AMERICAN ELECTRIC POWER

BOUNDLESS ENERGY™

2019 AEP HEALTH & WELFARE BENEFITS GUIDE

Annual Enrollment is October 18 through November 1, 2018

Review your benefit options for 2019 and enroll through the AEP Benefits Center by going to **www.ibenefitcenter.com/aep** or calling **1-888-237-2363**.

Retirees and survivors under age 65 and their dependents

The choice is yours

Explore your AEP benefit options for 2019

We are pleased to continue to offer you competitive coverage next year through the AEP Health & Welfare benefits program. This year's Annual Enrollment runs from October 18 through November 1, 2018, and it's your opportunity to elect the benefits that are right for you and your family in 2019.

Some important changes are being made for 2019, so please read this guide carefully to understand your benefit options before you enroll.

PLUG IN to Learn

Be sure to visit the AEP Benefits Hub at **www.aepbenefits.com** to learn all about the benefits offered to you as an AEP retiree. The AEP Benefits Hub is part of our ongoing commitment to provide you with the information, tools and resources necessary to do what's best for you and your family.

DO YOU NEED TO TAKE ACTION?

You will need to take action during this Annual Enrollment if you want to:

- Add, change or cancel your medical coverage for you and/or your eligible dependents for 2019. If you take no action, your current elections will carry over, assuming you remain eligible, covering the same eligible dependents. Note: Surviving spouses and dependents can't re-elect medical coverage if not currently enrolled.
- Add or cancel your vision coverage for you and/or your eligible dependents for 2019. If you take no action, your current elections will carry over, assuming you remain eligible, covering the same eligible dependents. Note: Surviving spouses and dependents can't re-elect vision coverage if not currently enrolled.
- Discontinue coverage in the dental plan. Note: If you waive dental coverage, you will not be able to enroll in dental coverage in the future. Refer to the "Dental Plans" section of this guide for exceptions relating to the sale of an operation.
- Change from the Dental Preferred Provider Organization (DPPO) Plan to the Dental Maintenance Organization (DMO) Plan (if available) or vice versa.
- You are a surviving spouse who must respond to the remarriage attestation question even if you make no changes to your current benefits.

HOW TO ENROLL

The AEP Benefits Center makes it easy to elect your benefits for 2019. Simply log on to the AEP Benefits Center website, **www.ibenefitcenter.com/aep**, and follow the simple enrollment instructions on page 20 of this guide. You may also enroll by calling **1-888-237-2363 (1-888-AEP-BENE)**, option 1.

Be sure to take action between October 18 and November 1, 2018. If you do not take action during Annual Enrollment, you will receive default coverage as follows:

- You will remain enrolled in your current medical plan at your current coverage level (single, family, etc.). If you currently waive AEP medical coverage, you will continue to be waived unless you enroll for 2019.
- You will remain enrolled in your current dental and vision coverage, if applicable. If you are currently enrolled in the Dental Maintenance Organization (DMO) Plan, review your dental plan options to ensure the DMO Plan is still available to you based on your home ZIP code. If the DMO Plan is no longer available, you will be defaulted into the Dental Preferred Provider Organization (DPPO) Plan, covering your same eligible dependents.

The choices you make during Annual Enrollment are effective January 1, 2019, through December 31, 2019, unless you have a qualifying change in family or employment status as described in the "Changing coverage during the year" section of this guide.

WHAT'S INSIDE

Questions?
Please call the AEP Benefits Center at **1-888-237-2363 (1-888-AEP-BENE)**, option 1, between 8 am and 5 pm ET, any business day, and confirm your identity to speak with a representative.

BENEFIT CHANGES FOR 2019

The following changes to AEP's Health & Welfare benefits will take effect January 1, 2019.

New Diabetes Prevention Program for AEP medical plan participants

Are you at risk of developing diabetes? We can help you find out — and help you take steps to reduce your risk. If you have medical insurance through AEP, you (and your covered dependents age 18 and older) now have access to a new benefit to help you lead a healthier life and potentially prevent the onset of diabetes. The Diabetes Prevention Program is available both in-person and virtually (based on your preference) and meets weekly for 16 weeks and then monthly for the rest of the year. AEP is covering the cost of the program — if you qualify, it won't cost you a penny! Text AEP to 81053 to receive a link or visit **www.solera4me.com/aep** to take a one-minute quiz to better understand your risk and find out more details about the program.

New Second Opinion Program for AEP medical plan participants

AEP medical plan participants and their covered dependents have access to many services through Anthem to help manage chronic conditions, such as diabetes, heart disease, COPD and many others. In addition to these core support services offered through the Anthem clinical team, medical plan participants will now have access to remote second-opinion services. These second opinions are designed to support complex health conditions where surgery or significant treatments for illnesses, such as cancer, may be recommended. The Anthem clinical team can recommend whether a second opinion from a nationally recognized, specialized physician may be right for you. Contact Anthem at **1-877-585-9572** for more details about the program.

Medical plan coverage changes

Members will have access to expanded services related to the diagnosis and treatment of developmental delays and learning disabilities, including physical, occupational and speech therapy. Also, beginning January 1, 2019, the AEP medical plan will adopt Anthem's standard benefit and limit visits for occupational therapy, physical therapy and speech therapy to 30 visits, per incidence.

Pharmacy plan coverage changes

Members prescribed certain medications that are classified as "specialty" will be required to use the specialty mail-order pharmacy, Accredo, the first time the medication is dispensed. Accredo specialty pharmacy serves patients with complex and chronic health conditions, including cancer, hepatitis C, HIV, bleeding disorders and multiple sclerosis. Treatment for these conditions can be difficult, and this change will ensure that well-trained clinicians specific to these conditions are able to support the member as well as connect them with payment-assistance programs, if available. Additional benefits, such as nutritional counseling, social worker support, coordination of care and training on proper medication administration, are available through Accredo. As a part of this program, manufacturer-funded patient assistance for widely distributed specialty drugs will not be considered as true out of pocket for members and may not apply to deductible and out-of-pocket maximums. Contact Express Scripts at **1-800-841-3045** for more details.

Increased Health Savings Account (HSA) contributions limits

In 2019, the maximum annual HSA contribution for individuals in a high deductible health plan will increase to $3,500. The maximum for those covering more than a single individual will increase to $7,000. The catch-up amount for those 55 and older remains at $1,000. Because you aren't actively working and receiving a paycheck directly from AEP, you can't elect to contribute to an HSA directly through AEP. If you are eligible, you can make your own contributions directly to your account, up to the IRS limits, and deduct those contributions on your federal income tax.

MEDICAL PLANS

Your options at a glance

For 2019, AEP will continue to offer three consumer-directed health plans (CDHPs), all administered by Anthem Blue Cross and Blue Shield and available in all areas. The three CDHP options are:

HRA Plan – CDHP with an AEP-funded Health Reimbursement Account (HRA).

HSA Plus Plan – CDHP with a Health Savings Account (HSA) that provides both AEP funding and optional retiree funding via deposits made directly to the account.

