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AEP Comprehensive Medical Plan

Summary Plan Description for Retirees & Surviving Dependents Age 65 and Older

Issued 2016

AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older

AEP is providing retirees and their families the opportunity to purchase quality health care at a cost you and the Company can afford. This booklet details coverage for eligible AEP Retirees who are age 65 and older.

What's Here:

IMPORTANT NOTICE

This is a summary of the American Electric Power System Comprehensive Retiree Medical Plan as in effect on January 1, 2016 as it applies to eligible retirees and surviving spouses who are age 65 and older and their eligible dependents (including surviving dependent children). This description of the American Electric Power Comprehensive Medical Plan is not intended as a contract or a guarantee of current or future benefits. 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 separate 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.

Retiree Medical Plan Overview

The following is an overview of the possible medical coverage options available to participants — retirees, their dependents and their survivors — for eligible AEP retirees who are age 65 and older.

Refer to the "Medical Comparison Chart" for a side-by-side comparison of each medical plan option.

Plan Provisions At-A-Glance

Effective date of coverage • Upon Retirement — Your coverage continues under the medical options you elect to be secondary to Medicare. • Annual Enrollment — January 1 of the year following your enrollment. • Qualifying Status Changes — On the date of the event, if you enroll or make your change within 31 days of the event (or within 90 days of birth or adoption of a newborn or within 60 days due to Children's Health Insurance Program "CHIP").	Medical Plan Options available to participants upon turning age 65 or retiring at age 65 or older • Aetna Medicare Coordination of Benefits (COB) Plan option: - May use any doctor, specialist or hospital you choose - Generally, you pay 20% after Medicare balance for most services - Benefits are coordinated with Medicare • Aetna Medicare Maintenance of Benefits (MOB) Plan option: - May use any doctor, specialist or hospital you choose - Benefits are coordinated with Medicare to provide a combined benefit no greater than the plan would have paid in the absence of Medicare, possibly resulting in higher out-of-pocket costs to you than the COB Plan option • Waive coverage* • Pre-merger AEP retirees who were age 65 or older as of December 31, 2000, and their surviving dependents may choose: - Aetna Medicare Coordination of Benefits (COB) Plan; or - Waive coverage*

*If you waive coverage for yourself, you automatically waive coverage for your eligible dependents, although coverage may then become available to them pursuant to COBRA (as further described in this booklet). However, you may be eligible to enroll during future annual enrollment periods. **Surviving dependents who waive or terminate coverage will not be eligible to elect medical benefits at a later time.**

Eligibility

Retiree Eligibility

As a retiree from a Participating AEP System Company, you are eligible to continue retiree medical coverage for yourself and your eligible dependents if you were last hired or rehired by an AEP Participating Company on or before December 31, 2013, and you retired from a Participating AEP System Participating Company at a time when you were at least age 55 with 10 or more years of service. If you are disabled and are considered otherwise a full-time employee of a Participating AEP System Company at the time you take a retirement plan distribution from the AEP System Retirement Plan, then the ten-year service requirement does not apply.

If you are an existing CSW retiree who retired before January 1, 2001, you were eligible to continue coverage for yourself and your eligible dependents if you had 15 years of service and were over age 40. If you were hired by CSW prior to January 1, 1993, you did not have to meet the years of service requirement if you retired after age 65.

In determining whether you are eligible for retiree medical coverage, any service you 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.

Also excluded are retirees whose benefits were the subject of a collective bargaining agreement that does not provide specifically for medical coverage.

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 medical coverage until the earlier of age 65 or remarriage, if the surviving spouse was enrolled in the medical plan at the time of the employee's death. Surviving dependent children of an active employee who were not retiree benefit eligible on the date of death can elect to continue medical coverage until they reach the limiting age (see the "Dependent Eligibility" section), if the surviving dependent child was enrolled in the medical 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 medical coverage until remarriage, if the surviving spouse was enrolled in the medical plan at the time of the employee's death. Surviving dependent child(ren) of active employees who were retiree benefit eligible on the date of death can elect medical coverage until the limiting age (see the "Dependent Eligibility" section), if the surviving dependent child was enrolled in medical coverage at the time of the employee's death.

Survivors of Retirees

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

Note: Domestic partners and the children of domestic partners are not eligible for survivor medical benefits. However, AEP will offer COBRA-like coverage to Alternative Family Members. Refer to the "Continuation of Coverage Under COBRA" section for additional information.

Once a survivor waives or terminates participation in the medical plan, he or she cannot re-elect it. See the "When Coverage Ends" section.

Participating AEP System 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 Medical Plan for Retirees and Surviving Dependents Age 65 and Older allows you to purchase coverage for your eligible dependents.

Survivors of active employees or Retirees generally cannot enroll any of their own dependents who were not covered by the medical plan at the time of the Employee's or Retiree's death.

Eligible dependents include your:

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 one for coverage as a domestic partner, you and your domestic partner must have certified and declared 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-like 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 your 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 covered domestic partner for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- Your foster child;
- A child who resides in your household and for whom you, your spouse or your eligible domestic partner are the court-appointed guardian;
- A child for whom you are required to provide coverage as a result of a Qualified Medical Child Support Order (QMSCO); or
- 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 age 26, your disabled child(ren) must meet the criteria listed under the "Children" section above, plus:

- Disability must have occurred prior to attaining age 26.
- The child must remain continuously covered under any of the options available under this 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 Medical 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 Dependents Have AEP Benefits

If both you and your spouse, domestic partner or eligible dependents are eligible for the medical plan as an AEP employee or retiree:

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

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) 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 federal law known as ERISA. ERISA contains a preemption provision that supersedes most state laws that "relate to an employee benefit plan."

Important Information to Consider

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 family or employment status may warrant benefit changes if they are due to and consistent with the qualifying change in family or employment status that affects your eligibility for the coverage. Notice of a requested change must be made to the AEP Benefits Center within 31 days of the event (or within 90 days of birth or adoption of a newborn).

If you decline coverage for yourself or your dependents because you or they have other benefits coverage, you may be able to enroll yourself or your dependents in the AEP health plans at a later date if that other coverage is lost. Also, you may request enrollment in the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older mid-year if you notify the AEP Benefits Center within 60 days after you or your dependent either (1) loses eligibility for Medicaid or coverage through the Children's Health Insurance Program ("CHIP") that is administered by your state, or (2) becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Tax Considerations When Covering Your Dependents

Certain AEP benefits qualify for tax advantages (such as nontaxable employer provided coverage) only to the extent that they cover the participant's "dependents" as defined for tax purposes with regard to coverage under a group health plan. AEP allows you to provide medical, dental, vision and certain other coverages for certain dependents who may not be your tax dependents. As a result, the value of their coverage that is provided by AEP may not qualify for tax-favored treatment.

Special rules apply to determining the tax status of children of parents who have divorced or separated.

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.

You can obtain materials that will help you to determine whether your dependents qualify for tax-favored treatment related to your medical coverage by contacting the AEP Benefits Center at 1-888-237-2363. You should also consult your tax advisor.

Enrolling in Benefits

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

As a New Retiree

After coverage ends under your active employee medical plan option or your employment with AEP ends after you have become retirement eligible, you have 31 days to enroll yourself and your eligible dependents in one of the AEP retiree medical plan options. If you are enrolled in the AEP medical plan and do not enroll within 31 days, you will be assigned the default medical coverage, Aetna Maintenance of Benefits, at the same coverage level, and be billed or pension deducted accordingly.

If you are not enrolled in the AEP medical plan at the time of your retirement, you will continue to waive coverage unless you contact the AEP Benefits Center within 31 days.

Unless you experience a qualifying change in family or employment status or other qualifying event, you will not be able to make changes to your benefit elections until the next annual enrollment period. Refer to the section "Life Events and Your Coverage" for more information on making changes during the year.

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 death, you will automatically be enrolled in the same medical plan you had as of the date of death if over age 65. You may NOT change medical plans. If you are under age 65 as of the date of death then you will automatically be enrolled in the HSA Basic Plan. If you do not wish to continue coverage as a surviving spouse or dependent, you must contact the AEP Benefits Center within 31 days. . If you choose not to enroll in medical 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.

IMPORTANT: If you or a covered dependent become eligible for Medicare, the plan will assume you are enrolled in Medicare Part A & B, whether or not actually enrolled, and will coordinate its payment of benefits accordingly. See the section of this summary entitled "When You Have Other Coverage" for details.

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 retirees 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

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 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 as explained below. 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.

Covering Your Family

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

- Participant Only;
- Participant + Spouse or Domestic Partner (applies to Retirees only);
- Participant + Child(ren) and/or Domestic Partner's Child(ren) (applies to Retirees only); or
- Participant + Family (applies to Retirees only).

You must enroll yourself in medical coverage to enroll your eligible dependents. Contact the AEP Benefits Center to confirm those enrolled or to add or remove eligible dependents from coverage.

Waiving Coverage

You may also waive coverage under the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older. If you elect to waive coverage for yourself, you automatically waive coverage for your eligible dependents. As a surviving spouse or dependent, once you waive or terminate coverage under the AEP medical plan, you will not have the option to re-elect 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 medical plan. Federal law requires group health plans, including the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older, 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 medical, dental and vision benefits in some situations, typically a divorce.

You must be enrolled in medical 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. Once you or your dependent furnishes a court or administrative order to the AEP Benefits 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 QMSCO. 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 will evaluate all costs and may adjust the cost of coverage for the next year's coverage. Your cost for the upcoming year is communicated during the Annual Enrollment period. You can enroll online or via phone as described in your enrollment materials.

You and AEP share the cost of your medical coverage. Your cost of coverage under the AEP retiree medical plan will depend on your:

- Eligible grandfathered retirement group, if applicable (based on age and date of retirement);
- The dependents you elect to cover; and
- The plan option in which you enroll.

If you elect payment of your pension benefit from the AEP System Retirement Plan (including the portion consisting of the former Central and South West Corporation Retirement Plan) as a monthly annuity, your contributions toward your medical coverage will be deducted from your pension check (unless your pension payment is insufficient). Otherwise, you will receive a monthly billing statement for your medical contributions. Failure to remit payments in a timely manner will result in loss of coverage.

