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**American Electric Power (AEP)  
System Comprehensive Medical Plan  
HRA Plan Option**

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Summary Plan Description for Active Employees, Retirees and Surviving Dependents

Under Age 65

Issued 2016

## Summary Plan Description

AEP is committed to providing eligible employees and their families the opportunity to purchase quality health care at a cost they and the company can afford. The AEP System Comprehensive Medical Plan is comprised of several medical plan options which vary by location. The HSA Basic Plan, the HSA Plus Plan and the Health Reimbursement Account (HRA) Plan are options available to all eligible employees and their families. In a few other locations, you may also have an HMO option.

This is a summary of the HRA Plan option under the American Electric Power System Comprehensive Medical Plan (the Plan or Group Health Plan) as in effect on January 1, 2016. A summary of the HSA Basic and the HSA Plus Plan options is contained in a separate booklet.

The summary descriptions of any Plan option is not intended as an employment contract or a guarantee of current or future employment. The Company reserves the right to amend, modify, suspend, or terminate the Plan, in whole or in part, at any time, at its discretion. Any such action may be taken with or without advance notice to participants, subject to applicable law. The Company further reserves the right to change the amount of required participant contributions for coverage under any option at any time, with or without advance notice to participants.

This Summary Plan Description (SPD) is one of the Plan documents that apply to the benefits described in this booklet. In the event of a conflict between this Summary and any Plan document that is not included in this summary, the applicable Plan documents shall govern. For fully insured benefits, any discrepancy will be governed by the insurance certificates or policies.

The following Claims Administrators have been designated by AEP to provide administrative services for this option under the Plan, such as claims processing, care management, and other services, and to arrange for a network of health care Providers whose services are covered by the Plan:

- Medical Benefit Claims – Anthem Blue Cross and Blue Shield, or “Anthem”
- Behavioral Health Benefit Claims – Magellan Healthcare Inc. or “Magellan”
- Prescription Drug Benefit Claims – Express Scripts, Inc. or “Express Scripts”

Important: This is not an insured benefit Plan. The benefits described in this SPD or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem, Magellan and Express Scripts provide administrative claims payment services only and do not assume any financial risk or obligation with respect to claims.

**NOTE:** As context permits, words and phrases within this document that are denoted with initial capitalization have the meaning ascribed to them within the document itself, or within the “Definitions” section.

**Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.**

**If you need assistance in Spanish to understand this document, you may request it for free by calling Customer Service at the number on your Identification Card.**

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## Your Medical Plan Options at a Glance

The AEP System Comprehensive Medical Plan offers three consumer-directed health plan options (CDHPs) to eligible employee and to electing eligible retirees and surviving dependents who have not reached age 65. Electing eligible retirees and surviving dependents who have reached age 65 should refer to the separate Summary Plan Description for the AEP Comprehensive Medical Plan applicable to them for additional information regarding their medical benefits.

The FirstCare HMO option is available only in certain ZIP codes in West and Central Texas.

The three CDHP options are:

- **HRA** – CDHP with an AEP-funded Health Reimbursement Account (HRA).
- **HSA Plus** – CDHP with a Health Savings Account (HSA) that allows both AEP funding and optional funding via payroll deduction (for active employees only) or via deposits made directly to the account.
- **HSA Basic** – CDHP with an optional Health Savings Account (HSA) that allows employee funding via payroll deduction (for active employees only) or via deposits made directly to the account.

General medical claims under each of the CDHP options are administered by Anthem Blue Cross and Blue Shield and each is available in all areas.

## What's included?

All of AEP's medical plan options include coverage under the prescription drug program, behavioral health and fully covered in-network preventive care (meaning you pay nothing for immunizations, routine annual exams, adult screenings and routine colonoscopies as long as you receive this type of care from in-network providers).

## Health Reimbursement Account (HRA plan)

The HRA Plan option provides medical coverage and convenience with an AEP-funded account that is used for covered out-of-pocket costs associated with your medical plan. AEP contributes to your HRA annually. 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 gets applied automatically to your medical and prescription drug claims until it is gone. However, until the process can be changed, it relies on you to submit to Anthem the Explanation of Benefits (EOB) forms that you receive from Magellan in order to verify your entitlement to reimbursement from the HRA for expenses you incur for behavioral health services. You cannot make contributions to the HRA account. Any unused balance can be carried over from year to year only if you remain in the HRA plan.

## How it works

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

**Annual deductible** – You pay the negotiated cost, up to your annual deductible, except to the extent there is an available balance in your HRA. Medical, prescription drugs and behavioral health claims all accrue toward your annual deductible.



**Coinsurance** – After your annual deductible is met, you pay 15% (in-network) of the cost of care, except to the extent there is an available balance in your HRA.

**Out-of-pocket maximum** – Once you reach the out-of-pocket maximum, 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).

**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 chart on the next page for more detail on how the plan pays in-network and out-of-network claims.

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

\* **Non-embedded 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.

\*\* **Non-embedded 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** – 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.

## Health Savings Account Plan Options

The Plan offers two options which may provide you the ability to fund a Health Savings Account (HSA).

The HSA Plus plan option provides health care coverage and convenience with an AEP-funded account that you can use for out-of-pocket medical costs. AEP contributes to an HSA that is set up for you in conjunction with your enrolling in this option. The amount of AEP's contribution depends on the coverage level you elect.

The HSA Basic plan provides health care coverage and convenience with an optional employee-funded HSA that you can use for out-of-pocket costs. Unlike the HRA and HSA Plus plan options, there is no annual AEP contribution to your HSA or any other account under this option.

The federal income tax code imposes limitations on the contributions that may be made each year to an individual's health savings account. If you want to learn more about those limitations, you may read IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans). AEP also may impose limitations on the ability of certain individuals to enroll in the HSA Plus Plan option. Please refer to the enrollment guide applicable upon your initial enrollment or any subsequent annual enrollment to learn more about any limitations that may be applicable to you.

You have control of where, when and how you use your HSA funds. You can even save the funds in your HSA account and invest them for future expenses. You also may be able to contribute through payroll deduction on a before-tax basis to your HSA account, up to IRS contribution limits. Your HSA is yours to keep even if you move to another plan or leave AEP. Any unused balance remains in your HSA regardless of whether you remain in the AEP plan or any of its benefit options.

### How it works

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

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

**Coinsurance** – After the annual deductible applicable to you has been met, you pay a percentage (in-network – 15% for HSA Plus and 10% for HSA Basic) 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 charts immediately below for more detail on how each of the HSA Plus and HSA Basic options pay in-network and out-of-network claims.

**HSA contribution limits** – There is a limit on the amount that can be contributed to your HSA each year. That limit takes into account the contribution made to your HSA by AEP under the HSA Plus option.

<b>HSA Plus Plan Option Summary</b>		
<b>AEP Annual Contribution to HSA</b>		
Participant only	\$500	
Participant + spouse/domestic partner	\$750	
Participant + child(ren)	\$750	
Participant + family	\$1,000	
<b>Preventive care</b>	<b>In-network</b>	<b>Out-of-network</b>
	<b>You pay</b>	
	\$0, no deductible	30%, after deductible
<b>Annual deductible</b> (includes medical, prescription drug and behavioral health)	<b>Nonembedded deductible*</b>	
Participant only	\$2,000	\$3,000
Participant + spouse/domestic partner	\$3,000	\$4,500
Participant + child(ren)	\$3,000	\$4,500
Participant + family	\$4,000	\$6,000
<b>Annual out-of-pocket maximum</b> (includes medical, prescription drug and behavioral health)	<b>Embedded out-of-pocket maximum**</b>	
Participant only	\$4,000	\$6,000
Participant + spouse/domestic partner	\$6,000	\$9,000
Participant + child(ren)	\$6,000	\$9,000
Participant + family	\$8,000	\$12,000
<b>Coinsurance</b>	15%, after deductible	30%, after deductible
<b>Coinsurance for Blue Distinction***</b>	5%, after deductible	n/a
<b>Prescription drugs</b>		
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** – 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.

<b>HSA Basic Plan Option Summary</b>		
<b>AEP Annual Contribution to HSA</b>	n/a	
<b>Preventive care</b>	<b>In-network</b>	<b>Out-of-network</b>
	<b>You pay</b>	
	\$0, no deductible	30%, after deductible
<b>Annual deductible</b> (includes medical, prescription drug and behavioral health)	<b>Embedded deductible*</b>	
Participant only	\$2,700	\$4,000
Participant + spouse/domestic partner	\$5,400	\$8,000
Participant + 1 child	\$5,400	\$8,000
Participant + child(ren)	\$8,100	\$12,000
Participant + family	\$8,100	\$12,000
<b>Annual out-of-pocket maximum</b> (includes medical, prescription drug and behavioral health)	<b>Embedded out-of-pocket maximum**</b>	
Participant only	\$4,000	\$8,000
Participant + spouse/domestic partner	\$8,000	\$16,000
Participant + 1 child	\$8,000	\$16,000
Participant + child(ren)	\$12,000	\$24,000
Participant + family	\$12,000	\$24,000
<b>Coinsurance</b>	10%, after deductible	30%, after deductible
<b>Coinsurance for Blue Distinction***</b>	5%, after deductible	n/a
<b>Prescription drugs</b>		
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 towards 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** – 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.

Please refer to the separate Summary Plan Description for the AEP Comprehensive Medical Plan (HSA Plan Options) for additional information regarding the HSA Plus and HSA Basic plan options.

## FirstCare HMO Plan Option

The FirstCare HMO is available in parts of West and Central Texas. You may contact the AEP Benefits Center for assistance in determining whether you are eligible for the FirstCare HMO. You may also contact FirstCare HMO directly for specific plan information at [www.firstcare.com](http://www.firstcare.com).