HSA Basic Plan – CDHP with an optional Health Savings Account (HSA) that allows retiree funding via deposits made directly to the account.

Waiving medical coverage

Retirees: Even if you have previously waived AEP retiree medical coverage or do not elect it this Annual Enrollment, you may still elect this coverage in the future — either during a future Annual Enrollment or within 31 days of a qualified change in family status.

Surviving spouses and dependents: Once you waive AEP retiree medical coverage, you lose your eligibility for this coverage permanently and will not be able to enroll at a later date.

What's included?

All of AEP's medical plan options include coverage for prescription drugs, behavioral health and fully covered in-network preventive care. This means you pay nothing for immunizations, routine annual exams, adult screenings, routine colonoscopies and other preventive care, as long as you receive this type of care from in-network providers.

What happens when you turn age 65?

Approximately two months prior to your 65th birthday, the AEP Benefits Center will send you information outlining eligibility and other details about benefits that will go into effect once you turn age 65, including the options and costs available to you under the AEP Group Medicare Advantage Plans

IMPORTANT: You must be enrolled in Medicare Parts A and B to be eligible to participate in AEP's Group Medicare Advantage Plans upon turning age 65. If a covered dependent under the age of 65 becomes eligible for Medicare, for any reason, including disability, the plan will assume they are enrolled in Medicare Parts A and B and will coordinate its payment of benefits accordingly.

You will also receive a letter from Express Scripts Medicare with information about the group-based, company-sponsored Medicare Part D plan.

Reminder: Medical coverage is required

The health care reform law, also known as the Affordable Care Act (ACA), requires almost all US citizens and legal residents to have medical coverage or pay a penalty when they file their taxes. Enrolling in a medical plan offered through AEP will meet this requirement. Depending on your situation, your other options may include enrolling in a plan through another employer (such as your spouse's employer, or your parent's employer if you're under age 26), a government plan such as Medicare or Medicaid, a private insurance plan or a plan offered through the public health insurance marketplace (learn more at **www.healthcare.gov**).

ALEX, the benefits counselor

ALEX walks you through the process of picking the best medical benefits for you, and provides easy-to-understand explanations for any questions you might have along the way. You can discover your lowest-cost, best-coverage health plan option for 2019 or see if your current plan choice is still the best one for you — from any computer, tablet or smartphone at **www.myalex.com/aep/2019/retirees**.

Health Navigator by Castlight

Enroll in and use Health Navigator as your personalized health care advisor. Here, you can receive tips and reminders specific to your health care needs, find in-network providers and compare them in terms of quality, cost and location. You can also review past Explanations of Benefits and research health care conditions and possible future treatments.

Go to the AEP Health Navigator **(www.mycastlight.com/aephealthnavigator)** to enroll and learn more about this important resource. You may also go to the Apple App Store or the Android Google Play Store to download on your mobile device. Note that you will need to use your name exactly as it appears on your Anthem ID card when you register. If you have any questions, call **1-866-259-4428** between 8 am and 9 pm ET for assistance.

Find a provider

Anthem Blue Cross and Blue Shield

Visit **www.anthem.com** to search for in-network providers in your area without requiring a login.

If you experience technical problems with the Anthem Find-a-Doctor website or you cannot locate your provider in the system, please call Anthem at **1-877-585-9572**, option 1 (8 am to 8 pm ET, Monday through Friday), or contact your provider directly to confirm network coverage.

Express Scripts

Visit the Express Scripts website, **www.express-scripts.com**, to search for a pharmacy. After logging in, select "Locate a Pharmacy" from the "Manage Prescriptions" drop-down menu and enter your ZIP code or city and state of residence. The search results will provide nearby in-network pharmacies along with driving directions.

MEDICAL PLAN SUMMARIES

The medical plan summaries on the following pages show each medical plan option and provide a general overview of how the plans work. For additional information on AEP's three medical plans, please visit **www.aepbenefits.com**.

Health Reimbursement Account (HRA) Plan

The HRA Plan provides medical coverage and convenience with an AEP-funded account that covers out-of-pocket costs associated with your medical plan. AEP contributes to your HRA annually, and the funds are available for use at the beginning of the calendar year. The amount of AEP's contribution depends on the coverage level you elect. Your account is automatically set up by AEP when you enroll in the plan. The money in your HRA is automatically applied to your medical, prescription drug and behavioral health claims until it is gone. You cannot make contributions to this account. Any unused balance can be carried over from year to year only if you remain in the HRA Plan.

How the HRA Plan works

Preventive care – Services are covered at 100% when you use in-network providers.

Annual deductible – You pay the negotiated cost of incurred services, up to your annual deductible. Medical, prescription drug and behavioral health claims all accrue toward your annual deductible.

Coinsurance – After the annual deductible applicable to you is met, you pay 15% (in-network) of the cost of care.

Out-of-pocket maximum – Once you reach the out-of-pocket maximum applicable to you, the plan pays 100% of covered charges. You have no further responsibility for covered expenses under the plan (for the remainder of the current plan year).

Health Reimbursement Account – Funds available in your HRA will be automatically applied to out-of-pocket medical, prescription drug and behavioral health expenses until depleted (includes deductible and coinsurance).

Use of network providers – Cost of services and your responsibility for these costs will vary based on if you use in-network or out-of-network providers. Review the plan summary on the next page for details on how the plan pays in-network and out-of-network claims.

Paying for in-network care

- Present your Anthem ID card at the time of service (when visiting a physician or other covered provider or a pharmacy). Your Anthem ID card serves as your medical, prescription drug and behavioral health ID card.
- Your provider/pharmacy will submit the claim to Anthem or Express Scripts.
- If funds are available in your HRA, the out-of-pocket expense will be paid to the provider/pharmacy automatically.
- If HRA funds have been exhausted, you will pay your provider/pharmacy what is owed.
- Review your Explanation of Benefits (EOB). You will be responsible for paying the negotiated amount (within the deductible) or the applicable coinsurance percentage (after the deductible), up to the out-of-pocket maximum, for the services received.

HRA Plan summary		
AEP annual contribution to HRA		
Participant only	$1,000	
Participant + spouse	$1,500	
Participant + child(ren)	$1,500	
Participant + family	$2,000	
	You pay	
	In-network	**Out-of-network**
Preventive care	$0, no deductible	30%, after deductible
Annual deductible (includes medical, prescription drug and behavioral health)	**Nonembedded deductible***	
Participant only	$1,500	$1,500
Participant + spouse	$2,250	$2,250
Participant + child(ren)	$2,250	$2,250
Participant + family	$3,000	$3,000
Annual out-of-pocket maximum (includes medical, prescription drug and behavioral health)	**Nonembedded out-of-pocket maximum****	
Participant only	$4,000	$6,500
Participant + spouse	$6,000	$9,750
Participant + child(ren)	$6,000	$9,750
Participant + family	$8,000	$13,000
Coinsurance	15%, after deductible	30%, after deductible
Coinsurance for Blue Distinction***	5%, after deductible	n/a
Prescription drugs		
Generic	15%, after deductible	15%, after deductible
Brand-name	15%, after deductible	15%, after deductible

* **Nonembedded deductible** – An individual within a family can satisfy the full family deductible, or it can be a combination of all family members meeting the full annual family deductible. There is no separate individual deductible limit.