When Coverage Begins

For New Retirees — If you timely enroll, or if your coverage automatically continues or if you fail to waive coverage, coverage as a retiree 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 medical plan coverage 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.

For Qualifying Status Changes — You must notify the AEP Benefits Center, toll-free, at 1-888-237-2363 within 31 days, or within 90 days of birth or adoption of a qualifying event, including a change in family or employment status. 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, your new coverage begins on the date of your qualifying event.

Definitions

Annual Deductible

For some medical plan options, you must pay a deductible amount before the plan begins to pay benefits for covered expenses. After you satisfy the deductible, the plan pays a percentage of the reasonable and customary (R&C) fee limit for eligible medical expenses. The family deductible is three times the individual deductible.

Once any combination of family members meet the family deductible – with no one person going over their individual deductible – then all family members will be considered as having met their annual deductibles.

Coinsurance

Coinsurance is the percentage of covered medical expenses you are responsible for paying after you meet any required annual deductible. The coinsurance for network providers is based on a special negotiated rate to help hold down your out-of-pocket costs.

Copays

For certain in-network expenses, some plans require you to pay a co-pay toward the cost of your care.

An emergency room copay is in addition to the applicable coinsurance and is waived if you are admitted.

Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Emergency Care

This means the treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

Emergency Medical Condition

A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use;
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply;
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a Service is Experimental/ Investigative, the Claims Administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof;
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies;
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply;
- Documents of an IRB or other similar body performing substantially the same function;
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply;
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Medically Necessary or Medical Necessity

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Claims Administrator to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Out-of-Pocket Maximum

The amount of coinsurance, copays, and deductible (if applicable) you pay is limited by the annual out-of-pocket maximum in one year for covered services. After you reach the out-of-pocket maximum, the plan pays 100% of your in-network covered expenses and 100% of reasonable and customary charges of out-of-network covered expenses. The dollar amount of your out-of-pocket maximums is based on whether you receive care in-network or out-of-network. All family members' eligible out-of-pocket expenses combined count toward the family out-of-pocket maximum.

Expenses that Do Not apply to your out-of-pocket maximum:

- Charges over the recognized charge;
- Expenses to which a copayment is applied;
- Non-covered expenses;
- Expenses that are not paid, or precertification benefit reductions because a required precertification for service(s) or supply was not obtained.

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 injury 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.

Recognized Charge

The covered expense is only that part of a charge which is the recognized charge.

As to medical, vision and hearing expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For the professional services and other services or supplies not mentioned below:
  - A percentile of the Prevailing Charge Rate;
  - For the Geographic Area where the service is furnished.

The medical vendor may also reduce the recognized charge by applying their Reimbursement Policies. Reimbursement Policies address the appropriate billing services, taking into account factors that are relevant to the cost of the service such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and necessary for the service;
- If follow up care is included;
- Whether there are any other characteristics that may modify or make a particular service unique; and
- When a charge includes more than on claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Reimbursement Policies are based on the medical vendor's review of:

- the policies developed for Medicare;
- the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and
- the views of physicians and dentists practicing in the relevant clinical areas.

Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes.
- Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically.

If:

- You were enrolled in an AEP medical plan option as an active employee or an Under Age 65 AEP retiree, and
- You had a qualifying event, such as becoming eligible for Medicare, and
- You enroll in the Aetna COB or MOB plan as an Age 65 and Older AEP retiree,

Then:
The amount met towards the annual deductible and out-of-pocket maximum while in the Under Age 65 Retiree Plan will not transfer to the Age 65 and Older Retiree Plan.

Medical/Large Case Management

Medical/Large Case Management is provided when you have a serious and potentially costly injury or illness. Through alternative care and treatment suggestions, Medical/Large Case Management may help you and the plan administrator control the costs related to your injury or illness.

Concurrent Review

Your hospital admission may be reviewed for medical necessity while you are hospitalized. A concurrent review means the claim administrator will periodically evaluate the need for continued hospitalization. If you are kept in the hospital longer that the number of days that have been pre-certified, no benefits will be paid for any days of hospitalization in excess of the number of days determined to be medically necessary. If you are in a non-network facility, you may be responsible for the balance of charges for unauthorized, in-patient days.

Women's Health and Cancer Rights Act of 1998
If you or a covered dependent has a mastectomy, the medical plan will cover all stages of reconstruction of the breast on which the mastectomy was performed, prosthesis, treatment of other physical complications and surgical reconstruction of the other breast for appearance. Coverage may be subject to appropriate annual deductibles and coinsurance provision for the medical plan option you choose.

Note: Both plans (COB and MOB) will pay benefits as if you are enrolled in Medicare Part A and Part B, even if you do not participate in Medicare coverage. Therefore it is important that you and any Medicare-eligible dependent enroll in Part B as soon as you are eligible.

Note: If you enroll in Medicare Prescription Drug coverage, you will lose eligibility to retain your AEP medical coverage as well as the prescription drug coverage provided as part of your AEP medical plan unless you are automatically enrolled due to low income subsidy.

Newborns' and Mothers' Health Protection Act Group health plans and health insurance issuers generally may not, under federal law, restrict group benefits for any hospital stay in connection with childbirth for the mother or newborn to:

- Less than 48 hours following a vaginal delivery; or
- Less than 96 hours following a caesarean section.

However, federal law does not prohibit the mother's or newborn's attending physician – after consulting with the mother – from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96) hours.

Medical Plan Options

If you or a covered dependent become eligible for Medicare, the plan will assume you are enrolled in Medicare Part A & B, whether or not actually enrolled, and will reduce payment accordingly.

This section provides a summary of the medical benefit options available to participants age 65 and older — retirees or surviving dependents. Please review each summary carefully before making your benefit elections. The AEP benefits program offers the following medical choices:

Former CSW Retirees and Surviving Dependents Age 65 and Older:

- Aetna Medicare Coordination of Benefits Plan option; or
- Aetna Medicare Maintenance of Benefits Plan option.

Pre-merger AEP Retirees and Surviving Dependents Age 65 and Older as of December 31, 2000:

- Aetna Medicare Coordination of Benefits Plan option.

If You Turned Age 65 After December 31, 2000:

- Aetna Medicare Coordination of Benefits Plan option; or
- Aetna Medicare Maintenance of Benefits Plan option.

Note: If you are over 65 and Medicare-eligible but your spouse (or other covered dependent) is under 65 and not Medicare eligible, you will both be covered under an age 65 and older medical plan option. As a result, your spouse will be subject to the same plan provisions as you (such as no network requirements and reasonable and customary limits) but Medicare will not be primary for your spouse's or dependent's claims. There is no network component for the claims for your under age 65 dependents. Therefore, any amount not paid by the plan would be your spouse's (or other covered dependent's) responsibility.

The Medical Plan Comparison Chart shows a side-by-side comparison of the medical plan options.

Medical Comparison Chart

Generally, covered health services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse or their symptoms. In-network benefits are paid based on negotiated fees. Out-of-network benefits are paid based on reasonable and customary (R&C) charges — what most health care providers in your geographic area charge for similar care.

The plan does not cover any charges over R&C levels. The claims administrator determines what services and supplies are considered a covered health service and whether the charges are reasonable and customary.

The "Medical Comparison Chart" shows the amount you pay for certain Aetna covered services.

The list of covered services shown includes examples only and is not intended to be a complete list. If you have any questions about specific eligible medical coverage, it is your responsibility to contact your medical plan vendor by calling the customer service number listed on your ID card.

	Aetna Medicare COB Plan	Aetna Medicare MOB Plan
Lifetime Maximum	None	None
You Pay . . .		
Annual Deductible	$200/Individual $600/Family	$200/Individual $600/Family
Annual Out-of-Pocket Maximum	$2,000/Individual $6,000/Family	$2,000/Individual $6,000/Family
Office Visits	20% after deductible	20% after deductible
Coinsurance	20% after deductible	20% after deductible
Annual Preventive Care	0%, no deductible	0%, no deductible
Emergency Room (copay waived if admitted)	20% after $50 copay and after deductible	20% after $50 copay and after deductible
Lab and X-rays	20% after deductible	20% after deductible
Inpatient or outpatient facility	20% after deductible	20% after deductible
Ambulance Transportation (i.e., between facilities)	20% after deductible	20% after deductible
Anesthesia	20% after deductible	20% after deductible
Oxygen and other gases and related health care services and supplies for their administration	20% after deductible	20% after deductible
Home health care (limited to 120 visits per calendar year)	20% after deductible	20% after deductible

	Aetna Medicare COB Plan	Aetna Medicare MOB Plan
Hospice care (inpatient and outpatient)	20% after deductible	20% after deductible
Extended or skilled nursing facility	20% after deductible	20% after deductible
Coordination of benefits	The plan will look at the amount you still owe after Medicare has made its payment and calculate plan benefits on this amount.	The plan determines what it would have paid in the absence of Medicare and then compares that amount to what Medicare actually paid.

Aetna Medicare Coordination of Benefits (COB) Plan

The Aetna Medicare COB Plan option allows you to direct your own care. This means you can receive care from any doctor, specialist or hospital that you choose, with no penalty.

You must meet a medical expense deductible of $200/person or $600/family before the plan will begin to cover medical expenses. Your monthly premiums under this plan are generally higher than those under the Aetna Medicare Maintenance of Benefits (MOB) Plan, since the way it coordinates benefits with Medicare typically results in lower out-of-pocket costs. When you receive care, generally you pay a percentage of each covered expense, then file for reimbursement. You pay 20% of the cost for most services, and the plan will pay 80% of the reasonable and customary (R&C) charges.

If you meet your annual out-of-pocket maximum, the plan will pay 100% of R&C of your covered medical expenses.

You are responsible for amounts over R&C.