<b>FirstCare HMO Plan Option Summary</b>	
<b>Plan features (in-network)</b>	<b>You pay</b>
<b>Annual medical deductible</b>	No deductible
<b>Annual medical out-of-pocket maximum</b> (includes medical coinsurance and copays; does not include prescription drugs)	\$3,000 participant/\$6,000 family
<b>Office visit – primary care provider</b>	\$20 copay
<b>Office visit – specialist</b>	\$30 copay
<b>Coinsurance</b>	15%
<b>Annual preventive maximum</b>	No limit
<b>Emergency room</b>	15% coinsurance
<b>Urgent care</b>	\$50 copay
<b>Routine lab/X-rays</b>	No copay
<b>Chiropractic care</b>	\$30 copay; medical director authorization required
<b>Annual prescription deductible</b>	Retail: \$50 individual/\$150 family; Mail: \$0
<b>Annual prescription out-of-pocket maximum</b>	\$1,000 individual /\$3,000 family includes annual prescription deductible)
<b>Generic prescription benefit</b>	Retail: \$10 copay; Mail: \$20 copay
<b>Brand-name prescription benefit</b>	Retail, preferred brand-name drug: 20% coinsurance (\$20 minimum/\$100 maximum)* Retail, nonpreferred brand-name drug: 35% coinsurance (\$35 minimum/\$200 maximum)* Mail, preferred brand-name drug: 20% coinsurance (\$50 minimum/\$200 maximum)* Mail, nonpreferred brand-name drug: 35% coinsurance (\$90 minimum/\$300 maximum)*

\* If you purchase a brand-name drug and a generic drug is available, you will pay the generic copay plus the difference in cost between the brand-name and generic drug regardless of your doctor's dispense-as-written instructions. All other rules described in the "Prescription Drug Benefits Program" section of this SPD (such as Exclusive Home Delivery, Preferred Drug Step Therapy, Member Pays Difference, Precertification, Preventive Drugs, Limitations and Exclusions, and the use of in- and out-of-network (participating and non-participating) pharmacies, apply.

## Eligibility

**Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.**

## Active Employees

This SPD describes the benefits an Employee may receive under this health care Plan. The Employee is also called a Subscriber.

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

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

- A part-time active employee scheduled to work an average of at least 20 hours per week.

You are not eligible to participate if you are:

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

## **Retirees**

You remain eligible to elect medical coverage for yourself and your eligible dependents if you were last hired or rehired by an AEP Participating System Company on or before December 31, 2013 and you are at least age 55 with 10 or more years of service with a Participating AEP Company at retirement. In addition, if you are rehired by a Participating AEP System Company on or after January 1, 2014, you may remain eligible to elect medical coverage for yourself and eligible dependents upon your later retirement if you were eligible to elect retiree medical benefits upon your pre-2014 termination of employment with AEP.

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

The benefits available to an eligible retiree once the Retiree is age 65 and become eligible for Medicare are described in a separate Summary Plan Description booklet. Please contact the AEP Benefits Center if you would like to be provided a copy of the summary plan description currently in effect with respect to those benefits.

## **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 was 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 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 dependents 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 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 dependents of retirees can elect medical coverage until the limiting age (see the "Dependent Eligibility" section), if the surviving dependent was enrolled in medical coverage at the time of the retiree's death.

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

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

## Participating AEP System Companies

Eligibility to participate in the Plan depends, in part, on employment with a Participating AEP System Company (generically called the "company" in this SPD). 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 Partners, Inc.
- AEP Energy Services, Inc.
- AEP Generation Company
- AEP Generating 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 allows Employees and Retirees covered by the Plan to purchase coverage for their eligible dependents. Survivors of active employees or Retirees generally cannot enroll any of their own dependents who were not covered by the medical plan at the time of the Employee's or Retiree's death. Covered Dependents are also called Members. Eligible dependents include the Employee's or Retiree's:

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

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

To qualify 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.



Note: The FirstCare HMO medical plan option also allows you to cover your grandchildren whom you claim as a dependent on your federal income tax return at the time of his or her initial enrollment, regardless of whether the child's natural parent resides with you or you are acting as the grandchild'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 Dependent 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.

## Tax Considerations When Covering Your Dependents

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

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

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

## State Eligibility Laws and ERISA

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

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

While an insurer (e.g., under a fully insured benefit option like the HMO 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."

## Enrolling For Coverage

### How and When to Make Enrollment Elections and Changes

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

#### As a New Employee

As a newly eligible employee of a Participating AEP System Company, you will receive information and instructions about how to enroll for your benefits. You must indicate your medical election either online or by phone to the AEP Benefits Center within 31 days of your date of hire. If you do not enroll within 31 days, you will be considered to have elected the default coverage which is the HSA Basic Plan option for yourself only, and to have your share of the cost for that coverage deducted from your paychecks.

#### **Social Security Numbers Generally Required for Enrollment**

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

For a newborn child, the newborn may be enrolled under your coverage without a Social Security number (provided you request the enrollment 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.

### **As a New Retiree**

Your coverage in effect as an active employee will automatically continue into retirement. If you are under age 65 at the time of your retirement and enrolled in the AEP Medical Plan, you will continue being enrolled in the same option under the plan, covering the same eligible dependents. If you are over age 65 at the time of your retirement and enrolled in the AEP Medical Plan, you will be automatically enrolled into the Maintenance of Benefit (MOB) option applicable to post-age 65 retiree, covering the same eligible dependents. If you wish to drop coverage or add/remove dependents at the time of your retirement, you must do so by contacting the AEP Benefits Center within 31 days of your retirement. You may NOT change options under the AEP Medical Plan due to your retirement event (although post-age 65 retirees may have the opportunity to select an option other than the default MOB option).

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

### **Late Enrollees**

If an Employee or Retiree or their Dependents are not enrolled when first eligible, it generally will be necessary to wait for the next annual enrollment period. However, the Employee or Retiree or their Dependents may be eligible for a mid-year enrollment under certain circumstances. See "Making Changes During the Year" section.

### **As a New Surviving Dependent**

As a new AEP surviving spouse or dependent, if all contributions are paid up to date at the time of the Employee's or Retiree's death, you will automatically be enrolled in the same medical plan option you had as of the date of death if under age 65. You may NOT change medical plan options. If you are over age 65 as of the date of death then you will automatically be enrolled in the Maintenance of Benefit (MOB) plan. If you do not wish to continue coverage as a surviving spouse or dependent (or, if you are over 65 and want to select an option other than the default MOB option), you must contact the AEP Benefits Center within 31 days of the Employee's or Retiree's death. If you choose not to enroll in 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.

### **Annual Enrollment**

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

## **Making Changes During the Year**

In general, after you enroll in benefits (or choose to waive a benefit), you may not add, change or cancel your election choices during the year until the next Annual Enrollment period. 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. If you experience a qualifying change in status, you can make certain mid-year changes to your medical coverage elections. Examples of these qualifying life events and what you need to do relative to your medical coverage are listed in the “Life Events and Your Coverage” section.

## **Covering Your Family**

When you enroll yourself in medical coverage, you decide if you want to enroll your eligible dependents. You can choose one of the following coverage levels:

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

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

## **Nondiscrimination**

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

## **Waiving Coverage**

You may waive coverage under the AEP Comprehensive Medical Plan. If you elect to waive coverage for yourself, you automatically waive coverage for your eligible dependents.

Note: If you are an Employee, even if you waive coverage for AEP’s medical plan, you and your covered dependents are eligible to use the Employee Assistance Program (EAP) offered by AEP as a stand-alone benefit at no cost to you. The EAP vendor is Magellan. The EAP offers confidential, professional, short-term counseling and referral services to all AEP employees, their spouses or eligible domestic partners and dependent children to age 26. EAP services can be accessed by calling Magellan at 1-877-705-4357 or online at [www.magelleanhealth.com/member](http://www.magelleanhealth.com/member). Please refer to the “Employee Assistance Program” section of this SPD for more details.

## **Qualified Medical Child Support Order (QMCSO)**

In some cases, you may be required by a court or administrative order to cover a dependent child under one or more group health plans. Federal law requires group health plans, including the AEP Comprehensive Medical Plan, 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 to the AEP Benefits Center. Once you or your dependent furnishes a court or administrative order to the AEP Benefit Center, you and each affected child you will be informed of receipt of the order and will be provided a copy of the procedures for determining if the order is a QMCSO. Subsequently, the interested parties will be notified of the determination. You may also obtain a copy of the QMCSO administrative procedures, free of charge, by contacting the AEP Benefits Center.

## **Cost of Coverage**

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

## **Employees**

You and AEP share the cost of your medical coverage. Your monthly contribution for medical coverage is automatically deducted from 24 paychecks per year. For any period that your paycheck is not sufficient to cover your cost, you will have to make payments as directed at that time.

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

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

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

## **Retirees and Surviving Dependents**

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

## **When Coverage Begins**

### **For new hires**

If you fail to waive coverage under the AEP Comprehensive Medical Plan within 31 days of your date of hire as an eligible employee, coverage under the option you select (or the option into which you are defaulted) begins on your date of hire. Coverage for your enrolled dependents begins the same day that your coverage begins.

### **For new retirees**

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

### **For newly surviving dependents**

If you fail to waive coverage as a surviving dependent, your coverage continues the first of the month following the date of the employee's or retiree's death.

## **During Annual Enrollment**

If you make changes to your medical plan coverage during the Annual Enrollment period, the elected coverage for you and your enrolled dependents begins on January 1 of the following year and continues through December 31.

## **If You Make Changes During the Year**

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

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

## **Member Rights and Responsibilities**

While you are a Member you have rights and responsibilities when receiving health care. As your health care partner, the each Claims Administrator wants to make sure your rights are respected while providing your health benefits. That means giving you access to each Claims Administrator's network health care Providers and the information you need to make the best decisions for your health. As a Member, you should also take an active role in your care.

### **You have the right to:**

- Speak freely and privately with your health care Providers about all health care options and treatment needed for your condition no matter what the cost or whether it is covered under your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect the Claims Administrator to keep your personal health information private by following the Claims Administrator's privacy policies, and state and Federal laws.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
  - The Claims Administrator's company and services.
  - The Claims Administrator network of health care Providers.
  - Your rights and responsibilities.
  - The rules of your health Plan.
  - The way your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care you receive.
  - Any Covered Service or benefit decision that your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may get in the future. This includes asking your Doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

### **You have the responsibility to:**

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your health care Providers if you don't understand any type of care you are getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care Providers.

- Give the Claims Administrator, your Doctors and other health care Providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health Plan. This may include information about other health coverage benefits you have along with your coverage with the Plan.
- Inform Member Services if you have any changes to your name, address or family members covered under your Plan.

Each Claims Administrator wants to provide high quality customer service to the Plan's Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan and not by this Member Rights and Responsibilities statement.

## Contacting the AEP Benefits Center

The AEP Benefits Center is available to assist you with questions regarding your eligibility, enrollment and participation in the Plan. You may contact the AEP Benefits Center at the following address by calling 1-888-237-2363, by visiting the AEP Benefits Center web site ([www.ibenefitcenter.com/aep](http://www.ibenefitcenter.com/aep)) or by mail at the following address:

AEP Benefits Center  
P.O. Box 622  
Des Moines IA 50306-0622

## HRA Plan Generally

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the "Definitions" and "Claims Payment" sections for more information.

Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are your responsibility, such as Deductibles or Coinsurance, the Claims Administrator may collect such amounts directly from you. You agree that the Claims Administrator has the right to collect such amounts from you.

## Welcome to the Health Reimbursement Account (HRA) Plan!

The Health Reimbursement Account (HRA) plan is an innovative approach to health benefits for eligible Employees of Participating AEP System Companies (generically, the "company" or your "Employer"). With the HRA plan, you have health coverage available to you for which you and the company share the cost. This coverage has two components designed to work together to provide you flexibility and control in choosing the health care services you and your family members receive and in choosing how the cost of these services are paid. Bottom line, the plan is designed to help you — and your family — take control of your health care dollars and decisions.



## The HRA Plan – In Brief

The components of the plan are:

### 1. Health Reimbursement Account (HRA)

As a participant in the HRA plan, the company will make an annual allocation to your own Health Reimbursement Account (HRA). This account is used to cover 100% of your share of the cost of Covered Services, up to the accrued allocation in your account. Covered Services are defined elsewhere in this SPD.

### 2. Traditional Health Coverage

In addition to your HRA, the plan offers Traditional Health Coverage to protect you and your enrolled dependents to the extent your expenses for Covered Services exceed your annual deductible. This coverage is called Traditional Health Coverage, and is made available by your Employer on a self-insured basis.

### 3. Preventive Care

The HRA plan also provides 100% coverage for nationally recommended services using Network Providers. Your HRA is not charged and you incur no Out-of-Pocket costs as long as you receive your preventive care from a Network Provider. If you choose to go to an Out-of-Network Provider, your Deductible or Traditional Health Coverage benefits will apply, and the balance in your HRA may be charged.

Any day and dollar limits associated with specific benefits under the plan apply at all times, including while you are using funds from the Health Reimbursement Account, or in the Traditional Health Coverage portion of the plan.

## Health Reimbursement Account (HRA)

Through the HRA plan, your Employer makes an annual allocation to a Health Reimbursement Account (HRA) for you and your Covered Dependents (the HRA is a bookkeeping account and not a trust of any sort). Your HRA is used to pay for Covered Services (such as the cost of office visits and lab tests) for you and your eligible dependents.

The HRA is only available for IRC Section 213(d) Qualified Medical Expenses, and even these are subject to the terms of the benefit plan; you can never take amounts out of the HRA in cash for other than the reimbursement of expenses covered under the HRA plan.

The annual company allocation to your HRA is:

<b>HRA Allocation</b>	
Individual Coverage	\$1,000
Employee + Spouse/Domestic Partner	\$1,500
Employee + Child(ren)	\$1,500
Family	\$2,000

**NOTE:** If you join the HRA plan at any time other than at the beginning of the Plan year (January 1), the initial amount allocated to your HRA will be prorated based on the month on a monthly basis when you joined the Plan.

The HRA approach gives you the opportunity to build your available health care dollars over time. If you don't use the full amount of your HRA each Plan year, unlimited dollars can be rolled over if you are an individual and if you are a family.

**NOTE:** If you experience a change in family status during the Plan year that results in a reduction in coverage (i.e. from Family to Individual), your allocation will not change until the beginning of the next Plan year. If the change in family status results in an increase in coverage (e.g., from Individual to Family), you will receive an additional prorated allocation equal to a portion of the difference between the levels allocation. If your participation in the HRA plan ends for any reason, any balance in your HRA account will be forfeited back to the company.

**Your Deductible is:**

<b>Deductible</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Individual	\$1,500	\$1,500
Employee + Spouse/Domestic Partner	\$2,250	\$2,250
Employee + Child(ren)	\$2,250	\$2,250
Family	\$3,000	\$3,000

**Note:** HRA dollars will be used first as you meet the plan Deductible each Benefit Period. After the applicable Out-of-Pocket Maximum has been met, the Plan will pay 100% of the Maximum Allowable Amount for Covered Expenses.

Any money remaining in the HRA at the end of the year can be carried forward to the next year as long as the Member remains a participant in the HRA plan. The maximum HRA balance that can accumulate in the account is unlimited for individual coverage and for family coverage.

**Note:** The Deductible applies to all Covered Services you incur in a Benefit Period other than those which the Plan covers at 100% (see, for example, sections describing “Preventive Care” benefits). The Network Deductible and Out-of-Network Deductible are not separate and do accumulate toward each other.

**Your Plan has a non-embedded Deductible which means:**

- If you, the Subscriber, are the only person covered by this Plan, only the “Individual” amounts apply to you.
- If you also cover Dependents (other family members) under this Plan, the applicable Deductible amounts can be satisfied by you and any other covered family member or a combination of family members. Once the applicable Deductible is met, it is considered met for you and all other covered family members.

**Traditional Health Coverage**

In addition to your HRA account, the Plan offers additional health coverage to protect you and your covered family members in case you incur health care expenses that exceed the balance in your HRA. This coverage begins once you have both used the balance in your HRA and satisfied the applicable Deductible on Covered Services.

## Coinsurance

When using the Traditional Health Coverage, you pay a certain percentage of the cost of Covered Services through Coinsurance. Generally, the Traditional Health Coverage pays 85% of the cost of most In-Network Covered Services and 70% of the Maximum Allowable Cost of most Out-of-Network Covered Services, and your Coinsurance amount is 15% or 30%, as appropriate, until you reach a limit called the Out-of-Pocket Maximum.

## Out-of-Pocket Maximum

The Plan's Out-of-Pocket Maximum may be the most that you will pay toward covered health expenses in a Plan year. Once you reach the Out-of-Pocket Maximum under the Plan, the Plan pays 100% of Covered Services for Network Providers and 100% of the Maximum Allowable Amount for Out-of-Network Providers.

### Your Out-of-Pocket Maximum is:

Out-of-Pocket Maximum	Network	Out-of-Network
Individual	\$4,000	\$6,500
Employee + Adult	\$6,000	\$9,750
Employee + Child(ren)	\$6,000	\$9,750
Family	\$8,000	\$13,000

**Note: The Out-of-Pocket Maximum includes all Deductibles and/or Coinsurance you incur in a Benefit Period (even taking into account the amounts to which your HRA balance is applied).**

Once the Out-of-Pocket Maximum is satisfied, no additional Coinsurance will be required for the remainder of the Benefit Period.

Network and Out-of-Network Coinsurance and Out-of-Pocket Maximums are not separate and do accumulate toward each other.

When more than you are covered, the Out-of-Pocket Maximum amount can be satisfied by any covered family member or a combination of covered family members (non-embedded).

Your Plan has a non-embedded Out-of-Pocket Maximum, which means:

- If you, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to you.
- If you also cover Dependents (other family members) under this Plan, the applicable Out-of-Pocket Maximum amounts apply. The applicable Out-of-Pocket Maximum amounts can be satisfied by any covered family member or a combination of covered family members. Once the applicable Out-of-Pocket Maximum is met, it is considered met for all family members.

**Note:** The Out-of-Pocket Maximum does not include Non-covered services, Services deemed not Medically Necessary by the applicable Claims Administrator, Penalties for non-compliance, or Charges over the Maximum Allowed Amount.

## Schedule of Benefits

Other sections of this SPD include additional information about the following:

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Acupuncture</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>ADD/ADHD</b> <ul style="list-style-type: none"> <li>• Attention Deficit Disorders includes Intellectual Disability, Developmental Delays and Learning Disabilities.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Allergy Care</b>		
Testing and Treatment – Physician or Specialist Physician	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Biofeedback</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Blood Processing and Storage</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Consultation, Second Opinion</b> <ul style="list-style-type: none"> <li>• Includes Family Planning.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Dental &amp; Oral Surgery/TMJ Services</b>		
<b>Accidental Injury</b> <ul style="list-style-type: none"> <li>• Covered for treatment of an injury to sound and natural teeth.</li> <li>• Only if treatment is completed within 12 months of the accident.</li> <li>• Care must commence within 90 days of accident.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Oral Surgery – Subject to Medical Necessity – excludes appliances and orthodontic treatment.</b> <ul style="list-style-type: none"> <li>• Dental Anesthesia is covered only if related to a payable oral surgery.</li> <li>• DOES NOT include removal of impacted teeth.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
TMJ – Subject to Medical Necessity <ul style="list-style-type: none"> <li>• Covered for medical treatment (surgical and non-surgical).</li> <li>• Excludes appliances and orthodontic treatment.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Diabetes Maintenance</b>		
Diabetes Education/Diabetic Nutritional Counseling Outpatient Institutional <ul style="list-style-type: none"> <li>• Nutritional Counseling for Diabetes.</li> <li>• May be covered at 100% under certain circumstances – refer to Preventive Care Benefits.</li> <li>• Covered for medical conditions that require a special diet.</li> <li>• Includes gestational.</li> <li>• Diabetic Supply – Covered only for glucometer or insulin infusion pump.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
- Maximum visits per calendar year	6 combined visits per year, combined with Non-Diabetes diagnosis combined Network and Out-of-Network	
<b>Diagnostic Physician's Services</b>		
Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:		
Physician / Specialist Physician Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Diagnostic X-ray and Lab – office or independent lab. <ul style="list-style-type: none"> <li>• Covered at the In Network benefit level.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.</b>		
<b>Dialysis/Hemodialysis Therapy</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Emergency Room, Urgent Care, and Ambulance Services</b>		
Emergency room for an Emergency Medical Condition <ul style="list-style-type: none"> <li>• Applies to Emergency Medical Condition diagnoses (as defined by Prudent Layperson). All services will be paid at the in Network level of benefit (accidental injury and medical emergency diagnoses pay as emergency).</li> <li>• Quick Care Options.</li> <li>• All other services.</li> </ul>	Deductible then 15% Coinsurance	Covered at the In Network benefit level  (See note below)
Use of the emergency room for non-Emergency Medical Conditions <ul style="list-style-type: none"> <li>• Applies to non-emergency Medical Condition diagnoses (as defined by Prudent Layperson).</li> <li>• Quick Care Options.</li> <li>• All other services.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Urgent Care clinic visit <ul style="list-style-type: none"> <li>• All other services.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Ambulance Services (when Medically Necessary) <ul style="list-style-type: none"> <li>• Land/Air (Air Ambulance will suspend for Medical Necessity).</li> </ul>	Deductible then 15% Coinsurance	Covered at the In Network benefit level at Billed Charges.  (See note below)
<b>Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply:</b> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, you are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Eye Care</b>		
Office visit – medical eye care exams (treatment of disease or Injury to the eye)		
<ul style="list-style-type: none"> <li>Physician / Specialist Physician Coinsurance</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<ul style="list-style-type: none"> <li>Treatment other than office visit</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<ul style="list-style-type: none"> <li>Glasses/Contacts after Cataract Surgery               <ul style="list-style-type: none"> <li>Limited to one (1) occurrence: includes initial frames, lenses or contacts following Cataract surgery.</li> </ul> </li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Hearing Care</b>		
Office visit – Audiometric exam/hearing evaluation test		
<ul style="list-style-type: none"> <li>Physician / Specialist Physician Coinsurance</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<ul style="list-style-type: none"> <li>Treatment other than office visit</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<ul style="list-style-type: none"> <li>Cochlear Implants</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<ul style="list-style-type: none"> <li>Hearing devices/hearing aids, including exams and hearing aid accessories.</li> </ul>	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>No coverage for hearing loss due to age.</li> </ul>		
<b>High Diagnostic Imaging</b>		
<ul style="list-style-type: none"> <li>Includes MRI/MRA/CAT/PET/SPECT.</li> <li>Hospital Based Provider services rendered by non-par providers are covered at the In-Network benefit level.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Home Health Care Services</b> <ul style="list-style-type: none"> <li>• Includes Private Duty Nursing and Home Infusion therapy (Services do NOT count toward the Home Health visit maximum.)</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
- Maximum Home Care visits	120 visits per calendar year combined Network and Out-of-Network (limit not applicable to Behavioral Health benefit)	
<b>Hospice Care Services</b> <ul style="list-style-type: none"> <li>• Respite Care is Not Covered.</li> <li>• Bereavement Counseling is Not Covered.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Hospital Inpatient Services – Precertification Required</b>		
Room and board (Semiprivate or ICU/CCU)	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical Medical Rehab, Inpatient Physical Therapy, etc.)	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Hospital Inpatient Services – Precertification Required (cont'd)</b>		
Pre-Admission testing	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Physician Services:		
▶ Surgeon	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
▶ Anesthesiologist	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
▶ Radiologist	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
▶ Pathologist	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Note:</b> Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits at Billed Charges when providing Inpatient services.		



Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Infusion Therapy</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Maternity Care (Dependent Daughters are covered) &amp; Other Reproductive Services</b>		
Physician's office: Global care (includes pre- and post-natal delivery)		
Primary Care Physician (includes obstetrician and gynecologist) Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Specialist Physician Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Midwife (Precertification required)	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Physician Hospital/Birthing Center Services (Precertification required)		
Physician's services	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Newborn nursery services (well baby care)	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Circumcision	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Note:</b> Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified.		
Outpatient Institutional <ul style="list-style-type: none"> <li>• Includes Therapeutic and Elective Abortion.</li> <li>• Dependent Daughters are covered.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Outpatient Professional/Office Professional Visit <ul style="list-style-type: none"> <li>• Includes Therapeutic and Elective Abortion.</li> <li>• Dependent Daughters are covered.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Infertility Services</b> <ul style="list-style-type: none"> <li>• Treatment for underlying medical conditions are covered as medical.</li> <li>• Covered for services to diagnose infertility only.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Maternity Care (Dependent Daughters are covered) &amp; Other Reproductive Services (cont'd)</b>		
<ul style="list-style-type: none"> <li>Treatment of infertility is not covered (except artificial insemination). Artificial Insemination is limited to 6 attempts per lifetime.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<ul style="list-style-type: none"> <li>Invitro Fertilization – Includes in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, and reversal of voluntary sterilization.) are Not covered.</li> </ul>	Not Covered	Not Covered
<b>Sterilization Services that do not qualify as “Preventive Care” benefits (Precertification Required for Inpatient procedures)</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Sterilizations for women may be covered under the “Preventive Care” benefit. Please see that section in Medical Benefits for further details.		
<ul style="list-style-type: none"> <li>Vasectomy</li> </ul> Reversals are Not Covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Contraceptives – that do not qualify as “Preventive Care” benefits</b> <ul style="list-style-type: none"> <li>Spermicide, vaginal ring, hormone patch Depo - Estradiol Cypionate.</li> <li>Covered for birth control as well as medical conditions.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Medical Supplies and Equipment</b>		
Medical Supplies	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Durable Medical Equipment (DME) <ul style="list-style-type: none"> <li>(Purchase &amp; Rental)</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Orthotics <ul style="list-style-type: none"> <li>Foot ( Foot Orthotics based on Medical Necessity) and shoe</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Medical Supplies and Equipment (cont'd)</b>		
Prosthetic Appliances (external) <ul style="list-style-type: none"> <li>• Wigs/Toupees limited to one per Benefit Period, subject to Medical Necessity.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Nutritional Counseling for Non-Diabetes</b> <ul style="list-style-type: none"> <li>• May be considered Preventive Care Benefits under certain circumstances.</li> <li>• Eating Disorders are covered.</li> <li>• Covered for medical conditions that require a special diet.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
- Maximum visits per calendar year	6 combined visits per year, combined with Non-Diabetes diagnosis combined Network and Out-of-Network	
<b>Nutritional Counseling for Eating Disorders</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Outpatient Hospital/Facility Services</b>		
Outpatient facility	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Lab and x-ray services	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Physician Services (Home and Office Visits)</b>		
Primary Care Physician	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Specialist Physician	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Office Surgery	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Physician Services (Home and Office Visits) (cont'd)</b>		
Online Visits from LiveHealth Online Provider	Not Covered	Not Covered
Prescription Injectables/Prescription Drugs Dispensed in the Physician's Office	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Prescription Drugs (other than Preventive Care)</b>		
Generic	Deductible then 15% Coinsurance	Deductible then 15% Coinsurance
Brand-name	Deductible then 15% Coinsurance	Deductible then 15% Coinsurance
<b>Preventive Services (regardless of Provider or setting where Preventive care is provided)</b>	Covered at 100%	Deductible then 30% Coinsurance
<b>Contraceptives — qualify as “Preventive Care” benefit</b> <ul style="list-style-type: none"> <li>• IUDs, injections for Depo-Provera, diaphragm fittings, and any other FDA approved birth control devices (other than the ones listed above that do not qualify as “Preventive Care” benefits).               <ul style="list-style-type: none"> <li>– Covered based on the diagnosis restriction within the “Preventive Care” benefits.</li> </ul> </li> </ul>	Covered at 100%	Deductible then 30% Coinsurance
<b>Other Preventive Services</b>		
Routine eye exams	Not Covered	Not Covered
Routine hearing exams <ul style="list-style-type: none"> <li>• Limited to one per calendar year.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Routine Foot Care <ul style="list-style-type: none"> <li>• Foot Orthotics may be covered as DME.</li> </ul>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Note: Preventive Care treatment generally applied to Covered Services only when claim submitted with a “well” diagnosis.</b>		
<b>Retail Health Clinics</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Skilled Nursing Facility</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<ul style="list-style-type: none"> <li>• Maximum days <span style="float: right;">120 days per calendar year combined Network and Out-of-Network.</span></li> </ul>		
<b>Surgical Services</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Bariatric Surgery</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<p><b>Blue Distinction Bariatric Services Benefit:</b> This benefit description applies to the Bariatric surgery, the pre-determination of eligibility by the Blue Distinction (BD) Bariatric Specialty Care Management unit, travel to a BD Designated Center of Excellence (COE) provider associated with the surgery event, and the after care provided by the BD Bariatric Specialty Care Management unit only.</p>		
<p><b>Designated BD Bariatric COE:</b> For the Covered Bariatric Procedure, you will pay 5% of the Maximum Allowable Amount for Bariatric Surgery facility.</p>		
<p>Prior to and after the Covered Bariatric Procedure, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.</p>		
<p><b>Out of Network Bariatric provider:</b> You will pay 30% of the Maximum Allowable Amount for a Bariatric procedure performed at an Out-of-Network facility.</p>		
<p><b>Transportation and Lodging –</b>            Distance the patient must live from the surgical facility to use this benefit: 50 Miles.  <b>Lodging allowance:</b> \$50 per day for single occupancy/\$100 per day for double occupancy. Meals are not covered. Facility must be 50 miles from member's residence.</p>		
<p>Participation in Anthem BD Bariatric Specialty Care Management Program is required for benefits to be considered.</p>		

<b>Benefits</b>		<b>Network</b>	<b>Out-of-Network</b>
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>			
<b>Blue Distinction Centers+/Blue Distinction Centers Transplant Surgery Benefit</b>			
<b>Designated BDC+ Provider for Transplant Surgery Procedures</b>	<b>Designated BDC Provider for Transplant Surgery procedures</b>	<b>PAR (Network) Transplant Provider (non-BDC+/BD Provider)</b>	<b>Non-PAR (Out-of-Network) Transplant Provider</b>
<b>Benefit Limits for Covered Transplant Procedure:</b>			
For the Covered <b>Transplant</b> Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated <b>BDC+</b> provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on your standard medical benefit.	For the Covered <b>Transplant</b> Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated <b>BDC</b> provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on your standard medical benefit.	For the Covered <b>Transplant</b> Procedure, you will pay 15% of the Maximum Allowable Amount when using a <b>PAR</b> , Network provider. As the provider is PAR (Network) you will NOT be responsible for amounts that exceed the Maximum Allowable Amount (you will NOT be required to pay any amounts due to providers after your health plan benefits have been applied, beyond your standard Out-of-Pocket costs).	For the Covered <b>Transplant</b> Procedure, you will pay 30% of the Maximum Allowable Amount when using a <b>non-PAR</b> Out-of-Network provider. As the provider is non-PAR (Out-of-Network) you WILL be responsible for amounts that exceed the Maximum Allowable Amount (you WILL be required to pay any amounts due to providers after your health plan benefits have been applied).
<b>Deductibles</b>			
Applicable Deductibles apply	Applicable Deductibles apply	Applicable Deductibles apply.	Applicable Deductibles apply.