** **Nonembedded out-of-pocket maximum** – An individual within a family can satisfy the full out-of-pocket maximum, or it can be a combination of all family members meeting the full family out-of-pocket maximum. There is no separate individual out-of-pocket maximum limit.

*** **Blue Distinction and Blue Distinction Plus** – These terms refer to facilities that are rated to provide high-quality specialty care. As a result, you pay less in coinsurance for certain services performed at these facilities.

MEDICAL PLAN SUMMARIES *(CONTINUED)*

Health Savings Account Plus (HSA Plus) Plan

The HSA Plus Plan provides health care coverage and convenience with an AEP-funded Health Savings Account (HSA) that you can use for out-of-pocket costs associated with your medical plan. In 2019, AEP will contribute the full annual employer contribution to your HSA at the beginning of the calendar year. The amount of AEP's contribution depends on the coverage level you elect. Your account is automatically set up by AEP when you enroll in the plan. You have control of where, when and how you use your HSA funds. You can even save the funds in your HSA and invest them for future expenses. Total contributions to your HSA each year are subject to applicable IRS contribution limits. The HSA is yours to keep if you move to another plan or leave AEP. Any unused balance can be carried over from year to year.

How the HSA Plus Plan works

Preventive care – Services are covered at 100% when you use in-network providers.

Annual deductible – You pay the negotiated cost of incurred services, up to your annual deductible. Medical, prescription drug and behavioral health claims all accrue toward your annual deductible.

Coinsurance – After the annual deductible applicable to you is met, you pay 15% (in-network) of the cost of care.

Out-of-pocket maximum – Once you reach the out-of-pocket maximum applicable to you, the plan pays 100% of covered charges. You have no further responsibility for covered charges under the plan (for the remainder of the current plan year).

Use of network providers – Cost of services and your responsibility for these costs will vary based on if you use in-network or out-of-network providers. Review the plan summary on the next page for details on how the plan pays in-network and out-of-network claims.

2019 HSA IRS contribution limits – IRS rules permit contributions up to $3,500 (self-only coverage) or $7,000 (more than self-only coverage) annually to an HSA. Catch-up contributions of up to $1,000 per year may be made by or on behalf of eligible individuals who will be age 55 or older by December 31, 2019. The limit takes into account contributions made to your HSA by AEP under this plan.

Setting up your HSA

An HSA will be automatically set up for you when you enroll in the HSA Plus Plan. AEP will deposit funds into your account at the beginning of the calendar year. Because you aren't actively working and receiving a paycheck directly from AEP, you can't elect to contribute to an HSA directly through AEP. If you select the HSA Plus Plan, you will receive the employer contribution into an HSA. You can make your own contributions directly to that same account, up to the IRS limits, and deduct those contributions on your federal income tax. Because the HSA Plus Plan has company contributions that are deposited into an HSA for you, you must meet the IRS qualifications for contributing to an HSA as of January 1, 2019, in order to enroll in the HSA Plus Plan.

You **cannot** select the HSA Plus Plan if you anticipate meeting any of the following criteria as of January 1, 2019:

- You are covered by any health plan that is not an HSA-compatible health plan. This includes a spouse's plan as secondary coverage or an executive medical plan.
- You are covered by or planning to enroll in an unlimited Health Care Flexible Spending Account established by you, your spouse or any other family member.
- You are a veteran who has or plans to receive veterans' medical benefits within the three months prior to January 1, 2019.
- You have received medical services from the Indian Health Service within the three months prior to January 1, 2019.
- You can be claimed as a dependent by someone else for the 2019 tax year.
- You are enrolled in Medicare or Medicaid.
- You are active in the military.

For specific information about eligibility to contribute to an HSA and how to use an HSA for eligible health care expenses, consult IRS Publication 969 at **www.irs.gov/pub/irs-pdf/p969.pdf**. More information is also available on the HealthEquity website at **www.healthequity.com/aep** or by calling **1-877-713-7712**.

Paying for in-network care

- Present your Anthem ID card at the time of service (when visiting a physician or other covered provider or a pharmacy). Your Anthem ID card serves as your medical, prescription drug and behavioral health ID card.
- Your provider/pharmacy will submit the claim to Anthem or Express Scripts.
- You have the option to use available funds in your HSA to cover the out-of-pocket expense associated with your claim, or you can use personal funds.
- For pharmacy claims, payment will be required at the time of service, and you can use your HSA or personal funds to cover the expense.
- Review your Explanation of Benefits (EOB). You will be responsible for paying the negotiated amount (within the deductible) or the applicable coinsurance percentage (after the deductible), up to the out-of-pocket maximum, for the services received.

HSA Plus Plan summary		
AEP annual contribution to HSA		
Participant only	$500	
Participant + spouse	$750	
Participant + child(ren)	$750	
Participant + family	$1,000	
	You pay	
	In-network	**Out-of-network**
Preventive care	$0, no deductible	30%, after deductible
Annual deductible (includes medical, prescription drug and behavioral health)	**Nonembedded deductible***	
Participant only	$2,000	$3,000
Participant + spouse	$3,000	$4,500
Participant + child(ren)	$3,000	$4,500
Participant + family	$4,000	$6,000
Annual out-of-pocket maximum (includes medical, prescription drug and behavioral health)	**Embedded out-of-pocket maximum****	
Participant only	$4,000	$6,000
Participant + spouse	$6,000	$9,000
Participant + child(ren)	$6,000	$9,000
Participant + family	$8,000	$12,000
Coinsurance	15%, after deductible	30%, after deductible
Coinsurance for Blue Distinction***	5%, after deductible	n/a
Prescription drugs		
Generic	15%, after deductible	15%, after deductible
Brand-name	15%, after deductible	15%, after deductible

* **Nonembedded deductible** – An individual within a family can satisfy the full family deductible, or it can be a combination of all family members meeting the full annual family deductible. There is no separate individual deductible in the family.

** **Embedded out-of-pocket maximum** – The plan will pay for all covered expenses of a covered individual within the family once the amount shown as the participant only out-of-pocket maximum has been reached. Remaining covered family members' claims will be used toward the out-of-pocket maximum shown for the applicable coverage level.

*** **Blue Distinction and Blue Distinction Plus** – These terms refer to facilities that are rated to provide high-quality specialty care. As a result, you pay less in coinsurance for certain services performed at these facilities.

MEDICAL PLAN SUMMARIES *(CONTINUED)*

Health Savings Account Basic (HSA Basic) Plan

The HSA Basic Plan provides health care coverage and convenience with an optional retiree-funded Health Savings Account (HSA) that you can use for out-of-pocket costs associated with your medical plan. Unlike the HRA and HSA Plus Plans, there is no annual AEP contribution to your HSA or any other account under this plan. Because you aren't actively working and receiving a paycheck directly from AEP, you can't elect to contribute to an HSA directly through AEP. You can open an HSA and make your own contributions directly to the account, up to the IRS limits, and deduct those contributions on your federal income tax. With an HSA, you have control of where, when and how you use your HSA funds. You can even save the funds in your HSA and invest them for future expenses. Total contributions to your HSA each year are subject to applicable IRS contribution limits. The HSA is yours to keep if you move to another plan or leave AEP. Any unused balance can be carried over from year to year.