Coordinating Benefits

If you enroll in the Aetna Medicare COB Plan option, benefits are coordinated with Medicare. In general, the plan will look at the amount you still owe after Medicare has made its payment and calculate plan benefits based on this amount. Here's how the coordination would work. Let's say you received $1,000 in services from your physician.

Your doctor charged:	**$1,000**
Medicare paid 80%:	**- $800**
Remaining balance due:	**= $200**
AEP pays 80%:	**$160**
You pay:	$200 -$160 **= $40**

If the AEP plan's $200 deductible has already been met, the 20% coinsurance will be applied to the remaining balance of $200. Therefore, you would be responsible for paying $40 (20% of the remaining $200 in charges).

Aetna Medicare Maintenance of Benefits (MOB) Plan

Like the Aetna Medicare COB Plan, the Aetna Medicare MOB Plan allows you to direct your own care. This means you receive care through any doctor, specialist or hospital you choose, with no penalty. You must meet a deductible of $200/person or $600/family before the plan will begin to cover medical expenses. Additionally, if you meet your annual out-of-pocket maximum, the plan will pay 100% of R&C of your covered medical expenses.

However, this plan uses a different approach to coordinate benefits with Medicare, which generally results in higher out-of-pocket costs to you.

You are responsible for amounts over R&C.

Coordinating Benefits

If you enroll in the Aetna Medicare MOB Plan option, your benefits are coordinated with Medicare. When you receive care, the plan determines what it would have paid if you were not enrolled in Medicare. It compares that amount to what Medicare actually paid. If the amount Medicare actually paid is at least what the plan would have paid, then no additional benefit will be payable from the plan. Using the same example, let's say you received $1,000 in services from your physician.

Your doctor charged:	$1,000
Medicare paid 80%:	- $800
Remaining balance due:	= $200
You pay:	$200

Again, assuming the AEP plan's $200 deductible has been met, the AEP plan would have paid up to 80%, or $800. If there were no Medicare payment, your out-of-pocket cost would have been $200. The benefit received from Medicare was as good as the benefit as if AEP had paid, so no additional payment will be made, and you would be responsible for paying $200.

Note: Both plans (COB and MOB) will pay benefits as if you are enrolled in Medicare Part A and Part B, even if you do not participate in Medicare coverage. Therefore it is important that you and any Medicare-eligible dependent enroll in Part B as soon as you are eligible.

Note: If you enroll in Medicare Prescription Drug coverage, you will lose eligibility to retain your AEP medical coverage as well as the prescription drug coverage provided as part of your AEP medical plan unless you are automatically enrolled due to low income subsidy.

Preventive Care Benefit

The Aetna Medicare COB and MOB plans cover nationally recommended preventive services at no cost to you.

Preventive Services for Women

In compliance with the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, collectively referred to as the Affordable Care Act in this SPD, the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older includes women's preventive services. When a covered retiree, spouse or dependent obtains preventive medical services with an in-network provider, there is no cost sharing; the services are free.

These services include:

- Health and Human Services (HHS) Guidelines - Annual well-woman preventive care visit is covered for adult women to obtain the recommended preventive care services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other related preventive services. Annual series of visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.
- HHS Guidelines - Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- HHS Guidelines - Human papillomavirus (HPV) testing in women with normal cytology results beginning at 30 years of age and should occur no more frequently that every 3 years.
- HHS Guidelines - Annual counseling for sexually transmitted infections for all sexually active women.
- HHS Guidelines - Counseling and annual screening for human immune-deficiency virus (HIV) for all sexually active women.
- HHS Guidelines - Contraceptive methods and counseling including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.
- HHS Guidelines - Breastfeeding support, supplies, and counseling including comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
- HHS Guidelines - Annual screening and counseling for interpersonal and domestic violence.

Aetna Discount Programs and Services

Included with your medical plan coverage under the options offered through Aetna are many extras. For more information on the following, contact Aetna directly. Unless otherwise noted, use the website and phone number listed on your Aetna ID card.

- Aetna Fitness Discount Program through GlobalFit network for discounted gym memberships.
- Aetna Hearing Discount Program through HearPO® — 1-888-HEARING (432-7464) or **www.hearpo.com**.
- Aetna Natural Products and Services Discount Program offers savings on massage therapy, acupuncture, chiropractic care and dietetic counseling.
- Aetna Vision Discount Program.
  - Eyeglasses and contact lenses – 1-800-793-8616.
  - Contact lenses (mail order) – 1-800-391-LENS (5367).
  - LASIK – 1-800-422-6600.
- Aetna Weight Management Discount Program through Jenny Craig.

Eligible Medical Expenses

The following items are considered covered medical services under all of the retiree medical plan options if the claims administrator determines that they are covered health services for diagnosis or treatment of the patient's condition.

Covered Health Services

Covered health services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

Covered health services must be provided:

- When the plan is in effect;
- Prior to the date that coverage is terminated; and
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the plan.

A covered health service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
  - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is the most cost-effective method and yields a similar outcome to other available alternatives.
- It is a health service or supply that is described in this section, and which is not excluded in the section titled, "What is Not Covered."

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

A service is **not** considered a covered health service if it is educational or experimental in nature.

The following expenses are **eligible** for medical plan benefits under the retiree medical plan options:

- Acupuncture, if administered by a legally qualified physician operating within the scope of his/her license for pain associated with certain conditions, nausea related to chemotherapy, or in lieu of anesthesia.
- Allergy serums and allergy injections.
- Allergy testing.
- Ambulance/emergency transportation to and from the nearest medical facility; must be true emergency or for transport between facilities. An ambulance is a vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.
- Artificial limbs, eyes and other prosthetic appliances, but not replacement unless a covered health service as determined by the claims administrator.
- Assistant surgeon services — limited to a percentage of the amount of covered health services for the surgeon's charge for the surgery.
- Biofeedback if medically necessary for certain conditions.
- Birthing centers, provided physician acting within scope of a medical license and facility meets all legal requirements.
- Blood, blood products and blood derivatives (if not donated or replaced) and related services and supplies for administration.
- Chiropractic care given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine, up to 15 visits per calendar year.
- Clinical trial medical expenses related to an FDA-approved clinical trial for a life-threatening disease are covered.
- Contraceptives requiring a prescription, including non-self-injectables, and contraceptive devices. Birth control pills are covered under the prescription drug plan.

- Convalescent facility or skilled nursing facility expenses including room, board, services and supplies for up to 120 days per calendar year.
- Dental, covered for initial treatment of accidental injury to sound or healthy natural teeth only.
- Diabetic supplies covered under prescription drug plan, except glucometer or Insulin Infusion Pump which are covered under medical plan.
- Diagnostic labs and X-rays, coverage is provided when services are performed to diagnose specific symptoms or rule out medical conditions. Services include:
  - Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine and magnetic resonance imaging.
  - Diagnostic laboratory and pathology tests.
  - Diagnostic medical procedures consisting of EKG, EEG, and other electronic diagnostic medical procedures.
  - Pre-admission presurgical tests which are made prior to a covered person's inpatient or outpatient surgery.
- Dressings, casts, crutches and other healthcare supplies.
- Drugs, dispensed in a physician's office, including injectable drugs and allergy serums.
- Durable medical equipment, covered through rental (purchase or repair may be covered if more economical).
- Educational and dietary counseling coverage for self-care programs — diabetic education, back school for patients with chronic back pain, pulmonary rehabilitation program for patients with chronic pulmonary disease, and cardiac rehabilitation for patients with cardiac disease.
- Emergency room care, including coverage for non-emergency services, unless routine care.
- Eye exams with a medical diagnosis (e.g., pink eye, conjunctivitis, cataracts).
- Foot care podiatry, including orthotics.
- Gender identity disorder treatment, including psychodrama and bioenergetics therapy, services or supplies for transsexual surgery.
- Genetic testing if medically necessary to establish the diagnosis of an inheritable disease.
- Glucometers (covered under durable medical equipment).
- Growth hormones.
- Hearing care, including one routine exam in 12 months, but not hearing aids.
- Home health care (limited to 120 visits per calendar year) includes physical, occupational, respiratory and speech therapy; nursing — up to four hours per visit of part-time or therapeutic care by a home health aide to change dressings, check blood pressure, pulse and temperature, administer oxygen, provide medical supplies/ services that would have been provided as an inpatient
- Hospitalization limited to semi-private room except where private room is approved as a covered health service. Precertification is required for an out-of-network facility and any in-patient stay prior to gastric bypass, gastric banding, or organ transplant surgery.
- Hospice care (precertification or notification recommended) for terminally-ill patient with life expectancy of six months or less; outpatient hospice care for terminally-ill patient with life expectancy of six months or less; includes coverage for assessment of social, emotional and medical needs; help in identifying and obtaining available community resources; psychological and dietary counseling; physical and occupational therapy, part-time or intermittent. Nursing care by a R.N. or L.P.N. for up to 8 hours in any one day, part-time or intermittent home health aids services for up to 8 hours in any one day mainly for the caring of the person.
- Infertility treatment and diagnosis including testing and drug therapy performed in the physician's office to facilitate natural conception. Artificial insemination is covered on an out-patient basis, up to six courses of treatment per lifetime.
- Massage therapy if services are performed by a licensed chiropractor.
- Maternity care and delivery (included in global maternity charges).