Benefits	Network	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>			
<b>Live Donor Searches</b>			
Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to 95% of the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to 95% of the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to 85% of the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to 70% of the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.
<b>Bone Marrow Donor Search</b>			
Bone Marrow Donor Search fees are covered up to a maximum of \$30,000 per transplant	Bone Marrow Donor Search fees are covered up to a maximum of \$30,000 per transplant	Bone Marrow Donor Search fees are covered up to a maximum of \$30,000 per transplant	Bone Marrow Donor Search fees are covered up to a maximum of \$30,000 per transplant
<b>Organ Transplants (institutional)</b>			
Donor expenses are covered at 95% of Maximum Allowed Amount	Donor expenses are covered at 95% of Maximum Allowed Amount	Donor expenses are covered at 85% of Maximum Allowed Amount	Donor expenses are covered at 70% of Maximum Allowed Amount
<b>Organ Transplants (professional)</b>			
Donor expenses are covered at 95% of Maximum Allowed Amount	Donor expenses are covered at 95% of Maximum Allowed Amount	Donor expenses are covered at 85% of Maximum Allowed Amount	Donor expenses are covered at 70% of Maximum Allowed Amount

Benefits	Network	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>			
<b>Travel Reimbursement</b>			
<p>Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required.</p> <p><b>Lodging allowance:</b> \$50 per day for single occupancy/\$100 per day for double occupancy. Meals are not covered.</p> <p>Reimbursed at 100% as long as transplant is covered and performed at BDC Transplant facility.</p> <p>Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion.</p> <p>Facility must be 50 miles from member's residence.</p>	<p>Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required.</p> <p><b>Lodging allowance:</b> \$50 per day for single occupancy/\$100 per day for double occupancy. Meals are not covered.</p> <p>Reimbursed at 100% as long as transplant is covered and performed at BDC Transplant facility.</p> <p>Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion.</p> <p>Facility must be 50 miles from member's residence.</p>	Not Covered	Not Covered
<b>Blue Distinction Cardiac Surgery Benefit</b>			
<b>Designated BDC+ Provider for Cardiac Procedures</b>	<b>Designated BDC Provider for Cardiac procedures</b>	<b>PAR (Network) Cardiac Provider (non-BDC+/BD Provider)</b>	<b>Non-PAR (Out-of-Network) Cardiac Provider</b>



Benefits	Network	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>			
<b>Benefit Limits for Covered Cardiac Procedure:</b>			
For the Covered Cardiac Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated <b>BDC+</b> provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on your standard medical benefit.	For the Covered Cardiac Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated <b>BDC</b> provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on your standard medical benefit.	For the Covered Cardiac Procedure, you will pay 15% of the Maximum Allowable Amount when using a <b>PAR</b> , Network provider. As the provider is PAR (Network) you will NOT be responsible for amounts that exceed the Maximum Allowable Amount (you will NOT be required to pay any amounts due to providers after your health plan benefits have been applied, beyond your standard Out-of-Pocket costs).	For the Covered Cardiac Procedure, you will pay 30% of the Maximum Allowable Amount when using a <b>non-PAR</b> , Out-of-Network provider. As the provider is non-PAR (Out-of-Network) you WILL be responsible for amounts that exceed the Maximum Allowable Amount (you WILL be required to pay any amounts due to providers after your health plan benefits have been applied).
<b>Deductibles</b>			
Normal Deductibles apply.	Normal Deductibles apply.	Normal Deductibles apply.	Out-of-Network Deductibles will apply.

Benefits	Network		Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>			
<b>Travel Reimbursement</b>			
<p>Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required.</p> <p><b>Lodging allowance:</b> \$50 per day for single occupancy/\$100 per day for double occupancy. Meals are not covered.</p> <p>Reimbursed at 100% as long as cardiac procedure is covered and performed at BDC facility.</p> <p>Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion.</p> <p>Facility must be 50 miles from member's residence.</p>	<p>Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required.</p> <p><b>Lodging allowance:</b> \$50 per day for single occupancy/\$100 per day for double occupancy. Meals are not covered.</p> <p>Reimbursed at 100% as long as cardiac procedure is covered and performed at BDC facility.</p> <p>Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion.</p> <p>Facility must be 50 miles from member's residence.</p>	<p>Not Covered</p>	<p>Not Covered</p>

Benefits		Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>			
<b>Blue Distinction Orthopedic Surgery Benefit</b>			
<b>Designated BDC+ Provider for Knee/Hip Replacements &amp; Spine Surgery Procedures</b>	<b>Designated BDC Provider for Knee/Hip Replacements &amp; Spine Surgery procedures</b>	<b>PAR (Network) Orthopedic Provider (non-BDC+/BD Provider)</b>	<b>Non-PAR (Out-of-Network) Orthopedic Provider</b>
<b>Benefit Limits for Covered Orthopedic Procedure:</b>			
For the Covered Orthopedic Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated <b>BDC+</b> provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on your standard medical benefit.	For the Covered Orthopedic Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated <b>BDC</b> provider. This benefit includes services directly related to the covered procedure (facility, professional and ancillary services) during the inpatient or outpatient stay. If the service is NOT directly related to the covered procedure, services will be covered based on your standard medical benefit.	For the Covered Orthopedic Procedure, you will pay 15% of the Maximum Allowable Amount when using a <b>PAR</b> , Network provider. As the provider is PAR (Network) you will NOT be responsible for amounts that exceed the Maximum Allowable Amount (you will NOT be required to pay any amounts due to providers after your health plan benefits have been applied, beyond your standard Out-of-Pocket costs).	For the Covered Orthopedic Procedure, you will pay 30% of the Maximum Allowable Amount when using a <b>non-PAR</b> , Out-of-Network provider. As the provider is non-PAR (Out-of-Network) you WILL be responsible for amounts that exceed the Maximum Allowable Amount (you WILL be required to pay any amounts due to providers after your health plan benefits have been applied).
<b>Deductibles</b>			
Normal Deductibles apply.	Normal Deductibles apply.	Normal Deductibles apply.	Out-of-Network Deductibles will apply.

Benefits	Network		Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>			
<b>Travel Reimbursement</b>			
<p>Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required.</p> <p><b>Lodging allowance:</b> \$50 per day for single occupancy/\$100 per day for double occupancy. Meals are not covered.</p> <p>Reimbursed at 100% as long as orthopedic procedure is covered and performed at BDC facility.</p> <p>Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion.</p> <p>Facility must be 50 miles from member's residence.</p>	<p>Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required.</p> <p><b>Lodging allowance:</b> \$50 per day for single occupancy/\$100 per day for double occupancy. Meals are not covered.</p> <p>Reimbursed at 100% as long as orthopedic procedure is covered and performed at BDC facility.</p> <p>Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion.</p> <p>Facility must be 50 miles from member's residence.</p>	<p>Not Covered</p>	<p>Not Covered</p>
<b>Telehealth Visits</b>			
<ul style="list-style-type: none"> <li>• Includes Teladoc.</li> <li>• All other providers are NOT Covered.</li> </ul> <p>Please contact Customer Service for additional information.</p>		<p>Deductible then 15% Coinsurance</p>	<p>Not Covered</p>

Benefits	Network	Out-of-Network
<b>Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.</b>		
<b>Therapy Services (Outpatient)</b>		
Physician – Coinsurance, per visit	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Specialist Physician or other – Coinsurance per visit	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Physical Therapy Occupational Therapy Speech Therapy  Note: Coverage is provided for Physical, Occupational, and Speech therapy services when used for treatment of a congenital defect, condition, sickness, or injury. To be covered, the therapy services must be rendered in accordance with a physician’s prescription. Therapy is covered for developmental delays. Learning disabilities are excluded.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Chiropractic Care  – Maximum per calendar year	Deductible then 15% Coinsurance  15 Visit Maximum Includes all services performed by a Chiropractor. Combined In and Out-of-Network. Massage Therapy is covered when performed by a chiropractor, and included in the chiropractic maximum.	Deductible then 30% Coinsurance
Cardiac Rehabilitation	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Radiation Therapy	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Chemotherapy	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Respiratory Therapy	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Vision Therapy	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
<b>Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.</b>		
<b>Transgender Surgery</b>	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
<b>Transplants</b>			
<p>Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Medical Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy.</p> <p><b>The Center of Excellence requirements do not apply to</b> Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.</p> <p><b>Note:</b> Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Medical Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)</p>			

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
<b>Transplant Benefit Period</b>			
	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)	Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.
<b>Covered Transplant Procedure during the Transplant Benefit Period</b>	Deductible then 5% Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Care coordinated through a Network Transplant Provider/ Center of Excellence subject to Deductible. When performed by Out-of-Network Transplant Provider, <b>you are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.</b>			
<b>Bone Marrow &amp; Stem Cell Transplant (Inpatient &amp; Outpatient)</b>	Deductible then 5% Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Includes unrelated donor search up to \$30,000 per transplant.			

<b>Benefits</b>	<b>Center of Excellence</b>	<b>Network Transplant Provider</b>	<b>Out-of-Network Transplant Provider</b>
<b>Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)</b>	Deductible then 5% Coinsurance, as approved, up to a \$30,000 benefit limit	Deductible then 15% Coinsurance, as approved, up to a \$30,000 benefit limit	Covered, as approved, up to a \$30,000 benefit limit. You are responsible for Deductible then 30% Coinsurance of search charges. These charges will NOT apply to the Out-of-Pocket Maximum.
<b>Eligible Travel and Lodging –</b> <ul style="list-style-type: none"> <li>• Lodging allowance: \$50 per day for single occupancy/\$100 per day for double occupancy. (Reimbursed at 100% as long as transplant is covered and performed at BDC Transplant/Center of Excellence facility). Meals are not covered.</li> <li>• Transportation for two companions if the patient is a minor child.</li> <li>• Travel is reimbursed for patient and companion.</li> </ul>	Covered at 100%	Covered at 100%	Not Covered
<b>All Other Covered Transplant Services</b>	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

## Health and Wellness Programs

Anthem offers a number of programs intended to assist in achieving health and wellness objectives. A number of these are described in this section.

If you would like to learn more about the health and wellness programs offered by other vendors assisting with the administration of the Plan, please call the number on the back of your Identification Card or exploring their respective websites:

Anthem: [www.anthem.com](http://www.anthem.com);

Magellan: [www.magellanhealth.com](http://www.magellanhealth.com); and

Express Scripts: [www.express-scripts.com](http://www.express-scripts.com).

## Quick Care Options

Quick Care Options helps to raise your awareness about appropriate alternatives to Hospital emergency rooms (ERs). When you need care right away, Retail Health Clinics and Urgent Care centers can offer appropriate care for less cost and leave the ER available for actual emergencies. Quick Care Options educates you on the availability of ER alternatives for non-urgent diagnoses and provides the Provider finder website to support searches for ER alternatives.