How the HSA Basic Plan works

Preventive care – Services are covered at 100% when you use in-network providers.

Annual deductible – You pay the negotiated cost of incurred services, up to your annual deductible. Medical, prescription drug and behavioral health claims all accrue toward the applicable annual deductible.

Coinsurance – After the annual deductible applicable to you is met, you pay 10% (in-network) of the cost of care.

Out-of-pocket maximum – Once you reach the out-of-pocket maximum applicable to you, the plan pays 100% of covered charges. You have no further responsibility for covered charges under the plan (for the remainder of the current plan year).

Use of network providers – Cost of services and your responsibility for these costs will vary based on if you use in-network or out-of-network providers. Review the plan summary on the next page for details on how the plan pays in-network and out-of-network claims.

2019 HSA IRS contribution limits – IRS rules permit contributions up to $3,500 (self-only coverage) or $7,000 (more than self-only coverage) annually to an HSA. Catch-up contributions of up to $1,000 per year may be made by or on behalf of eligible individuals who will be age 55 or older by December 31, 2019.

Setting up your HSA

Because you aren't actively working and receiving a paycheck directly from AEP, you can't elect to contribute to an HSA directly through AEP. You can make your own contributions directly to the account, up to the IRS limits, and deduct those contributions on your federal income tax.

You may enroll in this plan, but you are **not** eligible to contribute to an HSA if you meet any of the following criteria as of January 1, 2019:

- You are covered by any health plan that is not an HSA-compatible health plan. This includes a spouse's plan as secondary coverage or an executive medical plan.
- You are covered by or planning to enroll in an unlimited Health Care Flexible Spending Account established by you, your spouse or any other family member.
- You are a veteran who has or plans to receive veterans' medical benefits within the three months prior to January 1, 2019.
- You have received medical services from the Indian Health Service within the three months prior to January 1, 2019.
- You can be claimed as a dependent by someone else for the 2019 tax year.
- You are enrolled in Medicare or Medicaid.
- You are active in the military.

For specific information about eligibility to contribute to an HSA and how to use an HSA for eligible health care expenses, consult IRS Publication 969 at **www.irs.gov/pub/irs-pdf/p969.pdf**. More information is also available on the HealthEquity website at **www.healthequity.com/aep** or by calling **1-877-713-7712**.

Paying for in-network care

- Present your Anthem ID card at the time of service (when visiting a physician or other covered provider or a pharmacy). Your Anthem ID card serves as your medical, prescription drug and behavioral health ID card.
- Your provider/pharmacy will submit the claim to Anthem or Express Scripts.
- If you are contributing to an HSA, you have the option to use available funds in your HSA to cover the out-of-pocket expense associated with your claim, or you can use personal funds.
- For pharmacy claims, payment will be required at the time of service, and you can use your HSA or personal funds to cover the expense.
- Review your Explanation of Benefits (EOB). You will be responsible for paying the negotiated amount (within the deductible) or the applicable coinsurance percentage (after the deductible), up to the out-of-pocket maximum, for the services received.

HSA Basic Plan summary		
AEP annual contribution to HSA	n/a	
	You pay	
	In-network	**Out-of-network**
Preventive care	$0, no deductible	30%, after deductible
Annual deductible (includes medical, prescription drug and behavioral health)	**Embedded deductible***	
Participant only	$2,700	$4,000
Participant + spouse	$5,400	$8,000
Participant + one child	$5,400	$8,000
Participant + children	$8,100	$12,000
Participant + family	$8,100	$12,000
Annual out-of-pocket maximum (includes medical, prescription drug and behavioral health)	**Embedded out-of-pocket maximum****	
Participant only	$4,000	$8,000
Participant + spouse	$8,000	$16,000
Participant + one child	$8,000	$16,000
Participant + children	$12,000	$24,000
Participant + family	$12,000	$24,000
Coinsurance	10%, after deductible	30%, after deductible
Coinsurance for Blue Distinction***	5%, after deductible	n/a
Prescription drugs		
Generic	10%, after deductible	10%, after deductible
Brand-name	10%, after deductible	10%, after deductible

* **Embedded deductible** – A covered individual within a family can satisfy the amount shown as the participant only annual deductible, and coinsurance will be applied to additional covered expenses incurred by that individual. Remaining family members' claims will be used toward the deductible for the applicable coverage level.

** **Embedded out-of-pocket maximum** – The plan will pay for all covered expenses of a covered individual within the family once the amount shown as the participant only out-of-pocket maximum has been reached. Remaining covered family members' claims will be used toward the out-of-pocket maximum shown for the applicable coverage level.

*** **Blue Distinction and Blue Distinction Plus** – These terms refer to facilities that are rated to provide high-quality specialty care. As a result, you pay less in coinsurance for certain services performed at these facilities.

DENTAL PLANS

Your options at a glance

Dental health is an important part of your overall health. Depending on where you live, you may have more than one dental plan option from which to choose. The dental plan options for 2019 are:

- **Aetna Dental Preferred Provider Organization (DPPO) Plan:** Offered in all areas.
- **Aetna Dental Maintenance Organization (DMO) Plan:** Offered in limited areas; availability is based on your ZIP code.
- **No coverage:** You may choose to waive dental coverage. Once you waive AEP retiree dental coverage, you will lose your eligibility for this coverage permanently and will not be able to enroll at a later date.

Limited one-time enrollment opportunity for certain retirees

If you were retirement-eligible at the time that AEP sold an operation on or after November 12, 2015, and you went to work for the buyer of that operation as a part of the sale transaction, and if you waived AEP retiree dental coverage at that time, you may still elect AEP retiree dental coverage, if then available, one time after that sale — either during a future Annual Enrollment or within 31 days of a qualified change in family status. However, if you later waive continuation of that elected AEP retiree dental coverage, you will lose your eligibility for this coverage permanently and will not be able to enroll at a later date.

DPPO Plan

Under the DPPO Plan, you can visit a dentist in the Aetna DPPO Plan network or outside the network; however, you generally pay less out of your own pocket when you visit in-network dentists.

The DPPO Plan pays 100% of your preventive care expenses (subject to frequency limits) with no deductible, up to Aetna's recognized charges. It also pays a percentage of Aetna's recognized charges for most other expenses, after you meet an annual deductible.

The DPPO Plan also has a discount feature. Dentists participating in Aetna's Preferred Dental Program will offer discounted fees for care and services. So, while the percentage you pay for care and services will be the same regardless of the dentist you visit, you may pay less out of your pocket when you visit a preferred dentist. For more information, you can call Aetna at **1-800-243-1809**.

