehabilitation services.

Skilled nursing facility does not include:
- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialist Dentist
Any **dentist** who, by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described, the recognized charge is the rate established in such agreement.

Health Insurance Portability and Accountability Act ("HIPAA")

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations in 45 CFR Parts 160 through 164 contain provisions governing the use and disclosure of Protected Health Information ("PHI") by group health plans, and provide privacy rights to participants in those plans. An explanation of those rights as they pertain to your health benefits will be provided by the insurer or claims administrator, according to its policies described for each coverage option. A separate "Notice of Privacy Practices" contains additional information about how your individually identifiable health information is protected and whom you should contact with questions or concerns, and is incorporated into this SPD by reference.

PHI is information created or received by HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. The information typically identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

To the extent it receives PHI, the Plan Administrator will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA regulations and any other applicable federal, state, or local law. If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Insurer or claims administrator involved with the PHI in question. The Insurer or claims administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company with respect to such information. The Company or Plan Sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA regulations.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor becomes aware.

AEP Benefits Center
1-888-237-2363