## ComplexCare

The ComplexCare program reaches out to you if you are at risk for frequent and high levels of medical care in order to offer support and assistance in managing your health care needs. ComplexCare empowers you for self-care of your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with you and your Physician to offer:

- Personalized attention, goal planning, health and lifestyle coaching.
- Strategies to promote self-management skills and medication adherence.
- Resources to answer health-related questions for specific treatments.
- Access to other essential health care management programs.
- Coordination of care between multiple Providers and services.

The program helps you effectively manage your health to achieve improved health status and quality of life, as well as decreased use of acute medical services.

## ConditionCare Programs

ConditionCare programs help maximize your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).

### You will receive:

- 24/7 phone access to a nurse coach who can answer your questions and give you up-to-date information about your condition.
- A health review and follow-up calls if you need them.
- Tips on prevention and lifestyle choices to help you improve your quality of life.

## Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches supported by pharmacists, registered dietitians, social workers and medical directors. You will receive:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions.
- *Your Pregnancy Week by Week*, a book to show you what changes you can expect for you and your baby over the next nine months.
- Useful tools to help you, your Physician and your Future Moms nurse coach track your pregnancy and spot possible risks.

## **MyHealth Coach**

MyHealth Coach serves as a personal health guide for individuals and their families. Each coach provides education, counseling, tools and support to help you navigate the health care system and make wise decisions. MyHealth Coach is available if you are experiencing health issues or need assistance managing lifestyle issues. MyHealth Coach primarily uses the following:

- Coaching for education and self-care via web-based, self-help tools and the program's 24/7 NurseLine.
- Collaborative goal planning and intervention strategies with you.
- Facilitation, coordination and referral to necessary services.
- Incorporating clinical resources such as pharmacists, social workers and dietitians.
- Mailed and telephonic education, including healthy living support through the Healthwise Knowledgebase®.

The coach works with you and your family to create an individualized program that features personalized goals to ensure you are following your Provider's plan of care.

## **24/7 NurseLine**

You may have emergencies or questions for nurses around-the-clock. 24/7 NurseLine provides you with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, you can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer you to programs and tools appropriate to your condition.
- Bilingual RNs, language line and hearing impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison control and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.

## **MyHealth Advantage**

Under the MyHealth Advantage program, Anthem will review your incoming health claims to see if Anthem can save you any money. Anthem can check to see what medications you are taking and alert your Physician if Anthem spots a potential drug interaction. Anthem also keeps track of your routine tests and checkups, reminding you to make these appointments by mailing you MyHealth Notes. MyHealth Notes summarize your recent claims. From time to time, Anthem may offer tips to save you money on Prescription Drugs and other health care supplies.

## AIM Imaging Cost & Quality Program

The Imaging Cost & Quality Program is available to Anthem Blue Cross Blue Shield Members through AIM Specialty Health. This Program provides you with access to important information about imaging services you might need. This Program is **not** a benefit under the Plan.

If you need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where you go to receive the service. Sometimes the differences are significant — anywhere from \$300 to \$3000 — but a higher price doesn't guarantee higher quality. If your benefit plan requires you to pay a portion of this cost (like a Deductible or Coinsurance) where you go can make a very big difference to your wallet.

That's where the AIM Imaging Cost & Quality Program comes in — AIM does the research for you and makes it available to help you find the *right* location for your MRI or CT scan. Here's how the Program works:

- Your Physician refers you to a radiology Provider for an MRI or CT scan;
- AIM works with your Physician to help make sure that you are receiving the right test — using evidence-based guidelines;
- AIM also reviews the referral to see if there are other Providers in your area that are high quality but have a lower price than the one you were referred to;
- If AIM finds another Provider that meets the quality and price criteria, AIM will give you a call to let you know; and,
- You have the choice – You can see the radiology Provider your Physician suggested OR you can choose to see a provider that AIM tells you about. AIM will even help you schedule an appointment with the new Provider.

The AIM Imaging Cost & Quality Program gives you the opportunity to reduce your health care expenses (and those of your Employer) by selecting high quality, lower cost Providers or locations. No matter which Provider you choose, there is no effect on your health care benefits. This Program is being made available to you to give you information that helps you to make informed choices about where to go when you need care.

## Sleep Study Program

The Sleep Management Program is a program that helps your Physician make better informed decisions about your treatment. It is administered by AIM Specialty Health which is a wholly-owned division of Anthem Blue Cross Blue Shield. The Sleep Management Program includes outpatient and home sleep testing and therapy. If you require sleep testing, depending on your medical condition, you may be asked to complete the sleep study in your home. Home sleep studies provide the added benefit of reflecting your normal sleep pattern while sleeping in the comfort of your own bed versus going to an outpatient facility for the test.

As part of this program, you are required to obtain precertification for:

- Home sleep tests (HST).
- In-lab sleep studies (polysomnography or PSG, a recording of behavior during sleep).
- Titration studies (to determine the exact pressure needed for treatment).
- Treatment orders for equipment, including positive airway pressure devices (APAP, CPAP, BPAP, and ASV), oral devices and related supplies.

If you need ongoing treatment, AIM will review your care quarterly to assure that medical criteria are met for coverage. Your equipment supplier or your Physician will be required to provide periodic updates to ensure clinical appropriateness. Ongoing claim approval will depend partly on how you comply with the treatment your Physician has ordered.

Please talk to your Physician about getting approval for any sleep testing and therapy equipment and supplies. If you do not contact Anthem before receiving services, it may be more difficult for you to obtain approval for your benefit claim.

## How Your Plan Works

**Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the “Definitions” Section.**

### Introduction

Your health Plan is a Preferred Provider Organization (PPO) plan, which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If you choose a Network Provider, you will receive Network benefits. Utilizing this method means you will not have to pay as much money; your Out-of-Pocket expenses will be higher when you use Out-of-Network Providers.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

**All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.**

### Network Services

When you use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

**Network Providers** include Primary Care Physicians/Providers (PCPs), Specialists (Specialty Care Physicians/Providers - SCs), other professional Providers, Hospitals, Pharmacies and other Facilities who contract with one of the Claims Administrators to provide Covered Services for you. Referrals are never needed to visit a PCP, Network Specialist or other professional Provider, including behavioral health Providers.

To see a PCP, Network Specialist or other professional Provider, call their office:

- Tell them you are an Anthem or Magellan (as applicable) Member.
- Have your Member Identification Card handy. The Provider's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from Network Providers:

1. You will not need to file claims to get credit against your applicable Deductible or Out-of-Pocket Maximum. Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance and/or Deductibles that apply.) You may be billed by your Network Provider(s) for any Non-Covered Services you get or when you have not followed the terms of this SPD.<sup>1</sup>
2. Precertification will be done by the Network Provider. (See the “Health Care Management – Precertification” section for further details.)

Please read the “Claims Payment” section for additional information on Authorized Services.

### **After Hours Care**

If you need care after normal business hours, your PCP may have several options for you. You should call your PCP's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest emergency services provider.

### **Out-of-Network Services**

When you do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this SPD.

For services from an Out-of-Network Provider:

- The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance;
- You may have higher cost sharing amounts (i.e., Deductibles and Coinsurance);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see “Health Care Management – Precertification” for more details.)

### **How to Find a Provider in the Network**

There are three ways you can find out if a Provider or facility is in the Network for this Plan. You may also be able to find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at [www.anthem.com](http://www.anthem.com) or [www.magellanhealth.com/member](http://www.magellanhealth.com/member), which lists the Doctors, Providers, and facilities that participate in this Plan's Network. The Networks are different depending on whether the care you are seeking is medical or behavioral health, so be sure to check the correct Network directory for the care you are seeking. To determine whether a retail pharmacy is a Network Provider as participating pharmacy, log into the Express Scripts website ([www.express-scripts.com](http://www.express-scripts.com)), select “Locate a Pharmacy” from the “Manage Prescriptions” menu and search by ZIP code or city and state.

<sup>1</sup> To obtain a reimbursement from your HRA in connection with behavioral health services, You may need to file with Anthem a copy of your Explanation of Benefit (EOB) provided by Magellan and/or a copy of your itemized bill or receipt from your Provider along with a an Qualified Health Expense (QHE) form. To obtain the QHE form, please contact Magellan or Anthem.

- Call Customer Service at Anthem, Magellan or Express Scripts at the number on your plan Identification Card to ask for a list of doctors, Providers or pharmacies that participate in this Plan's Network, based geographic area, and specialty (if applicable).
- Check with your doctor, Provider or pharmacy.

## Health Care Management – Precertification

Your Plan includes the processes of Precertification and Post Service Clinical Claims Review to determine when services should be covered by your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization: Network Providers are required to obtain Precertification in order for you to receive benefits for certain services. Precertification will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The applicable Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments which are more cost effective.

If you have any questions regarding the information contained in this section, you may call the Customer Service telephone number for the applicable Claims Administrator on your Identification Card or visit [www.anthem.com](http://www.anthem.com) or [www.magellanhealth.com/member](http://www.magellanhealth.com/member).

### Types of Requests:

**Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify the Claims Administrator within two business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

**Post Service Clinical Claims Review** – A retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification. Medical reviews occur for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and may be initiated by you or the Claims Administrator.

## **If You Fail to Obtain Precertification:**

**IMPORTANT NOTE: IF YOU OR YOUR NON NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, THE CLAIMS WILL BE DENIED FOR NO PRECERTIFICATION. ONCE INFORMATION IS RECEIVED CLAIMS CAN BE RE-OPENED BASED ON MEDICAL INFORMATION PROVIDED. ANY SERVICES OR DAYS FOUND NOT TO BE MEDICALLY NECESSARY WILL NOT BE COVERED.**

**The following list is not all inclusive and is subject to change; please call the Customer Service telephone number on your Identification Card to confirm the most current list and requirements for your Plan.**

### **Medical:**

- Inpatient Admission for Medical or Behavioral Health care
- Elective Admissions for Medical or Behavioral Health care
- Emergency Admissions for Medical or Behavioral Health care (require notification no later than two business after admission)
- Bariatric Surgery
- Maternity Admission Precertification only needed if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery.
- Acute Inpatient Rehabilitation
- Home Health Care (includes Home Infusion billed by Home Health Care agency)
- Home Infusion Therapy (billed by home infusion specialist)
- Visiting Nurses, Private Duty Nursing (Home)
- Skilled Nursing Facility (SNF)
- Hospice (inpatient and outpatient)
- Organ and Tissue Transplant (inpatient and outpatient)
- Bone Marrow and Stem Cell Transplant (inpatient and outpatient)
- Air Ambulance
- American Imaging Management (AIM-IHM)

Utilizing a Provider outside of the Network may result in significant additional financial responsibility for you, because your health benefit plan cannot prohibit Out-of-Network Providers from billing you for the difference between the Provider's charge and the benefit the Plan provides.