DPPO Plan coverage	
Your annual deductible (applies to basic and major restorative expenses only)	$50 individual/$150 family
Preventive care	Plan pays 100% of eligible expenses (no deductible)
Basic restorative care	Plan pays 80% after deductible*
Major restorative care	Plan pays 50% after deductible*
Orthodontia care (eligible dependent children under age 19)	Plan pays 50% of eligible expenses (no deductible)
Lifetime orthodontia maximum	$1,750/lifetime per covered person
Annual maximum benefit	$1,750/year per covered person

* Up to network discounted rates or recognized charge if out-of-network provider is used.

DMO Plan

If you are enrolled in the DMO Plan for 2018 and you are no longer eligible for the DMO Plan in 2019, you will be automatically defaulted into the DPPO Plan covering the same eligible dependents if you do not make a dental election during Annual Enrollment (October 18 through November 1, 2018).

If you enroll in the DMO Plan, you must choose a primary care dentist (PCD) who participates in Aetna's DMO Plan network. Each covered family member you enroll can select his or her own PCD.

- For assistance confirming dentists who participate in Aetna's DMO network, call Aetna Member Services at **1-800-243-1809**.
- When you visit your PCD to receive covered services, your PCD will verify your eligibility from a member roster.
- You can change your PCD as often as once a month by logging on to Aetna Navigator at **www.aetna.com** or by calling Aetna at **1-800-243-1809**. Any change made on or prior to the 15th of the month will take effect the first of the next month. Any change made after the 15th will take effect the first of the month following the next month.

If you need more information on the DMO Plan, refer to your Summary Plan Description (SPD) and Summaries of Subsequent Changes.

Important note

Aetna cannot guarantee the availability or continued participation of a particular dental provider. Either Aetna or any DPPO Plan or DMO Plan network provider may terminate the provider contract or limit the number of patients accepted in a practice. Before enrolling in a dental plan, it's a good idea to verify that the provider is in-network and is accepting new patients.

For additional information regarding AEP's dental plans, please visit **www.aepbenefits.com**.

DENTAL PLANS *(CONTINUED)*

DPPO Plan/DMO Plan comparison		
Plan feature	**DPPO Plan**	**DMO Plan**
Cost-sharing arrangement	Coinsurance (the percentage of covered expenses you pay)	Copay (the amount you pay at the time of service)
Primary care dentist (PCD) election	Not required	Required at enrollment. Contact Aetna with your election after December 1, 2018.
Annual deductible (the amount you pay before the plan pays)	$50 individual/$150 family	No deductible
Annual maximum (the maximum amount the plan will pay out in a plan year, excludes orthodontia)	$1,750 maximum per year per covered person	No limit
Orthodontics eligibility	Children under age 19	Adults and children
Orthodontics out-of-pocket maximum	No limit	$2,400 copay
Orthodontics lifetime benefit maximum	$1,750 per lifetime per covered child	No limit
Out-of-network benefits	Visit any licensed dentist to receive benefits. You will typically pay lower out-of-pocket costs if you choose a dentist who participates in the Aetna DPPO Plan network.	Contact Aetna at **1-800-243-1809** for state-required benefits (out-of-network coverage not available in Arizona, Texas, North Carolina, New Jersey and California).
Referrals (the PCD directs you to seek dental care from another dental professional)	None required	Referrals are required, except when you visit an orthodontist in the DMO Plan network.
Procedures NOT covered	You are responsible for the cost of procedures not covered by your plan. **Note:** Participating DPPO Plan dentists offer discounts on procedures not covered by the plan.	You are responsible for the cost of procedures not covered by your plan.

Tip

For significant dental expenses, it's always a good idea to have your dentist file a request for predetermination of coverage with Aetna prior to undergoing the procedure.

VISION PLAN

Your options at a glance

AEP offers you vision plan coverage for eye care and vision correction. The vision plan options for 2019 are:

- **AEP Comprehensive Vision Plan:** Offered in all areas.
- **No coverage:** You may choose to waive vision coverage.
  - **Retirees:** Even if you have previously waived AEP vision coverage or do not elect it this Annual Enrollment, you may still elect this coverage in the future — either during a future Annual Enrollment or within 31 days of a qualified change in family status.
  - **Surviving spouses and dependents:** Once you waive AEP vision coverage, you will lose your eligibility for this coverage permanently and will not be able to enroll at a later date.

AEP Comprehensive Vision Plan

AEP's Comprehensive Vision Plan provides coverage through EyeMed Vision Care for eye exams, contacts (including disposable contacts) and eyeglass lenses and frames. It also offers discounts on special features, such as scratch-resistant lenses, laser eye surgery and more.

Proper eye care can lead to the early detection and treatment of vision-related complications. Vision plan participants can take advantage of the discounted retinal-imaging exam option; in addition, members who have Type 1 or Type 2 diabetes are eligible for a follow-up exam and additional testing twice per benefit year.

Benefits are provided through EyeMed's Access national network of private practice optometrists, ophthalmologists, opticians and retailers, such as Sears Optical, Target Optical, most Pearle Vision locations and LensCrafters. Some discounts may not be available at all network providers. Prior to an appointment, you should confirm with your provider whether all EyeMed discounts are offered. To locate an EyeMed network provider, contact EyeMed at **1-866-723-0513** or visit **www.enrollwitheyemed.com/access**.

If you use an out-of-network provider, you will pay in full at the time of your appointment; submit your receipts and claim form to EyeMed and receive reimbursement according to the vision plan coverage table on the next page. Be sure to submit your claim for services and materials (even if purchased on different dates) at the same time to receive the maximum reimbursement.

Refer to the Vision Care Summary Plan Description at **www.aepbenefits.com** for complete details of the benefits under this plan, or contact EyeMed at **1-866-723-0513** or **www.eyemedvisioncare.com**.

EyeMed secondary purchase plan

After your initial benefits have been utilized, you are able to receive the following additional discounts when you use network providers:

- 20% discount off frames or lenses.
- 40% discount off a complete pair of eyeglasses.
- 15% discount off conventional contact lenses.

For additional information regarding AEP's vision plans, please visit **www.aepbenefits.com**.

Accessing your explanation of benefits

Your explanation of benefits (EOB) will automatically be provided in electronic format via EyeMed's member website. If you wish to receive paper EOBs through the mail, contact EyeMed customer service at **1-866-723-0513**.