- Mental health care.
- Midwife delivery services if certain criteria are met.
- Organ and tissue transplants.
- Physician services for hospital, office and home visits, emergency room services, and surgery. Multiple surgical procedures are defined as more than one surgical procedure performed during the same operative session and are covered as determined by the claims administrator.
- Prenatal care (included in global maternity charges).
- Positron Emission Tomography (PET) scan for certain diagnosis.
- Preventive care — services such as well-baby care and well check-up exams for adults based on national guidelines from the U.S. Preventive Task force including well-woman exams; mammograms; immunizations and testing for TB and prostate exams. Flu shots are covered.
- Reconstructive surgery, plastic surgery, cosmetic surgery if medically necessary and approved in advance, provided it:
  - Improves the function of the body (other than a tooth or structure that supports teeth), that is malformed as a result of a severe birth defect or as a direct result of disease.
  - Repairs an injury with surgery within that calendar year or the next and it is performed to treat disease or non-occupational injury.
- Second surgical opinions.
- Services, supplies and counseling for sexual dysfunctions or inadequacies that have a physiological or organic basis; includes treatment of erectile dysfunction and impotence.
- Sex change surgery or treatment of gender identity disorders
- Skilled nursing care - precertification is required under the Aetna medical plan options— care must be prescribed by attending physician, and not for convenience of family, not be performed during hospital confinement, and requires training of an R.N that could not have been provided by general nursing staff.
  - Visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
  - Private duty nursing by a R.N. or L.P.N. if the person's condition requires skilled nursing services and visiting nursing care is not adequate (usually 24-hour care rendered in the patient's home).
- Skilled nursing facility expenses including room, board, services and supplies for up to 120 days per calendar year.
- Specialist office visits.
- Substance abuse treatment.
- Therapy Services when used for the treatment of a congenital defect condition, sickness or injury to promote the recovery of the covered person. To be covered, the therapy services must be rendered in accordance with a physician's written treatment plan.
  - Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents. The cost of the antineoplastic agent is included.
  - Dialysis Treatment - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis.
  - Occupational Therapy - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living.
  - Physical Therapy - the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part.
  - Radiation Therapy - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

  - Respiratory Therapy - the introduction of dry or moist gases into the lungs for treatment purposes.
  - Speech Therapy - Speech therapy is covered to restore speech loss or correct impairment due to a congenital defect, illness or injury; such as stroke, head injury or vocal cord injury. Therapy must be ordered and monitored by a physician, must be given in accordance with a written treatment plan approved by a physician, the therapist must submit progress reports at the intervals stated in the treatment plan, and the therapy must be expected to result in significant objective measurable physical improvement in the covered person's condition within two months of the start of treatment.
- Treatment of the jaw joint (temporomandibular joint, or TMJ, dysfunction), including initial diagnostic exam, diagnostic X-ray, diagnostic lab work, injection of therapeutic agents, surgical treatment.
- Voluntary sterilization.
- Wig or hairpiece prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease.

Organ/Tissue Transplants

Services and supplies for necessary and approved organ or tissue transplants are payable under the retiree medical plan options. Benefits for donor charges, and transportation and lodging are available.

Donor Charges for Organ/Tissue Transplants

In the case of an organ or tissue transplant, donor charges are considered covered health services ONLY if the recipient is covered under this plan. If the recipient is not covered, no benefits are payable for donor charges.

The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a covered health service UNLESS the search is made in connection with a transplant procedure arranged by a designated transplant facility.

If the transplant is considered to be a covered health service and performed at a designated transplant facility, the transportation and lodging provisions described in the next section apply.

Transportation and Lodging

Aetna's National Medical Excellence Program will assist the patient and family covered under one of the Aetna medical plans with travel and lodging arrangements when the distance is at least 100 miles from home; expenses for travel and lodging for the transplant recipient and a companion are available under the plans as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purpose of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

This list is not all-inclusive and should not be used to determine whether you may receive a treatment. All services are subject to the exclusions listed in following section.

What is Not Covered Under the Medical Plan

Services are not covered if they are performed before coverage is effective or after it ends. Benefits are not payable for the following services that the claims administrator determines are not a covered health service:

- Any charge for services and supplies not necessary, as determined by the claims administrator, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's physician or dentist.
- Any charges to the extent they are not reasonable charges, as determined by the claims administrator.
- Any charge for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending physician or dentist.
- Any charge for or in connection with services or supplies that are, as determined by the claims administrator, to be experimental or investigational, 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 disease or injury involved; or
  - If required by the FDA, approval 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, investigational, or for research purposes; 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, investigational, or for research purposes.
  - However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease if the claims administrator determines that:
    - The disease can be expected to cause death within one year, in the absence of effective treatment; and
    - The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination the claims administrator will take into account the results of a review by a panel of independent medical professionals. They will be selected by the claims administrator. This panel will include professionals who treat the type of disease involved.

  Also, this exclusion will not apply with respect to drugs that:
  - Have been granted treatment investigational new drug (IND) or group c/treatment IND status; or
  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; if the claims administrator determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.
- Any charge incurred before coverage for that individual begins.
- Any charge you are not legally required to pay in the absence of plan coverage.
- Any charge after coverage of that individual ends.
- Any charges for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Any charge for services of a resident physician or intern rendered in that capacity.
- Any charges that are made only because there is health coverage.
- Any charges billed separately by an employee of a health care facility if the facility also charges for those same services.
- Any expense incurred while serving in active military duty, or during participation in a riot or for benefits which are provided or required because of military service.

- Any charges resulting from injuries arising out of or in the course of commission of a crime.
- Any expenses from a preferred provider in excess of such provider's negotiated rate for that service or supply. This exclusion will not apply to any services or supply for which a benefit is provided under Medicare before this plan's benefits are paid.
- Services for which charges are waived by the provider.
- Services and supplies that are furnished, paid for, or for which benefits are provided or required under any law of government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis.)
- Services or supplies that are not covered health services, including any related confinements, treatments, services or supplies.
- Any charges for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Care, treatment, services or supplies furnished by the Company.
- Charges for failing to keep an appointment.
- Charges for filling out claim forms.
- Charges for any services or supplies which are for the correction of malocclusion and treatment of any related diseases, TMJ appliances and TMJ therapy (certain other expenses for TMJ are covered) (TMJ appliances may be covered under the dental plan).
- Charges for hospital room/board if you are not confined.
- Cosmetic, reconstructive or plastic surgery, or supplies, which improve, alter or enhance appearance regardless of emotional or psychological reasons except as already described under eligible medical expenses.
- Counseling for family, marriage, child, career, social adjustment, pastoral, or financial.
- Court-ordered treatment, unless otherwise considered a covered health service.
- Custodial care as determined by the claims administrator. This is care made up of services and supplies furnished to a person mainly to help in the activities of daily life. Such services and supplies are custodial care without regard to who recommends, provides, performs or directs the care.
- Dental, hearing or vision care except as otherwise noted.
- Diet counseling other than an approved self-care or physician-supervised plan as described as educational and dietary counseling under Eligible Medical Expenses.
- Drugs or supplies for performance, athletic performance or lifestyle enhancement, except to the extent coverage for such drugs or supplies is specifically provided in this booklet.
- Eye exams and refractions that are routine.
  - Eyeglasses and contact lenses unless post-cataract surgery for aphakia or to correct a change in vision directly resulting from an accidental bodily injury.
- Hearing Aids.
- Home health care expenses that are not part of an approved home health care plan or are provided by a person who normally resides with you or is a member of your family (or your spouse's family), or social work services, or for transportation.
  - Hospice expenses for respite care, bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling (including estate planning/drafting of will), homemaker or caretaker services which are not solely related to patient's care (including sitter or companion services for patient or family members).
- Insurance coverage that is required by state or local law, unless otherwise required by federal law.
- In vitro fertilization, or embryo transfer procedures.
- Nonprescription drugs, medications or supplies (except insulin).
- Nutritional supplies (such as diet foods or over-the-counter diet pills) that do not require a prescription.
- Occupational accidents, occupational diseases, and occupational injuries.

- Orthoptic and visual training exclusively for treatment of reading or learning disability.
- Paternity testing.
- Personal convenience or comfort items including, but not limited to, such items as first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Prescription drugs not approved by the FDA.
- Radial keratomy/laser eye surgery and other eye surgeries mainly to correct refractive errors.
- Reversal of voluntary sterilization.
- Services, treatment, educational testing, or training related to learning disabilities or developmental delays (such as autism or Asperger's Syndrome) and except for speech therapy for developmental delays regarding speech.
- Sex therapy, treatment for sexual deviance
- Special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Therapies: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; carbon dioxide therapy.
- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- TMJ appliances.
- Travel and accommodations, except in the case of an approved transplant situation.
- Treatment that is educational, experimental, investigational, unproven, obsolete, or done primarily for research.
- Ultrafast heart scan.
- Unlawful treatment.
- Weight control, except for approved weight reduction surgery, weight reduction medications and physician supervision of weight reduction programs considered medically necessary.

This list is not intended to be exhaustive. An expense is not covered under the retiree medical plan unless affirmatively described as an eligible medical expense. The exclusions listed in this section may have the effect of excluding coverage for an expense that might otherwise be an eligible expense, but the failure to exclude a particular item should not, in itself, reflect an intention that such items be considered an eligible medical expense.

Prescription Drug Program

If you enroll in retiree medical coverage (the Aetna Medicare COB Plan or the Aetna Medicare MOB Plan), you and your covered dependents will be automatically enrolled in one of the following two prescription drug plans based on your/their age. You do not have the option of choosing one prescription plan over the other.

- **Express Scripts Medicare Plan:** A group-based, company-sponsored Medicare Part D plan offered by Express Scripts Medicare on behalf of AEP. It covers retirees, survivors and dependents who are age 65 and older. This plan is separate from the AEP retiree medical plans, meaning each has separate deductibles and out-of-pocket maximums. Eligible retirees and/or dependents will receive an Annual Notice of Change packet from Express Scripts Medicare with complete details. Note: If the information in this Summary Plan Description differs from what you receive from Express Scripts Medicare, the information from Express Scripts Medicare will apply.
- **AEP Prescription Drug Plan:** A company-provided plan that covers under age 65 dependents of retirees and survivors over age 65. The plan also covers retirees whose permanent residence is outside the U.S.