The ordering Provider, facility or attending Physician should contact the applicable Claims Administrator to request a Precertification review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies and procedures to assist in making Medical Necessity decisions. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. The terms of the Plan will be used to determine whether a particular service is covered.

**You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your benefits request. To request this information, contact the Customer Service telephone number on your Identification Card.**

The Claims Administrator may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if at the Claims Administrator's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the Claims Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt your claim from medical review if certain conditions apply.

Just because the Claims Administrator exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that the Claims Administrator will do so in the future, or will do so in the future for any other Provider, claim or Member. The Claims Administrator may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by contacting the customer service number on the back of your Identification Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

#### **Request Categories:**

- **Urgent** – A request for Precertification that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective** – A request for Precertification that is conducted prior to the service, treatment or admission.
- **Concurrent/Continued Stay Review** - A request for Precertification that is conducted during the course of treatment or admission.
- **Retrospective** – A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

#### **Decision and Notification Requirements**

Timeframes and requirements listed are based in general on Federal regulations. You may call the telephone number on your Identification Card for additional information.



Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent/Continued Stay Review when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent/Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent/Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent/Continued Stay Review Non-Urgent for ongoing outpatient treatment	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make a decision, the Claims Administrator will notify the requesting Provider and send written notification to you or your authorized representative of the specific information necessary to complete the review. If the Claims Administrator does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in the Claims Administrator's possession.

The Claims Administrator will provide notification of its decision in accordance with Federal regulations.

Notification may be given by the following methods:

- **Verbal:** oral notification given to the requesting Provider via telephone or via electronic means if agreed to by the Provider.
- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and the Member or authorized Member representative.

**Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:**

1. You must be eligible for benefits;
2. The service or surgery must be a Covered Service under your Plan;
3. The service cannot be subject to an exclusion under your Plan; and
4. You must not have exceeded any applicable limits under your Plan.

### Individual Case Management

The Claims Administrator's individual health plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to you. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, the Claims Administrator will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Physician(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

## Medical Benefits

**Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.**

### Acupuncture

Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

### Ambulance Service

Medically Necessary Ambulance Services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
  - From your home, the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Medical Claims Administrator requires you to move from an Out-of-Network Hospital to a Network Hospital;
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Medical Claims Administrator requires you to move from an Out-of-Network Hospital to a Network Hospital;
  - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Medical Claims Administrator. Emergency ambulance services do not require Precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by the Medical Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Medical Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Medical Claims Administrator selects, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases the Medical Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or Injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance Services are not covered when another type of transportation can be used without endangering your health. Ambulance Services for your convenience or the convenience of your family or Physician are not a Covered Service.

Other non-covered Ambulance Services include, but are not limited to, trips to:

- A Physician's office or clinic; or
- A morgue or funeral home.

### **Important Notes on Air Ambulance Benefits**

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

### **Hospital to Hospital Transport**

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

### **Assistant Surgery**

Services rendered by an assistant surgeon are covered based on Medical Necessity.

### **Breast Cancer Care**

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

## **Breast Reconstructive Surgery**

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

## **Cardiac Rehabilitation**

Covered Services are provided as outlined in the "Schedule of Benefits" section.

## **Consultation Services**

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals (the transfer of a patient from one Physician to another for treatment) are not consultations under this Plan.

## **Dental Services**

### **Related to Accidental Injury**

Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Treatment must be completed within the timeframe shown in the "Schedule of Benefits" section.

### **Other Dental Services**

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- The Member is under the age of five (5);
- The Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

## **Diabetes**

Equipment and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

## Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

## Durable Medical Equipment

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item; and
- it is related to the Member's physical disorder.

## Emergency Services

### Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care including a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Precertification from the Plan.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method the Medical Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

The Coinsurance percentage payable for both Network and Out-of-Network are shown in the “Schedule of Benefits” section.

## **General Anesthesia Services**

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- Spinal or regional anesthesia;
- Injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

## **Habilitative Services**

Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

## **Home Health Care Services**

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the “Schedule of Benefits” section. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

### **Some special conditions apply:**

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the “Physical Therapy” section shown in this Plan.
- A Member must be essentially confined at home.

### **Covered Services:**

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.

- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

**Covered Services for Home Health Care do not include:**

- Food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- Services and/or supplies which are not included in the Home Health Care plan as described;
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse or a Member's covered Domestic Partner;
- Any services for any period during which the Member is not under the continuing care of a Physician;
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member;
- Any services or supplies not specifically listed as Covered Services;
- Routine care and/or examination of a newborn child;
- Dietician services;
- Maintenance therapy;
- Dialysis treatment; or
- Purchase or rental of dialysis equipment.

## **Hospice Care Services**

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- Social services and counseling services from a licensed social worker;
- Nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies; and

Your Physician and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Medical Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this SPD.

## Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

### Network

#### Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

#### Service and Supplies

- Services and supplies provided and billed by the Hospital while you are an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

#### Length of Stay

- Determined by Medical Necessity.

#### Out-of-Network

##### **Hospital Benefits**

If you are confined in an Out-of-Network Hospital, your benefits will be significantly reduced, as explained in the "Schedule of Benefits" section.

##### **Hospital Visits**

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

## Human Organ and Tissue Transplant Services

### Notification

**To maximize your benefits, you need to call the Medical Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.**

Contact the customer service telephone number on your Identification Card and ask for the transplant coordinator. The Medical Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.



### **Covered Transplant Benefit Period**

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Medical Claims Administrator for specific Network Transplant Provider information for services received at, or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.

### **Prior Approval and Precertification**

In order to maximize your benefits, the Medical Claims Administrator strongly encourages you to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. The Medical Claims Administrator will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card **and ask for the transplant coordinator**. Even if the Medical Claims Administrator issues a prior approval for the Covered Transplant Procedure, you or your Provider must call the Medical Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

### **Transportation and Lodging**

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Medical Claims Administrator when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Medical Claims Administrator when claims are filed. Contact the Medical Claims Administrator for detailed information. The Medical Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

## **Licensed Speech Therapist Services**

Services must be ordered and supervised by a Physician as outlined in the “Schedule of Benefits” section. Speech therapy is not covered when rendered for the treatment of Developmental Delay.

## **Maternity Care and Reproductive Health Services**

Covered Services are provided for Network Maternity Care as stated in the “Schedule of Benefits” section. If you choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the “Schedule of Benefits” section.

Routine newborn nursery care is part of the mother’s maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See “Changing Coverage (Adding a Dependent)” to add a newborn to your coverage.)

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member’s attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician’s office or in the Member’s home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member’s attending Physician.

### **Abortion (Therapeutic or Elective)**

Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape. Your Plan also provides benefits for an elective (voluntary) abortion, which is an abortion performed for reasons other than those described above.

### **Contraceptive Benefits**

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under as a “Preventive Care” benefit. Please refer to the section below describing “Preventive Care” and the section on “Prescription Drug Benefits” for further details.

## **Infertility Services**

Your Plan also includes benefits for the diagnosis and treatment of Infertility. Covered Services include diagnostic and exploratory procedures to determine whether a Member suffers from Infertility. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. Covered fertilization services include artificial insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), or ZIFT (zygote intra-fallopian transfer) procedures. See the "Schedule of Benefits" section for benefit limitations, Coinsurance and Copayment amounts.

## **Sterilization Service**

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women may be covered under the "Preventive Care" benefit.

## **Medical Care**

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

## **Nutritional Counseling**

Nutritional counseling related to the medical management of a disease state as stated in the "Schedule of Benefits" section.

## **Out-of-Network Freestanding Ambulatory Facility**

Any services rendered or supplies provided while you are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at no more than the Maximum Allowed Amount.

## **Out-of-Network Hospital Benefits**

If you are confined in an Out-of-Network Hospital, your benefits will be significantly reduced, as explained in the "Schedule of Benefits" section.

## **Obesity**

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan.

## **Oral Surgery**

Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;

- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within the timeframes shown in the “Schedule of Benefits” section after the accident.

Although this Plan covers certain oral surgeries as listed above, many oral surgeries (e.g. removal of wisdom teeth) are not covered. Covered Services also include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral/surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

## **Other Covered Services**

Your Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- Diagnostic x-ray and laboratory procedures;
- Dressings, splints and casts when provided by a Physician;
- Oxygen, blood and components, and administration;
- Pacemakers and electrodes; or
- Use of operating and treatment rooms and equipment.

## **Outpatient CT Scans and MRIs**

These services are covered at regular Plan benefits.

## **Outpatient Hospital Services**

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

## **Outpatient Surgery**

Network Hospital outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services.”

## **Physical Therapy, Occupational Therapy, Chiropractic Care**

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the "Schedule of Benefits" section. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when such services are necessitated by Developmental Delay.

## **Physician Services**

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to your Deductible, Co-Insurance and other Out-of-Pocket requirements.

## **Preventive Care**

Preventive care services include screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Notwithstanding the above, coverage for Preventive Care Services provided under the Plan shall meet requirements as determined by Federal law, as those requirements change and become applicable to the Plan. Many preventive care services are covered by this Plan with no Deductible or Coinsurance from the Member when provided by a Network Provider. That means the Plan pays 100% of the Maximum Allowed Amount.

Cost-sharing is permitted for office visits when Preventive Care Services are billed separately (or are tracked as individual encounter data separately) or are not the primary purpose of an office visit. On the other hand, the Plan will pay at 100% when Preventive Care Services are not billed separately (or are not tracked as individual encounter data separately) by the Network Provider and are the primary purpose of an office visit.

Preventive Care services fall under the following broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.  
Examples of these services are screenings for:
  - a. Breast cancer;
  - b. Cervical cancer;
  - c. Colorectal cancer;
  - d. High blood pressure;
  - e. Type 2 Diabetes Mellitus;
  - f. Cholesterol;
  - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - a. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
  - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per pregnancy.
  - c. Gestational diabetes screening.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
  - a. Counseling;
  - b. Prescription Drugs; and
  - c. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
  - a. Aspirin;
  - b. Folic acid supplement;
  - c. Vitamin D supplement;
  - d. Iron supplement; and
  - e. Bowel preparations.