VISION PLAN *(CONTINUED)*

Vision plan coverage		
Service	**In-network member cost**	**Out-of-network reimbursement**
Exam with dilation as necessary	$0 copay	$35
Retinal imaging benefit	Up to $39	n/a
Exam options		
Standard contact lens fit and follow-up	Up to $55	n/a
Premium contact lens fit and follow-up	10% off retail price	n/a
Frames (any available frame at a provider location)	$0 copay; $135 allowance (20% off balance over $135)	$50
Standard plastic lenses		
Single vision	$10 copay	$25
Bifocal	$10 copay	$40
Trifocal	$10 copay	$55
Lenticular	$10 copay	$55
Standard progressive lenses	$75 copay	$40
Premium progressive lenses	$75 copay; 80% of charge less $120 allowance	$40
Lens options		
UV treatment	$0 copay	$8
Tint (solid and gradient)	$0 copay	$8
Standard plastic scratch coating	$0 copay	$8
Standard polycarbonate (adults)	$40	n/a
Standard polycarbonate (children under 19)	$40	n/a
Standard antireflective coating	$45	n/a
Polarized	20% off retail price	n/a
Other add-ons	20% off retail price	n/a
Contact lenses (allowance includes materials only)		
Conventional	$0 copay; $135 allowance (15% off balance over $135)	$92
Disposable	$0 copay; $135 allowance (plus balance over $135)	$92
Medically necessary	$0 copay; paid in full	$210
Laser vision correction (Lasik or PRK from the U.S. Laser Network)	15% off retail price or 5% off promotional price	n/a
Amplifon Hearing Health Care	For hearing health care from Amplifon Hearing Health Care, network members receive a 40% discount on hearing exams and a low price guarantee on discounted hearing aids.	n/a
Additional pairs benefit	Members receive a 40% discount on complete-pair eyeglass purchases and a 15% discount on conventional contact lenses once the funded benefit has been used.	n/a
Frequency		
Examination	Once every calendar year	
Lenses or contact lenses	Once every calendar year	
Frames	Once every calendar year	

ADDITIONAL VOLUNTARY BENEFITS

Auto & home group insurance

MetLife offers homeowner, auto and other types of property and casualty insurance to AEP participants at group rates. You can get quotes from up to four leading insurance companies. Policies include auto, home, renters, condo, boat, recreational vehicle, landlord's rental dwelling, fire, mobile home and personal excess liability (umbrella).

You may be eligible for one or more policy discounts, such as multicar, antitheft device, safety device (airbags, etc.), good student, resident student, new home, security system, etc. Identity theft resolution service is included in your auto or home policy at no additional cost.

The cost is based on the type of coverage you elect and will be billed to you each month by MetLife. For more information, contact MetLife at **1-800-438-6388** or visit **www.metlife.com/mybenefits**.

If you are currently enrolled in the MetLife Auto & Home Insurance plan, enrollment in 2019 will automatically continue, unless you notify MetLife that you do not want to continue participation. You can enroll or discontinue coverage at any time directly through MetLife.

Pet insurance

All participants are eligible to purchase pet insurance, brought to you by Nationwide. A pet insurance policy provides protection for your pet at discounted group rates. You can also purchase coverage for pet well care (vaccination, dental, heartworm, etc.).

The cost is based on the type of coverage you elect and will be billed to you each month by MetLife. You can enroll or discontinue coverage at any time. Call MetLife at **1-800-438-6388** or visit **www.metlife.com/mybenefits** to enroll.

If you are currently enrolled in pet insurance, enrollment in 2019 will automatically continue, unless you notify MetLife that you do not want to continue participation. You can enroll or discontinue coverage at any time directly through MetLife.

TOOLS AND RESOURCES

Tools to help you learn

We understand it's not always easy to decide which Health & Welfare benefits are best for you and your family. That's why AEP provides you with tools and resources to help you make confident, well-informed decisions. We strongly encourage you to use the available tools and resources before you elect your benefits this Annual Enrollment (October 18 through November 1, 2018).

AEP Benefits Hub – Online information and resources

- Learn about AEP's benefit offerings.
- Utilize the search feature that will allow you to find information quicker and easier.
- Find links and contact information relating to all of AEP's various benefit offerings.
- Access tools and resources to help you make informed decisions about your health.
- Visit **www.aepbenefits.com**.

ALEX, the virtual benefits advisor – Plan selection tool

- Helps you discover your lowest-cost, best-coverage medical plan option.
- Visit **www.myalex.com/aep/2019/retirees**.

Health Navigator, delivered by Castlight – Health care consumerism guide

- Find providers that fit your criteria.
- Quickly compare estimated prices for health care services before you schedule them.
- Compare doctors, medical facilities and health care services based on the estimated price you'll pay and quality of care.
- Look up the discounted cost of a prescription.
- Determine your most cost-effective care option.
- See personalized cost estimates based on your selected location, your medical plan and whether or not you've already paid your deductible.
- Review step-by-step explanations of past medical spending so you know how much you paid and why.
- Receive recommendations about ways to save money and find high-quality care based on your own past care.
- Learn more about this resource and enroll now at **www.mycastlight.com/AEPHealthNavigator**.
- Reach Health Navigator Guides by calling **1-866-259-4428** between 8 am and 9 pm ET, by email at support@castlighthealth.com or by web chat at **www.mycastlight.com/AEPHealthNavigator** between those same hours.

CancerBridge – Personalized cancer guidance

CancerBridge is a cancer information-based navigation service that provides you with personalized access to cancer experts who can answer general questions you have about cancer and its treatment. When you call CancerBridge, you will connect with an oncology nurse who may also bring into the conversation a physician who specializes in the type of cancer diagnosed, if needed. CancerBridge provides immediate, informative guidance at a time of uncertainty; it is not a physician referral service and does not provide medical advice or medical consultations.

To connect with CancerBridge, call **1-855-366-7700** between 8 am and 5 pm ET, Monday through Friday.

Anthem Health Guide – Personalized customer service

- Agents can assist you with questions about your medical plan and claims. They also work closely with health care professionals like nurses, health coaches, social workers and others to make sure you get the benefits information you need when you need it. This combined super-service team is available to guide you through the sometimes confusing health care system.
- Can be reached by phone, email or by web chat. Call **1-877-585-9572** or visit **www.anthem.com**.

LiveHealth Online (LHO) – www.anthem.com

With LHO, you can talk face-to-face with a licensed medical doctor, therapist or psychologist through your computer's webcam, smartphone or tablet, from home or while on the go. Your LHO doctor can assist you with routine medical issues and can provide prescriptions, if needed. You can choose to speak with a general practice doctor or a specialist, such as a pediatric doctor, allergy specialist or breastfeeding coach for new and expecting parents. You can also schedule online consultations with a behavioral health therapist when it's most convenient for you, including evenings and weekends. If you have questions regarding how this service works with your AEP medical plan, please contact Anthem at **1-877-585-9572**. Should you need assistance registering for the service, please call **1-888-548-3432**.

Anthem 24/7 Nurseline – 1-800-700-9184

Day or night, talk with a registered nurse about a health concern at no cost to you.

Anthem Care Management – 1-877-585-9572

Get support and advice related to health care needs such as a hospital stay, surgery and management of a chronic condition, such as diabetes.

ENROLLMENT INSTRUCTIONS

During this year's Annual Enrollment window — October 18 through November 1, 2018 — you will need to elect your 2019 benefits through the AEP Benefits Center, either online or by phone. Simply follow the steps below.

Note: Be sure to take action between October 18 and November 1, 2018. If you do not take action during Annual Enrollment, you will receive default coverage as specified on page 1.