Prescription Drug Plan Comparison

	Express Scripts Medicare Plan	AEP Prescription Drug Plan
Who's covered?	Covers retirees and dependents age 65 and older	Covers under-age-65 dependents of age 65 and older retirees, as well as retirees with permanent residence outside the U.S.
ID Card	Use an Express Scripts pharmacy ID card	Use an Express Scripts pharmacy ID card
Network	Includes Walgreens, Happy Harry's and Duane Reed pharmacies. Toll free number: 1-877-703-7344	Excludes Walgreens, Happy Harry's and Duane Reed pharmacies. Toll free number: 1-800-841-3045
Exclusive Home Delivery Rule	Does not apply	After the third fill at a retail pharmacy, you will pay 100% unless you use mail-order.
Availability of 90-day supply	Can obtain up to a 90-day supply at either a retail pharmacy or mail-order	Can obtain up to a 90-day supply only through mail-order
Brand-name versus generic drugs	No penalty for obtaining a brand-name medication when a generic is available.	If you purchase a brand-name medication, you will pay the generic copay plus the difference in cost between the brand-name and the generic medication.

Under either plan, your share of the cost of your prescription medications depends if you use retail or mail order, and if you use generic or brand-name drugs.

The program covers most FDA approved drugs or medicines that by law require a physician's prescription. The program does not cover homeopathic drugs or medicines not requiring a prescription.

Under the Federal Food, Drug & Cosmetic Act, unapproved, misbranded, and all adulterated drugs are prohibited from importation into the U.S., including foreign versions of U.S.-approved medications, as is re-importation of approved drugs made in the U.S. In general, all drugs imported by individuals fall into one of these prohibited categories and are not covered under the AEP System Comprehensive Medical Plan for Retirees and Survivors Age 65 and Older.

The program offers prescription drug benefits two ways:

- For short-term (up to a 30-day supply) or emergency prescriptions, you should fill your prescription at a retail pharmacy.
- For long-term, maintenance prescriptions (up to a 90-day supply), you may save money when you take advantage of the Express Scripts Pharmacy prescription drug service. You can obtain a form to use to submit your prescription to Express Scripts by printing it from www.express-scripts.com, or by contacting the AEP Benefits Center, toll-free, at 1-888-237-2363 or calling Express Scripts at the number on the back of your prescription ID card.

If the cost of a generic drug is less than the copay (if applicable), you will pay the lesser amount.

If the cost of a preferred brand-name drug (or of a nonpreferred brand-name drug) is less than its minimum (if applicable), you will pay the lesser amount.

All other plan provisions such as annual deductibles, out-of-pocket maximums, and the use of in-network retail and mail pharmacies, apply.

Preventive Drugs

To comply with the Affordable Care Act, certain preventive medications are covered at zero copay and no cost to you. You must be covered by the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older, have a written prescription from a physician, and meet the applicable age and gender guidelines.

Included medications/products at a glance:

- Aspirin products (men and women ages 45 to 79);
- Bowel preps (limit 2 prescriptions per year);
- Contraceptive methods for women (includes certain over-the-counter (OTC) methods, oral contraceptives and contraceptive devices for women with reproductive capacity, which the plan presumes to continue through age 50);
  - Includes both prescription and over-the-counter (OTC) products, both generic and single source brands along with multi-source brands when medically necessary.
- Immunizations;
- Fluoride products (children older than 6 months through age 5 years);
- Folic Acid products (women through age 50 years);
- Iron supplements (children ages 6 to 12 months);
- Smoking cessation products (men and women age 18 and older);
- Vitamin D supplements (men and women age 65 and older); and
- Breast cancer prescription drugs such as tamoxifen and raloxifene when taken as a preventive measure. (Exception: This provision is not covered under the Express Scripts Medicare Plan but is included under the AEP Prescription Drug Plan.)

How the Express Scripts Medicare Plan Works

Coverage for Retirees and Dependents Age 65 and Older

Paying for Prescriptions under the Express Scripts Medicare Plan

Out-of-pocket maximum: The Express Scripts Medicare Plan has an annual out-of-pocket maximum of $1,000. Once you reach this amount, you will pay zero copay or zero coinsurance for your covered prescriptions.

Long-term care (LTC) pharmacy: Residents of a long-term care facility using an in-network LTC pharmacy will pay the cost-sharing amount for a one-month supply at retail for each stage described below.

Out-of-network coverage: You must use pharmacies in the Express Scripts Medicare network to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You may incur additional costs for drugs received at an out-of-network pharmacy.

Payment Process under the Express Scripts Medicare Plan

1. Deductible Stage

You pay a $50 ($150/family) yearly deductible for prescriptions filled at a retail pharmacy. Prescriptions filled by mail-order will not be subject to a deductible.

2. Initial Coverage Stage

After you pay your yearly retail-only deductible, you stay in this initial coverage stage until you reach the member out-of-pocket maximum of $1,000 ($3,000/family), or until your total yearly drug costs (what you and the plan pay) reach $3,310, whichever comes first.

During this initial coverage stage, you will pay the following:

Generic Drugs (tier 1)
Retail one-month (31-day) supply: $10 copay
Retail three-month (90-day) supply: $30 copay
Mail order (90-day supply): $20 copay

Preferred Brand-Name Drugs (Tier 2)
Retail one-month (31-day) supply: 20% coinsurance ($20 minimum/$100 maximum)
Retail three-month (90-day) supply: 20% coinsurance ($60 minimum/$300 maximum)
Mail order (90-day supply): 20% coinsurance ($50 minimum/$200 maximum)

Nonpreferred Brand-Name Drugs (Tier 3)
Retail one-month (31-day) supply: 35% coinsurance ($35 minimum/$200 maximum)
Retail three-month (90-day) supply: 35% coinsurance ($105 minimum/$600 maximum)
Mail order (90-day supply): 35% coinsurance ($90 minimum/$300 maximum)

3. Coverage Gap Stage

Note: The description of this stage is required to be provided as per Medicare Part D guidelines. AEP members will not experience any change in cost-sharing amounts during this stage.

If you have not met the member out-of-pocket maximum of $1,000, but your total yearly drug costs reach $3,310, you will continue to pay the same cost-sharing amounts. You will continue to pay these amounts until your total out-of-pocket costs reach $4,850.

4. Catastrophic Coverage Stage

If you have not met your member out-of-pocket maximum, but your yearly out-of-pocket drug costs — including manufacturer discounts — exceed $4,850, you will pay the greater of 5% coinsurance or:

- A $2.95 copay for covered generic drugs (including brand-name drugs treated as generics), with a maximum not to exceed the standard copay during the initial coverage stage.
- A $6.70 copay for all other covered drugs, with a maximum not to exceed the standard copay during the initial coverage stage.

Note: If you enroll in Medicare Prescription Drug coverage through anyone other than AEP, you will lose your eligibility for AEP retiree medical plan coverage, including the prescription drug coverage that is provided as part of your AEP retiree medical plan for that year.

How the AEP Prescription Drug Plan Works

Coverage for Under Age 65 Dependents of Age 65 and Older Retirees

Three-tier Prescription Drug Model

Participants in the AEP Prescription Drug Plan have a "three-tier" prescription drug model. This three-tier model includes a list of prescription drugs that are "preferred" because they help control rising prescription drug costs for you as well as the Company. This list, sometimes called a formulary, features a wide selection of generic and brand-name medications. You can access a Preferred Prescriptions Member Guide (Express Scripts' formulary) by contacting Express Scripts either through its website or by calling an Express Scripts customer service representative.

Retail pharmacy (up to a 30-day supply):

- $10 copay for generic drugs;
- 20% coinsurance for preferred brand-name drugs ($20 minimum/$100 maximum); and
- 35% coinsurance for nonpreferred brand-name drugs ($35 minimum/$200 maximum).

Express Scripts Pharmacy (up to a 90-day supply):

- $20 copay for generic drugs;
- 20% coinsurance for preferred brand-name drugs ($50 minimum/$200 maximum); and
- 35% coinsurance for nonpreferred brand-name drugs ($90 minimum/$300 maximum).

Ordering New Prescriptions or Refills

At participating pharmacies:

- Show your prescription ID card at the pharmacy.
- Pay your copay or coinsurance. A representative at the pharmacy will inform you of the dollar amount when you pick up your prescription.

At nonparticipating pharmacies:

- You must pay the full cost of the prescription if you fill your retail prescription at a nonparticipating pharmacy.
- Complete a direct reimbursement claim form, attach the receipt, and submit it to Express Scripts.
- You will be reimbursed for a discounted amount of the medication (as if you had obtained it at a participating pharmacy) minus the copay or coinsurance you would have paid if you had obtained it at a participating pharmacy.

Express Scripts Pharmacy

The AEP Prescription Drug Program offers members a home delivery prescription drug feature through Express Scripts called "Express Scripts Pharmacy." You can conveniently order your maintenance medication, up to a 90-day supply, and have it delivered to your home. Standard shipping is at no cost to you. You can request expedited shipping at an extra fee that will be charged to you.

Submit an original prescription from your physician, along with an Express Scripts claim form, to start this service. Subsequent refills can be ordered from Express Scripts by phone or online. Claim forms are available for print on **www.express-scripts.com**. To receive a claim form in the mail, contact Express Scripts at the member services number on your ID card or call the AEP Benefits Center at 1-888-237-2363.

Note: If your cost share of your prescription drug order through Express Scripts By Mail is $200 or more, Express Scripts will not ship without a payment. Therefore, if you do not have a credit or debit card on file with Express Scripts, or if you do not send a check or money order in with your prescription or refill, you will not receive your order. If you have any questions about payment to Express Scripts, call the Express Scripts customer service number listed on your ID card.

Exclusive Home Delivery

Participants in the AEP Prescription Drug Plan are subject to limits on prescriptions filled at a retail pharmacy. The Exclusive Home Delivery program limits the filling of prescriptions for maintenance medications to up to three times at a participating retail pharmacy. After the third fill, participants will be required to fill their maintenance medications through Express Scripts Pharmacy mail order. If you would continue to fill these prescriptions at a retail pharmacy, you will pay the entire cost of the medication and this cost will not be applied toward your prescription drug deductible or annual out-of-pocket maximum.

Note: Nursing home residents are exempt from this plan provision.

Member Pays Difference Rule

If you purchase a brand-name medication and there is a generic equivalent, you will pay the generic cost share plus the difference in cost between the brand-name and generic medication. This rule applies regardless of your doctor's DAW (Dispense As Written) instructions. The amount you pay under the Member Pays Difference rule will not apply to your prescription drug deductible or your annual out-of-pocket maximum.

Preferred Drug Step Therapy

This program targets certain prescription medications in the following drug classes:

- Acne
- Asthma
- BPH (Benign prostatic hyperplasia)
- Non-narcotic pain
- Gastroenterology
- High Cholesterol
- Hypnotics
- Nasal Steroids
- Osteoporosis
- Overactive Bladder
- Topical Steroids

Ask your physicians to prescribe lower-cost preferred brand or generic alternatives.

Nonpreferred brand drugs are not covered under the prescription plans. If your physician believes that the nonpreferred brand drug is clinically necessary, a coverage review process is available. Contact Express Scripts by calling the toll-free number on your ID card for instructions regarding a coverage review or on how to obtain an alternative medication that will be covered under the plan. Brand-name drugs that have an equivalent generic are considered nonpreferred.

Prior Authorization

Certain rare, specialty and non-specialty drug classes require prior authorization. Prior authorization will require a coverage review questionnaire to be completed by your physician before certain prescriptions can be filled. These drugs include certain drugs that treat Multiple Sclerosis, Rheumatoid Arthritis, Psoriasis, Crohn's disease and some cancers.

Limitations and Exclusions

The following limitations and exclusions apply to the prescription drug plan:

- Limitations
  - Impotency medications covered at 6 units per 30-day supply at a retail pharmacy and 18 units per 90-day supply through the Express Scripts Pharmacy.
  - Topical Retinoids for patients over age 25 including Avita, Differin, Retin A and Tazorac are covered through Express Scripts Pharmacy and retail pharmacies and require prior authorization and medical review from Express Scripts.
  - Prescription vitamins are covered only through Express Scripts Pharmacy.
- Exclusions
  - Allergy serum.
  - Growth hormones are excluded under the prescription drug program for members enrolled in one of the Aetna medical plan options. In that case, benefits for growth hormones are covered to the extent provided under the Aetna medical plan option.
  - Renova.

Behavioral Health Benefits

All behavioral health benefits are provided through the medical plan. Medicare is primary and the Aetna COB or MOB plan coordinates and processes claims accordingly.

Filing Claims and Appeals Under the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older

Eligibility and Benefit Claim Determinations

The Company has generally delegated its claims administration authority for reviewing and processing claims under the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older to a number of claims administrators. The AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older also will begin to offer claimants who are not satisfied with certain benefit determination on their second-level appeal, the right to request an external review of that determination by an independent review organization (IRO).

The Company has retained the authority, responsibility and discretion to determine eligibility to participate in the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older and has appointed the AEP Benefits Center to make initial determinations of eligibility and an internal Medical Appeals Committee to consider appeals of adverse eligibility determinations made by the AEP Benefits Center.

Filing Claims for Benefits

When you use network providers, your providers may file claims for you. If you use an out-of-network provider, you are required to file a claim. You may request a form from the appropriate claims administrator or the AEP Benefits Center. To file a claim, you (or your provider) must complete a claim form and attach an itemized bill from your provider that includes the following information:

- Name of the person who received treatment;
- Type of service (such as office visit or X-Ray);
- Date of service;
- Diagnosis of the condition;

- Amount charged; and
- Name of the physician or other health care provider.

If the claim is for a prescription, the bill must show the:
- Name of the person for whom it was prescribed;
- Name of the drug and NDC number;
- Quantity dispensed;
- Days' supply;
- Dispensing instructions (e.g., Dispense As Written);
- Date of purchase;
- Name of physician who wrote the prescription; and
- Amount charged.

Mail your claim form to the address shown on the website or claim form and attach all receipts. **You must file all claims within one year of the date the expense is incurred, or it will not be eligible for reimbursement under the plan.**

You may file claims for plan benefits, and appeal adverse claim decisions, either by yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from the claims administrator (or, with regard to a decision in connection with an external appeal, from the independent review organization assigned to review your appeal). The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of a claim involving urgent care, a health care professional with knowledge of your condition may act as your authorized representative.

Questions about Benefit Determinations

If you have questions or concerns about a benefit determination, you may informally contact the Member Services Department of your claims administrator before requesting a formal appeal. If the Member 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 sections that follow, without first informally contacting Member Services.

The Member Services telephone number is generally shown on your ID card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

Benefit Determinations for Aetna Claims

For general medical benefits, the claims administrator performs all internal levels of appeal.

Benefit Determinations for Prescription Claims

For prescription drug benefits, Express Scripts performs all internal levels of appeal.

Benefit Determination Process (Internal)

There are different processes and deadlines that apply depending upon whether the claim is pre-service, concurrent, post-service or for urgent care. The process for each type of claim is described in this section.

Should you be notified of an adverse benefit determination, you will be provided the following:

- Information sufficient to allow you to identify the claim involved.
- 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 applicable 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 the denial is based on a medical necessity, experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefit determination (or a statement that such explanation) will be provided free of charge upon request.

Here is how it works:

Pre-Service Claims

Pre-service claims are claims that require notification or approval prior to receiving medical care. Pre-service claims that are urgent care claims are addressed under "Urgent Care Claims."

If your pre-service claim is submitted properly with all needed information, the claims administrator will send you a notice of the benefits determination, whether adverse or not, no later than 15 days after it receives the claim.

If your pre-service claim is not filed in accordance with the plan's procedures, the claims administrator will notify you of the improper filing and how to correct it.

If an extension is necessary to process your pre-service claim, the claims administrator will notify you in writing within the initial 15-day response period, and may request a one-time extension of up to 15 days. 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 then have 45 days to provide the additional information. If all the needed information is received within 45 days, the claims administrator will notify you of the determination 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.

Urgent Care Claims

Urgent care claims are claims that require notification or approval prior to receiving medical care but a delay in the care for the periods otherwise applicable to your claim:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If you file an urgent care claim in accordance with the plan's procedures and include all needed information, the claims administrator will notify you of the determination, whether adverse or not, as soon as possible, but not later than 72 hours after receipt of the urgent claim.

However, if you do not provide sufficient information to determine whether, or to what extent, benefits are payable under the plan, the claims administrator will notify you of the improper filing and of the specific information necessary to complete the claim and how to correct it within 24 hours of receipt of the improper claim. This notification may be oral, unless you request a written notification. You will then have 48 hours to provide the requested information. You will be notified of the determination on your claim no more than 72 hours after the earlier of:

- The claims administrator's receipt of the requested information; or
- The end of the 48 hours given to you to provide the requested information.

Any notification of an adverse benefit determination for an urgent care claim will include the same information previously listed under "Benefit Determination Process." Notifications regarding urgent care claim determinations may be oral, in which case written or electronic confirmation will follow within three days.

Should you receive an adverse benefit determination for an urgent care claim and the time frame to complete an internal review would seriously jeopardize your life or health or your ability to regain maximum function, you could have the right to immediately request an expedited external review, prior to exhausting the internal process, provided you file your request for an expedited external review at the same time you file your request for an internal appeal of the adverse benefit determination (see "Expedited External Reviews" section, below).

Concurrent Care Claims (Ongoing Treatment)

There are two types of concurrent care claims:

- A claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments; or
- A determination on behalf of the plan (other than by reason of a plan amendment) to reduce or terminate coverage by the plan before the end of a previously approved period of time or number of treatments.

You must submit a request to extend an ongoing course of treatment at least 24 hours before the end of the previously approved limit. If your request for extension is timely made and involves urgent care, the claims administrator will notify you of the determination, whether adverse or not, within 24 hours after the claim is received. If your claim is not made at least 24 hours prior to the end of the previously approved limit, the request will be treated as an urgent care claim (not as a concurrent care claim) and decided according to the time frames described above for urgent care claims.

A request to extend coverage that does not involve urgent care will be considered a new claim and will be decided according to the post-service or pre-service time frames previously described, whichever applies.

If an ongoing course of treatment previously approved by the plan is terminated or reduced for continued coverage, the claims administrator will notify you sufficiently in advance to allow you to submit an appeal and receive a decision on that appeal before the termination or reduction takes effect.

Any notification of an adverse benefit determination for a concurrent care claim will include the same information mentioned previously listed under the section titled "Benefit Determination Process."

Post-Service Claims

Post-service claims are claims for benefits that are filed after medical care has been received. If your post-service claim is denied, you will receive a written notice from the claims administrator not later than 30 days after it received the claim, 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 its 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 for a post-service claim will include the same information mentioned previously under the section titled "Benefit Determination Process."

Claims Appeal Process (Internal Appeals)

If you disagree with an adverse benefit determination, you may contact the claims administrator, in writing, to formally request an appeal. Except for concurrent claims (see "Concurrent Care Claims" section, above), you have 180 days from receipt of the notice of denial to file an appeal. Except for appeals involving urgent care (see "Urgent Care Appeals" section), all appeals must be in writing. You may submit written comments, documents, records and other information in support of your appeal. The review on appeal will take into account any information you submit, even if not submitted or considered as part of the initial determination. Upon request and free of charge, you will also be provided reasonable access to and copies of all documents, records, and information relevant to your claim.

If the appeal relates to a claim for payment, your request for appeal must include the following:

- The provider's name.
- The date of the medical service.
- The patient's name and identification number as shown on the medical plan ID card.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

If you are appealing an adverse benefit determination on an urgent care claim, please refer to the section "Urgent Care Appeals," below, and call the Member Services number on your medical plan ID card immediately. All other appeals will be processed as described below.

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if the claims administrator, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under ERISA.

First-Level Appeals

The claims administrator for your medical plan is responsible for reviewing first-level appeals. The review of the first-level appeal will afford no deference to the initial benefit determination. Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the first-level appeal.