Online

1. Visit **www.ibenefitcenter.com/aep**.
   - **Returning visitor?** Log in with your user name and password. In addition, you will need to enter a temporary numeric code that is sent to you. This process, known as multifactor authentication (MFA), prevents unauthorized access to your account and keeps your information secure.
   - **New visitor?** For your initial login to the AEP Benefits Center website, click **Get Started** and follow the prompts to set up your account. Confirm or enter your email address, which will serve as your user name. You will also need to provide a second contact method (mobile or landline phone number). Select your desired contact method to receive a temporary code. Enter the code into the website when you receive it to confirm your identity.
2. To see your existing elections, click on the **Health** tab, and then click on the **Current Coverages** link at the top of the page. Review your existing elections and determine whether you'd like to make any changes for 2019. Some elections do not carry over from year to year; refer to the "Do You Need to Take Action?" section of this guide for more details. Refer to page 18 of this guide for additional tools and resources that can assist you in the decision-making process.
3. When you're ready to make your elections, return to the **Home** page and click **Enroll Now**. You may be prompted to answer several questions to determine your eligibility. Answer each question appropriately and click **Continue**. After answering all of the questions, you will come to a **My Benefit Election Summary** page. To change an existing election, click on the **Change** button located to the left of the election you wish to change. You can view your associated dependents on the **My Benefit Election Summary** page under **Covered Family Members**.
4. Once you are satisfied, click **Submit My Elections**. You will then see a screen verifying that your elections have been submitted. It's highly recommended that you click **Print** to review all of the elections you submitted. You can either print the confirmation or save the document to your computer/device for your records. **You can review your elections or make changes as many times as you would like during the enrollment period** (refer to step 3 above). Your most recent submitted elections will supersede any prior elections.

By phone

If you have questions or need help enrolling, experienced service representatives are ready to help. Call the AEP Benefits Center at **1-888-237-2363 (1-888-AEP-BENE)**, option 1, between 8 am and 5 pm ET, any business day, and confirm your identity to speak with a representative. Representatives are also available for online chats at **www.ibenefitcenter.com/aep** during those hours, or you can email a representative from the website anytime.

In mid-November, if you confirm your same elections for 2019, make any changes to your elections or do not take action and any default elections are applied, you will receive a paper confirmation statement in the mail; please review it carefully for accuracy. If you find any discrepancies, contact the AEP Benefits Center immediately.

CONTACT INFORMATION*

If you have a question about	Contact this provider	Phone	Website
AEP retiree website			www.aepretirees.com
Auto & home group insurance and pet insurance	MetLife	1-800-438-6388	www.metlife.com/mybenefits
Dental plans	Aetna	1-800-243-1809	www.aetna.com
General benefit inquiries	AEP Benefits Center	1-888-237-2363 (1-888-AEP-BENE), option 1	www.ibenefitcenter.com/aep
Health care decision guidance	Castlight	1-866-259-4428	www.mycastlight.com/AEPHealthNavigator
Health Savings Account (HSA)	HealthEquity	1-877-713-7712	www.healthequity.com/aep
Medical/behavioral health services/LiveHealth Online	Anthem Blue Cross Blue Shield	1-877-585-9572	www.anthem.com
Personalized cancer guidance	CancerBridge	1-855-366-7700	No website available
Prescription drug program	Express Scripts	1-800-841-3045	www.express-scripts.com
Vision plan	EyeMed	1-866-723-0513	www.eyemedvisioncare.com

* This is a list of possible provider contact information. It does not imply you are a participant of each plan.

BENEFITS ELIGIBILITY AND COVERAGE

When coverage begins

The elections you make this Annual Enrollment take effect on January 1, 2019, and continue through December 31, 2019, unless you have a qualifying change in family or employment status as described in the "Changing coverage during the year" section of this guide.

When coverage ends

Your coverage in the plans ends on the last day of the month in which:

- Your required contributions are not paid.
- The plan ends.
- You are no longer eligible.
- You elect to enroll in a Medicare Part D prescription drug program other than the AEP-sponsored Part D plan (which would disqualify you from the medical and prescription drug plan only).
- You die.

Coverage for your dependents ends on the last day of the month in which:

- Your coverage ends.
- Your dependent enrolls in a Medicare Part D prescription drug program other than the AEP-sponsored Part D plan (which would disqualify your dependent from the medical and prescription drug plan only).
- Your dependents are otherwise no longer eligible.

If your coverage under the medical, dental or vision plan ends, you and your dependents may, under certain circumstances, be eligible to continue coverage under COBRA. Also see "Surviving spouse and dependent eligibility for AEP benefits" section of this guide.

Changing coverage during the year

After the Annual Enrollment period for your 2019 benefits (October 18–November 1, 2018), you may not elect to change or cancel your coverage until the next Annual Enrollment period unless you experience a qualifying life event that affects your eligibility for coverage, and you process that change through the AEP Benefits Center no later than 31 days after it occurs. In addition, a change can only be made if it is due to, and consistent with, the qualifying life event that affects your eligibility for coverage.

A qualifying life event may include:

- Change in your legal marital status, including marriage, divorce or annulment.
- Change in the number of your dependents — including birth, adoption of a child, placement for adoption or acquiring a child through marriage or legal guardianship.
- Death of your spouse or a covered dependent child.
- Gain or loss of legal custody of a dependent.
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements, including attainment of limiting age.
- A significant change in your health coverage or the coverage provided through your spouse's employment.
- A change in the employment status of you, your spouse or your dependent (part-time to full-time, commencement or termination of employment, etc.).
- Taking or returning from an unpaid leave of absence for your spouse.
- A court order requiring a change in coverage.
- A change in residence that affects your eligibility for coverage.
- You or your covered dependent becomes eligible for Medicare.

To process a qualifying life event and change your coverage, you may:

- Log on to **www.ibenefitcenter.com/aep**, go to the **Health** tab, then click on the **Life Status Change** link and follow the prompts to enter your changes and elect your new coverage.
- Or call the AEP Benefits Center at **1-888-237-2363 (1-888-AEP-BENE)**, option 1, between 8 am and 5 pm ET, any business day, and confirm your identity to speak with a representative.

Coverage changes due to a qualified life event become effective the day the change in status occurred, as long as you processed the event within 31 days.

BENEFITS ELIGIBILITY AND COVERAGE *(CONTINUED)*

Other opportunities to enroll/change coverage outside of Annual Enrollment

- If you decline coverage for yourself or your dependents because you have other medical or vision coverage, you may be able to enroll yourself or your dependents in the AEP medical or vision plan at a later date if you lose that other coverage. Also, if you add a dependent as a result of a marriage, birth or the placement of a child through adoption or legal guardianship, you may be able to enroll other eligible dependents in that plan.
- You may request enrollment in the AEP medical plan midyear if you notify the AEP Benefits Center within 31 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.