First-Level Appeal Addresses:

Aetna
Aetna National Accounts-CRT
P.O. Box 14463
Lexington, KY 40512

Express Scripts
PO Box 66587
St. Louis, MO 63166-6587
1-800-946-3979

The claims administrator will provide you written or electronic notification of the determination, as follows:

- For first-level appeals of pre-service claims, not later than 15 days after receipt of your request for a first-level appeal
- For first-level appeals of post-service claims, not later than 30 days after receipt of your request for a first level appeal

If you receive an adverse benefit determination on your first appeal, the notification from the claims administrator will include:

- Information sufficient to allow you to identify the claim involved.
- 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 second-level appeal procedures offered by the plan.
- A statement of your right to bring civil action under federal law following a denial of your second-level appeal.
- A statement disclosing any internal rule, guideline, protocol, or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request), if applicable.
- If the denial on appeal is based on a medical necessity, experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefit determination (or a statement that such explanation) will be provided free of charge upon request, if applicable.

Second-Level Appeals

If you are not satisfied with the determination on your first-level appeal, you can submit a second-level appeal to the claims administrator. All second-level appeals should be submitted in writing to the appropriate party within 60 days after you receive the notice of determination on your first-level appeal. Your second-level appeal would be mailed to the claims administrator at the same address listed under "First-Level Appeals."

Like first-level appeals, the review of a second-level appeal will afford no deference to prior determinations and will be conducted by someone other than individuals involved in the prior determinations or subordinates of such individuals.

If the claims administrator considers, generates or relies upon any new or additional evidence as it reviews your second-level appeal, it will provide you with a copy or description of that evidence free of charge and offer you a reasonable opportunity to respond before the claims administrator makes its determination. In addition, if the claims administrator develops a new or additional rationale for an adverse benefit determination in connection with your second-level appeal, it will advise you of that rationale free of charge and offer you a reasonable opportunity to respond before the claims administrator makes its determination.

The claims administrator will provide you written or electronic notification of the determination, as follows:

- For appeals of pre-service claims, not later than 15 days after receipt of your request for a second-level appeal.
- For appeals of post-service claims, not later than 30 days after receipt of your request for a second-level appeal.

Denial notifications of second-level appeals will include the applicable information previously described for adverse benefit determinations on first-level appeals.

Urgent Care Appeals

An appeal involves urgent care if a delay could significantly increase the risk to your health or impairs your ability to regain maximum function or, in the opinion of a physician with knowledge of your condition, could cause severe pain.

If your appeal involves urgent care, the appeal does not need to be submitted in writing. You or your physician should call the claims administrator for urgent care appeals at the toll-free telephone number on your medical plan ID card as soon as possible.

The claims administrator will notify you of the determination on your appeal as soon as possible, but not later than 72 hours after receipt of the appeal. The notification may be written or electronic and will include the information previously described for other adverse benefit determinations on appeal.

In situations where the time frame for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function, you could have the right to immediately request an expedited external review, prior to exhausting the internal process, provided you file your request for an expedited external review at the same time as you file your request for an internal appeal of the adverse benefit determination. See section entitled “Expedited External Reviews” below, for additional information.

External Reviews

If you file a voluntary appeal for external review, any applicable statute of limitations will be suspended while the appeal is pending. The filing of a request for external review will have no effect on your rights to any other benefits under the Plan. However, the appeal for external review is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary external review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Standard External Reviews

The external review process under this Plan gives you the opportunity to receive review of an adverse benefit determination upon your second-level appeal conducted pursuant to applicable law. Your request will be eligible for external review if the following are satisfied:

- The claims administrator (or other applicable Plan designee) does not strictly adhere to all claim determination and appeal requirements under federal law; or
- The standard levels of appeal (first and second levels) have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An adverse benefit determination based upon your eligibility is not eligible for external review.

If upon the final standard level of internal appeal, the coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

Upon an external review, an independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, the claims administrator and the Plan unless otherwise allowed by law.

Your written request for an external review must be made within four months after receiving an adverse benefit determination on your second level appeal.

Preliminary Review

Within 5 business days (immediately for urgent care claims) following the date of receipt of the request, the claims administrator must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the external review.

Within one business day after completion of the preliminary review, the claims administrator must issue to you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the claims administrator must allow you to perfect the request for external review within the four-month period after receiving an adverse benefit determination on your second-level appeal or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to External Independent Review Organization (IRO)

The claims administrator will assign an IRO accredited as required under federal law, to conduct the external review. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the IRO must consider when conducting the external review.

Within one (1) business day after making the decision, the IRO must notify you, the claims administrator and the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to you, the claims administrator and the Plan.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, Plan, or governmental oversight agency upon request, except where such disclosure would violate applicable privacy laws.

Upon receipt of a notice of a final external review decision reversing an adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Reviews

If you receive an adverse benefit determination to your urgent care appeal, you may request an expedited external review. In situations where the time frame for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function, you could have the right to immediately request an expedited external review, prior to exhausting the internal process, provided you file your request for an expedited external review at the same time as you file your request for an internal appeal of the adverse benefit determination.

You may also request an expedited external review if you receive a second-level appeal adverse benefit determination that concerns an admission, availability of care, continued stay, or health care for which emergency services were received but discharge from a facility has not occurred.

Upon receipt of the expedited external review request, the claims administrator will immediately conduct a preliminary review and provide written notification in the same manner as described under "Standard External Reviews." The approved expedited review request will be reviewed by an independent organization. The independent organization will not be bound by any decisions or conclusions during the internal claim and appeals process. You will be provided notice of the independent organization's final determination as expeditiously as needed, but in no event more than 72 hours after the independent organization receives the expedited external review request. If the notice of the final determination is not in writing, the independent organization must provide written confirmation within 48 hours after the date of providing that notice.

When You Have Other Coverage

The AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older coordinates benefits using a non-duplication, or maintenance of benefits provision that determines which plan is primary and how benefits will be paid when you or your dependent is covered by more than one plan.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expenses.

When the other plan of health care coverage is Medicare, and the AEP plan is the secondary plan to Medicare, the AEP plan will adjust its benefits in a manner described under the option you selected. Refer to the descriptions "Coordinating Benefits" under "Aetna Medicare Coordination of Benefits (COB) Plan" and under "Aetna Medicare Maintenance of Benefits (MOB) Plan" sections.

No plan pays more than it would without the coordination of benefits provision. A plan without a coordination of benefits provision is always the primary plan. If all plans have such a provision:

a) The plan covering the person directly, rather than as a retiree's dependent, is primary and the others are secondary;
b) For dependent children of parents not separated or divorced, the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second.

   However, if the other plan does not have this rule but instead has a rule based upon 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;
c) Dependent children of separated or divorced parents: When parents are separated or divorced, neither the male/female nor the birthday rule apply. Instead:
   1) The plan of the parent with custody pays first;
   2) The plan of the spouse of the parent with custody (the stepparent) pays next; and
   3) The plan of the parent without custody pays last.

      However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefit of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided before that entity has actual knowledge, this "court decree" rule is not applicable during the remainder of the calendar year;
d) Active/Inactive Employee: The plan covering a person as an employee who is neither laid off nor retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid off or retired employee (or as that person's dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

e) If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

This coordination of benefits provision may operate to reduce the total amount of benefits otherwise payable during any claim determination period with respect to a covered person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an allowance expense and a benefit paid.

If the other plan has no guidelines for coordinating benefits, that plan will pay benefits before the Company's Medical Plan.

The general rule is that the benefits otherwise payable under this plan for each transaction will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this plan and an "other plan" both agree that this plan determines its benefits before such "other plan," the benefits of the "other plan" will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, the claims administrator can release or obtain data. The claims administrator can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this plan.

Other Plan

When coordinating benefits, references to "other plan" mean any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.
- Government or tax sponsored programs, including Medicare and Medicaid.

Right of Recovery

The amount of your plan benefits will be adjusted if:

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

If a benefit is overpaid or duplicated, you are required to repay the plan immediately upon the plan's request. If you do not repay the plan within the time requested, 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.

In addition, you will be required to repay the plan if:

- You receive payment for expenses that did not legally have to be paid.
- You receive duplicate payments from this plan and from another source — other than another health care plan to which coordination of benefits rules apply — such as payments resulting from a claim for negligence, wrongful acts or omissions.
- You receive an overpayment due to an administrative error.

Right of Subrogation and Reimbursement

If you or a covered family member suffers an accidental injury or medical condition and, as a result, has claims against a third party, the plan will pay the covered expenses. As a condition of receiving benefits from the plan, you agree to:

- Cooperate fully with the plan in recovering the amount it has paid.
- Protect the plan's right to act in your place (subrogation) to pursue the claim against the third party.
- Reimburse the plan for the amount it paid for your injury if the other party is found to be liable and you receive a recovery as the result of your claim. You shall hold any amount recovered as the result of your claim in a separate account until paid over to the plan.

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an **injury**, **illness** or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery with respect to any claim or potential claim against any party, due to an **injury**, **illness** or condition to the full extent of benefits provided or to be provided by the plan. The plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement
If you receive any payment as a result of an **injury**, **illness** or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that **injury**, **illness** or condition, up to and including the full amount of your recovery.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an **injury**, **illness** or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan.

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the **illness**, **injury** or condition upon any recovery whether by settlement, judgment, or otherwise, related to treatment for any **illness**, **injury** or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the plan.

Assignment
In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim
By accepting benefits from the plan, you acknowledge that the plan’s recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your **injury**, **illness** or condition. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery you receive may result in the termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan. If you fail to cooperate with the plan in its efforts to recover such amounts or do anything to hinder or prevent such a recovery, you will cease to be entitled to any further plan benefits. The plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or recovery you obtain, regardless of whether the settlement, judgment or recovery is designated to cover future medical benefits or expenses.

You acknowledge that the plan has the right to conduct an investigation regarding the **injury**, **illness** or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq,* to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Right to Exchange Information

In order to coordinate benefit payments, the claims administrator needs certain information and may need to get facts from or give them to any other organization or person. The claims administrator need not tell, or get the consent of any person to do this. You must give the claims administrator the information it asks for about other plans. If you cannot furnish all the information the claims administrator needs, the claims administrator has the right to get this information from any source.

If any other organization or person needs information to apply its coordination provision, the claims administrator has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this. For additional information about the use and disclosure of plan information, refer to the "Notice of Privacy Practices" Section in this booklet.

When Coverage Ends

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

- You stop paying required contributions;
- You are no longer eligible;
- You elect to enroll in a Medicare prescription drug plan (unless you are automatically enrolled due to low income subsidy);
- The plan ends; or
- You die.

Coverage for your dependents ends on the last day of the month in which your coverage ends, or in which they elect to enroll in Medicare's prescription drug coverage or are otherwise no longer eligible.

If your coverage ends, you and your dependents may, under certain circumstances, be eligible to continue coverage under COBRA.

Continuing Medical Coverage through 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 your medical plan benefits maintained by the Participating Companies within the AEP System (generally referred to in this notice as the "Company"). 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;
- Spouse or former legal spouse of the retiree; or
- Natural and legally adopted (or placed for adoption) dependent child(ren) of the retiree.

Therefore, you, your spouse and natural or adopted 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 medical plan.

COBRA Qualifying Events

Retiree. You have a right to choose this continuation coverage if you lose your coverage 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 filing.

Spouse or Domestic Partner. Your spouse or domestic partner, if covered by the Plan, has the right to choose continuation coverage for him or herself if he or she lost coverage under that plan for ANY of the following three (3) reasons:

1. Your death;
2. Your divorce, legal separation or termination of domestic partnership; or
3. 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 five (5) reasons:

1. Your death;
2. Your divorce, legal separation or termination of domestic partnership;
3. You become eligible for benefits under Medicare Part A, Part B, or both;
4. Your dependent ceases to be a "dependent child" under the Plan; or
5. 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/domestic partner 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").

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, legal separation, termination of domestic partnership 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.

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.

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 above, to inform the Company of your decision, please contact 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 premiums for the continuation coverage in a timely manner. (See the section on "Conditions on Continuation of Coverage.")

Duration of Continuation of Coverage. COBRA requires that a spouse and dependent children incurring one of the qualifying events previously described (other than the Company filing for Title 11 bankruptcy protection) be afforded the opportunity to maintain continuation coverage for 36 months. A retiree incurring a qualifying event as a result of the Company filing for bankruptcy protection under Title 11 has a maximum coverage period of the retiree's lifetime. The surviving and dependent children of a covered retiree will be afforded up to 36 month of coverage after the date of death of the covered retiree if their coverage is lost as a result of the Company filing for bankruptcy under Title 11.

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 Plan offers no such conversion coverage, none will be made available following the expiration of continuation coverage for any qualified beneficiary.

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 premium for continuation coverage is not paid in a timely fashion;
3. You, your spouse/domestic partner 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/domestic partner 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/domestic partner or any of your covered dependents become eligible for benefits under Medicare.

Conditions on Continuation of 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 premiums 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. 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 a 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) for a one time exception under the AEP plan.

The AEP Benefits Center

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

American Electric Power Service Corporation
AEP Benefits Center
P.O. Box 622
Des Moines, IA 50306-0622
Phone number: 1-888-237-2363

Retiree Reimbursement Account (RRA)

If you were enrolled in the Anthem HRA Plan as an active employee or as an under-age 65 retiree immediately prior to your status of an over-age 65 retiree, you may be eligible for a RRA. If you have unused HRA (Health Reimbursement Account) dollars 90 days after the end of your Anthem coverage, the money remaining in your HRA will be automatically converted to a Retiree Reimbursement Account (RRA) administered by Aetna Life Insurance Company. You will receive a welcome letter directly from Aetna with details such as the member website and toll free number.

You will be able to use the money in your RRA to pay for many of your out-of-pocket medical expenses. These include expenses that the Aetna Plan options consider eligible, covered medical expenses and which require an out-of-pocket expense from you, like your prescription drug expenses.

You can also be reimbursed for any eligible out-of-pocket expenses associated with your spouse or dependent children (if applicable).

Post-tax contributions, including retiree contributions for your AEP Medical Plan coverage, premiums for coverage with another employer or Medicare premiums, are also reimbursable.

As long as you continue to participate in AEP's over-age 65 Retiree Medical Plan, reimbursement of your out-of-pocket expenses will be streamlined through Aetna's automated reimbursement process, meaning there is no need to fill out a claim form.

If you are no longer covered by the AEP Medical Plan, or have medical coverage through a non-Aetna plan, you will have to submit a completed and signed Aetna RRA claim form, along with copies of your receipts or the explanation of benefits letter from your other plan cover age in order to be reimbursed from your RRA. These claims cannot automatically streamline to Aetna.

The account balance will carry over from year to year during your life span. However, the balance remaining in the retiree's RRA is forfeited to the extent not used to reimburse claims incurred prior to the retiree's death. Once all the funds in your RRA have been used, the account will be closed. No additional funds will be available.

RRA Reimbursement Processing

Submit completed reimbursement forms and documentation to the following address or fax:

Aetna
P.O. Box 4000
Richmond, KY 40476
Fax Number 1-888-238-3539

Life Events and Your Coverage

In general, once you enroll in medical care 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 in certain circumstances), you may not change your elections until the next Annual Enrollment period.

You Get Married

Your marriage is considered a qualifying change in family status which allows you to adjust your participation in the medical 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 must be submitted to the AEP Benefits Center in order to enroll your new spouse. A marriage event does NOT allow you to change your medical 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 medical 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 any ineligible dependents from your medical 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) medical 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 medical care plan, you have 31 days from the date your marriage ends to apply for AEP medical coverage in your own name.

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

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 medical care coverage. You will need to supply a "Declaration of Termination of Domestic Partnership" form to the AEP Benefits Center in order to change your medical coverage.

- If you have domestic partner or family medical 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 ineligible dependents from your medical 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 medical coverage, you have 31 days from the date of the end of the partnership to apply for AEP medical coverage.

The termination of your domestic partnership does not allow you the option to change your medical your medical plan.

You Die

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

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

If you die while employed at AEP, your eligible surviving dependents may be eligible to continue medical 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 Medical 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 death does NOT allow your survivors to change medical plans unless your surviving dependent is under age 65 at the time of your death.

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 medical plan. (Normally, you can change certain benefits coverage only once a year, during the Annual Enrollment period.) Remember that any changes must be made within 31 days of the death.

Review your medical 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 medical 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 or the Medical Claims Administrator for requirements to continue coverage during the child's disability.

Medical coverage ends for your ineligible dependent on the last day of the month in which he or she loses eligibility. Your child may continue coverage through COBRA.

Birth/Adoption/Legal Guardianship of a Child

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 medical 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 month of adding a dependent. The AEP Benefits Center will request a copy of the birth certificate, adoption decree or guardianship papers 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 Medical Plan for Retirees and Surviving Dependents Age 65 and Older to the extent that would be consistent with the events affecting your spouse/domestic partner. You may not change your medical plan option if you are already enrolled in the AEP medical plan.

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

You Return after Retirement

If you return to work with a Participating 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 medical coverage at the applicable retiree contribution rate when you return to work and your contributions will be deducted from your paycheck on a before-tax basis.

In general, employees hired after 1/1/2014 are not eligible for medical coverage at retirement. However, any retiree who was eligible for retiree medical coverage upon their initial retirement date and rehired after 1/1/2014 as a regular full-time or part-time employee will continue to be eligible for retiree medical coverage upon their second retirement.

Your Legal Rights

Participants in the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older 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 all 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 a 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 Medical Plan for Retirees and Surviving Dependents Age 65 and Older Summary Plan Description (SPD) provides a summary of the medical benefits available to eligible employees. In some instances, full details of the plans 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 medical plan benefits belong to you and, in certain cases, to members of your family. Your medical 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 medical plan.

In the event that you or your beneficiary is unable to attend your legal 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 and Termination

The Company reserves the right to change or end the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older, in whole or in part, at any time and for any reason, which could result in modification or termination of medical benefits to employees, former employees, retirees or other participants.

AEP's decision to amend, replace or terminate the medical 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 the medical plan.

If the AEP Comprehensive Medical Plan for Retirees and Surviving Dependents Age 65 and Older 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 plans are administered, the way claims are processed and related topics. If you have questions about any of your benefits that are not answered in this booklet, please contact the AEP Benefits Center, toll-free, at 1-888-237-2363.

Plan Name: American Electric Power System Comprehensive Medical Plan for Retirees & Surviving Dependents Age 65 and Older

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

Type of Administration: The following medical plan options (including the associated behavioral health and prescription drug plans) are 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.

- Aetna COB Plan
- Aetna MOB Plan

Trustee: AEP maintains trusts that hold funds contributed by the employers and participants to the Plan. The Trustee of each of those trusts is The Bank of New York Mellon, whose principal place of business is One Mellon Center, Pittsburgh, PA 15258.

Plan Sponsor and Administrator: The plan is sponsored and administered by American Electric Power Service Corporation (AEP) and its subsidiaries and affiliates that have adopted the plans for the benefits of their employees. 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 the plan. The rights to carry out responsibilities and use maximum discretionary authority permitted by law are assigned to the plan administrator and the claims administrator identified in this Summary Plan Description (or including any additional or replacement claims administrators as may be identified from time to time), and to the claims administrator for insured plans. These rights and responsibilities include the following:

- Interpret, construe and administer the plan;
- 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 plan and to receive benefits and payments pursuant to the plan.

The decisions of these parties are final and binding.

Plan Numbers: Documents and reports for some plans are identified by the United States Department of Labor using two numbers: the Company's Employer Identification Number (EIN) and the Plan Number. The EIN for AEP is 13-4922641. The three-digit Plan Identification Number is 501.

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 above.

Benefit	Claims Administrator
Medical	Aetna COB/MOB Plans Aetna Life Insurance Company P.O. Box 981107 El Paso, TX 79998-1107 1-800-243-1809
Prescription Drugs	Express Scripts One Express Way St. Louis, MO 63121314-996-0900

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 insurance 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-regulated group health 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 its 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.

To the extent required by the Health Breach Notification Rule (16 CFR Part 18), The Plan intends 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 becomes aware.

AEP Benefits Center
1-888-237-2363