Your eligibility for AEP retiree benefits

You are eligible to participate in the retiree benefits if you were an active, full-time or permanent part-time employee who was last hired or rehired by a participating AEP company on or before December 31, 2013, or if you retired from a participating AEP company and you were at least age 55 with 10 or more years of service* on your retirement date. In addition, if you were rehired by a participating AEP company on or after January 1, 2014, you may remain eligible to elect medical coverage for yourself and your eligible dependents upon your later retirement if you were eligible to elect retiree medical benefits upon your pre-2014 termination of employment with AEP. If you were disabled when you elected to take a distribution from the company-provided qualified defined benefit pension plan, you may be eligible for benefit coverage. Refer to the AEP Comprehensive Medical Plan Summary Plan Description for Retirees and Surviving Dependents Age 65 and Older, issued 2017, found in the "Plan Information" section of **www.ibenefitcenter.com/aep**.

You are not eligible for retiree benefits if you were subject to a collective bargaining agreement that does not provide specifically for coverage under a particular plan.

* You will not receive service credit toward eligibility for retiree coverage for any service during which you were classified as a temporary employee, independent contractor or leased employee or otherwise paid for your services based upon a fee or contract.

Surviving spouse and dependent eligibility for AEP benefits

- **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, dental and/or vision coverage until the earlier of age 65 or remarriage, if the surviving spouse was enrolled in those plans at the time of the employee's death. Surviving dependent children of an active employee who was not retiree-benefit-eligible on the date of death can elect to continue medical, dental and/or vision coverages until they reach the limiting age (see the "Eligible dependents" section of this guide), if the surviving dependent child was enrolled in those plans 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 to continue medical, dental and/or vision coverage until remarriage if the surviving spouse was enrolled in those plans at the time of the employee's death. Surviving dependent children of an active employee who was retiree-benefit-eligible on the date of death can elect to continue medical, dental and/or vision coverages until they reach the limiting age (see the "Eligible dependents" section of this guide), if the surviving dependent child was enrolled in those plans at the time of the employee's death.
- **Survivors of retirees:** Surviving spouses of retirees can elect medical, dental and/or vision coverage until remarriage, if the surviving spouse was enrolled in the medical, dental and/or vision plans at the time of the retiree's death. Surviving dependent children of retirees can elect medical, dental and/or vision coverage until the limiting age (see the "Eligible dependents" section of this guide) if the surviving dependent child was enrolled in those coverages at the time of the retiree's death.

Paying for coverage

Your cost of coverage under the AEP benefit program will depend on:

- Your eligibility for a grandfathered retirement group, if applicable.
- The dependents you elect to cover.
- The option in which you enroll.

Unless you are in a grandfathered group, your contributions for retiree medical coverage for 2019 are based on your age and years of service at retirement, as follows:

Age + years of service	Contribution percentage of total cost
65–69	46%
70–74	42%
75–79	36%
80–84	32%
85–89	26%
90–94	22%
95+	20%

Your 2019 Personalized Enrollment Worksheet provides your monthly cost for each of the benefit options available to you. If you receive a monthly pension benefit, your contribution will generally be deducted from your pension check. Otherwise, you will be billed monthly for your contribution.

Important note

Failure to make required contributions will result in the termination of coverage and may prohibit your future enrollment in AEP plans.

Coverage levels

When you enroll in either the medical, dental or vision plan, you may also choose whom you want to cover. Your coverage level and cost is based on the dependents you enroll. Coverage levels include:

- Participant* only.
- Retiree + spouse.
- Retiree or surviving spouse + child(ren).
- Retiree + family.

You may choose the same or different coverage levels for the medical, dental and vision plans. You must enroll in coverage before you can enroll your eligible dependents.

* A retiree's surviving spouse or surviving child will be considered a "participant" only if described in the "Surviving spouse and dependent eligibility for AEP benefits" section on the previous page.

BENEFITS ELIGIBILITY AND COVERAGE *(CONTINUED)*

Eligible dependents*

It is important that you review the AEP dependent eligibility definitions to ensure that all of your covered dependents or any dependents you want to add during Annual Enrollment meet the eligibility requirements. If any one of your currently covered dependents no longer meets the eligibility requirements listed, you should contact the AEP Benefits Center as soon as possible to report this information. **Covering ineligible dependents under your AEP medical, dental or vision plans is considered a violation of AEP's rules of conduct and could subject you to disciplinary action, up to and including termination of benefits.**

Note: Your eligible dependents do not include any individual who is also covered as an AEP employee or retiree or who is covered by another AEP employee or retiree as a dependent.

* Surviving dependents may be covered only if they also are described in the "Surviving spouse and dependent eligibility for AEP benefits" section of this guide.

Your eligible dependents include your:

Legal spouse:

Note: Upon termination of your marriage (by divorce, legal separation by a court decree or otherwise), a spouse ceases to be eligible for coverage regardless of whether the divorce decree or court order requires you to provide coverage for your former spouse. It is your responsibility to inform the AEP Benefits Center of the termination of your marriage. **Failure to do so within 60 days after the date the marriage ends will not prevent their loss of coverage retroactively BUT WILL result in their loss of eligibility to elect COBRA continuation coverage.**

Children:

To qualify for coverage, your dependent child(ren) must meet all of the following criteria:

- Child is under age 26, and the child is:
  - Your natural child or the natural child of your spouse.
  - Or a child legally adopted by you or your spouse or placed with you or your spouse for adoption.
  - Or your foster child.
  - Or a child who resides in your household for whom you or your spouse is the court-appointed guardian.
  - A child for whom you are required to provide coverage as a result of a Qualified Medical Child Support Order (QMCSO).
  - Any other child you claim as a dependent on your federal income tax return, provided that neither natural parent of the child lives with the child and you are acting as the child's guardian.

Disabled dependents:

To qualify for coverage beyond the child-limiting age, your disabled child(ren) must meet all the criteria listed under the "Children" section above plus:

- Disability must have occurred prior to age 26.
- Remain continuously covered.

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

Tax considerations when covering your dependents

Certain AEP benefits qualify for tax advantages (such as nontaxable employer contributions) only to the extent that they cover the employee's dependents as defined for tax purposes. AEP allows you to provide medical coverage for certain dependents who may not qualify as your tax dependents. As a result, the contributions you make for their coverage may not qualify for tax-favored treatment, and you will be subject to imputed income on the value of the company-paid portion of their coverage and be taxed accordingly.

If your dependent child qualifies under any of the following relationships and has not attained age 27 before the end of the year, he or she is considered your qualified tax dependent for group health plan purposes:

- Your son or daughter.
- Your stepson or stepdaughter.
- Your foster child (placed with you by an authorized placement agency or by court order).
- Your or your spouse's adopted child.
- A child placed with you or your spouse for adoption.

If your dependent child does not qualify under any of the relationships listed above, you should review the additional information provided on the AEP Benefits Center website before you enroll to help you determine whether your child qualifies as a tax dependent for group health plan purposes.

Important note

Dependent Social Security numbers, or tax identification numbers for non-US citizens, must be provided to AEP within six months of adding a dependent. You must enroll your dependent within 31 days of a qualifying event (or within 90 days of birth or adoption of a newborn), even if a Social Security number has not yet been obtained.

If both you and your eligible dependents have AEP benefits

If both you and your spouse or eligible dependents are eligible for an AEP benefit plan as an AEP retiree or employee:

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

NOTES

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