Please note that certain age and gender and quantity limitations apply.

You may call Customer Service using the number on your Identification Card for additional information about these services or view the Federal government's web sites, <http://www.healthcare.gov/center/regulations/prevention.html>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>).

## **Prosthetic Appliances**

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic Injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

## **Reconstructive Surgery**

Precertification is required. Reconstructive surgery does not include any service otherwise excluded in this SPD. (See the "Limitations and Exclusions" section.)

Reconstructive surgery is covered only to the extent Medically Necessary:

- To correct significant anatomic deformities which are not within normal anatomic variation and which are caused by congenital or developmental abnormalities, illness, or Injury for the purpose of improving the significant anatomic deformity toward a normal appearance; or
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

**Note:** Coverage for reconstructive services does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

## **Retail Health Clinic**

Benefits are provided for Covered Services received at a Retail Health Clinic.

## **Skilled Nursing Facility Care**

Benefits are provided as outlined in the “Schedule of Benefits” section. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions require Pre-Certification. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member’s residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient; and
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician’s continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental or intellectual disability, and has no medical condition requiring care; or
- The care rendered is for other than Skilled Convalescent Care.

## **Surgical Care**

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

### **Blue Distinction Bariatric Surgery Benefit**

Blue Distinction is a national designation program which recognizes hospitals that have demonstrated expertise in delivering quality specialty care for patients with highly complex medical needs.

Your Employer has implemented the following benefit requirements related to the use of designated Blue Distinction facilities.

Covered Bariatric Procedure(s). This benefit applies to the following Medically Necessary bariatric procedure(s) as determined by the Medical Claims Administrator:

- Gastric banding
- Gastric stapling

### **Blue Distinction Cardiac Surgery Benefit**

Blue Distinction is a national designation program which recognizes hospitals that have demonstrated expertise in delivering quality specialty care for patients with highly complex medical needs.

Your Employer has implemented the following benefit requirements related to the use of designated Blue Distinction facilities.

Covered Cardiac Procedure(s). This benefit applies to the following Medically Necessary cardiac procedure(s) as determined by the Medical Claims Administrator:

- Coronary artery bypass graft
- Percutaneous coronary intervention

### **Blue Distinction Orthopedic Surgery Benefit**

Blue Distinction is a national designation program which recognizes Hospitals that have demonstrated expertise in delivering quality specialty care for patients with highly complex medical needs.

Your Employer has implemented the following benefit requirements related to the use of designated Blue Distinction facilities.



### **Covered Orthopedic Procedures.**

This benefit only applies to Medically Necessary Knee/Hip Replacement or Spine Surgery Procedures as designated by the Medical Claims Administrator restricted to the following procedures:

- Total knee replacement;
- Revision knee replacement;
- Total hip replacement;
- Revision hip replacement;
- Discectomy;
- Decompression;
- Primary spinal fusion; and,
- Revision spinal fusion.

### **Prescription Drug Benefits**

Prescription drug benefits under the HRA Plan option are administered by Express Scripts as the Claims Administrator. Your share of the cost of your prescription medications depends if you use participating retail pharmacies, the Express Scripts Pharmacy (for home delivery), 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.

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](http://www.express-scripts.com)**, or by contacting the AEP Benefits Center, toll-free, at 1-888-237-2363 or calling Express Scripts at 1-800-841-3045.

If you purchase a brand-name medication when your physician has allowed for a generic substitution – and a generic drug is available – you and the Plan will share the cost based on the cost of the generic, and you will be responsible for any difference in cost between the brand-name and generic medication.

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

## Ordering New Prescriptions or Refills

At participating retail pharmacies:

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

At nonparticipating retail 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) to the extent covered by the available HRA amount or the Plan's portion of any coinsurance it would have covered if you had obtained it at a participating pharmacy.

## Express Scripts Pharmacy (Order for Home Delivery)

The 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](http://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.

## Preventive Drugs

Coverage for under the Plan shall meet requirements as determined by Federal law, as those requirements change and become applicable to the Plan. 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, have a written prescription from a physician, and meet the applicable age and gender guidelines. The Member Pays Difference and Exclusive Home Delivery rules described later in this section will apply.

Medications/products covered as Preventive may change from time to time. To access the most up-to-date information about such medications/products, log in to [www.express-scripts.com](http://www.express-scripts.com). You will find a "click here" indicator to view the list of the Plan's preventive medications. You may also call the Express Scripts Member Services number listed on the back of your Identification Card.

## **Exclusive Home Delivery**

The HRA Plan participants 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 reimbursed from your HRA balance or applied toward your deductible or annual out-of-pocket maximum.

**Note:** Nursing home residents are exempt from this Exclusive Home Delivery plan provision.

## **Preferred Drug Step Therapy**

This program targets certain prescription medications in certain drug classes, that may change from time to time. At the effective date for this SPD, those targeted drug classes include:

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

The Plan wants you to encourage your physicians to prescribe lower-cost preferred brand or generic alternatives.

Nonpreferred brand drugs (for example, Prevacid, Prilosec, Lunesta, and Travatan) generally are not covered under the Plan. 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 Identification 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.

## **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 be reimbursed from your HRA balance or apply to your deductible or your annual out-of-pocket maximum.

## Precertification

Certain rare, specialty and non-specialty drug classes require precertification. Precertification will require a coverage review questionnaire to be completed by your physician before certain prescriptions can be filled.

Drugs that require precertification currently include certain drugs that treat Multiple Sclerosis, Rheumatoid Arthritis, psoriasis, Crohn's disease and some cancers, such as Adcirca, Letairis, Revatio, Tracleer, Tyvaso and Ventavis (PAH), Celebrex (COX-II Inhibitor) and Imitrex, Amerge, Axert, Frova, Treximet, Zomig and Sumavel (Migraine Therapy).

The drug classes and drugs listed here could change from time to time. Call the Express Scripts Member Services number listed on the back of your Identification Card to inquire about other prescription drugs that require a precertification.

## Medications

While outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are covered under the Plan to the extent described in this "Prescription Drug Benefits" and other sections of this SPD, certain Prescription Drugs are covered as medical or behavioral health benefits (administered by the Medical Claims Administrator or the Behavioral Health Claims Administrator, as appropriate) when rendered in a Hospital, in a Provider's office, or as part of a Home Health Care benefit. These would include prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, and drugs administered in your Provider's office.

## Limitations and Exclusions

In addition to the circumstances described in the "Limitations and Exclusions" section of this document, the following limitations and exclusions apply to the prescription drug benefits provided under the HRA 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 the Express Scripts Pharmacy.
- Exclusions
  - Allergy serum.
  - Renova.

The limitations, exclusions and drugs listed here could change from time to time. Call the Express Scripts Member Services number listed on the back of your Identification Card to inquire about the limitations and exclusions then applicable.

## Behavioral Health Benefits

In addition to benefits for physician services and hospitalization described in the “Medical Benefits Program” section, the HRA Plan provides coverage for behavioral health services. The Claims Administrator for mental health/substance abuse benefits described in this section is Magellan Healthcare Inc. (Magellan).

Express Scripts remains the Claims Administrator for prescription drugs, including those used to treat behavioral health conditions.

Benefits covered by this Behavioral Health Benefits program include treatment for:

- Mental illness;
- Emotional and psychological disorders; and
- Substance abuse (alcoholism, drug addiction, chemical dependency).

Magellan administers behavioral health benefits similarly to the way medical benefits are administered by Anthem. You may seek behavioral health services from any qualified Provider whether that Provider is in or out of Magellan’s Network.

Magellan offers a national network of Network Providers. The Magellan Network is made up of credentialed mental health/substance abuse professionals. All Network Providers have agreed to treat you and your eligible dependents at negotiated rates. In addition, there are also participating Hospitals, rehabilitation centers, day hospital programs and outpatient centers that are credentialed by Magellan.

You receive a higher level of coverage when care is utilized through the Magellan Network of Providers. You are encouraged to call Magellan at 1-877-705-4357 prior to entering any type of behavioral health treatment so that Magellan can help guide you through the services that may be available to you. For more information regarding precertification for behavioral health services, call the Magellan number on your medical Identification Card or log on to [www.magellanhealth.com/member](http://www.magellanhealth.com/member).

For services from Network Providers:

- You will not need to file claims. Network Providers will file claims for Covered Services for you. (You will still need to pay any Deductible or Coinsurance that applies.) You may be billed by your Network Provider(s) for any Non-Covered Services you get or when you have not followed the terms of this SPD.
- Precertification will be done by the Network Provider. (See the “Health Care Management – Precertification” section, above, for further details.)

## After Hours Care

If you need behavioral healthcare after normal business hours, your PCP may have several options for you. You should call your PCP’s office for instructions if you need behavioral healthcare in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency services provider.

## Out-of-Network Services

When you do not use a Magellan Network Provider or do not get behavioral healthcare as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this SPD.

For services from an Out-of-Network Provider:

- The Out-of-Network Provider can charge you the difference between his, her or its bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance;
- You may have higher cost sharing amounts (i.e., Deductibles and Coinsurance);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see "Health Care Management – Precertification" for more details.)

## How to Find a Provider in the Network

There are three ways you can find out if a Provider or facility is in the Magellan Network. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at [www.magellanhealth.com/member](http://www.magellanhealth.com/member), which lists the Doctors, Providers, and facilities that participate in this Plan's Network. The Networks are different depending on whether the care you are seeking is medical or behavioral health, so be sure to check the correct Network directory for the care you are seeking.
- Call Customer Service at Magellan to ask for a list of doctors and Providers that participate in this Plan's Network, based on specialty and geographic area. Again, the Networks are different depending on whether the care you are seeking is medical or behavioral health, so be sure to call the correct Customer Service for the care you are seeking.
- Check with your PCP, Specialist or other Provider.

If you need details about a Provider's license or training, or help choosing a Provider who is right for you, call the Magellan Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available. A special operator will get in touch with us to help with your needs.

## Precertification

All inpatient care must be precertified by calling Magellan at 1-877-705-4357. Precertification is available for the following:

- Inpatient admissions (including residential treatment);
- Behavioral Home Health Care;
- Biofeedback;
- Outpatient Electroconvulsive Therapy;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychological testing;
- Partial hospitalization;
- Office-based opioid treatment; and
- Intensive outpatient care.

If you do not obtain Precertification from Magellan, the care will be subject to post-treatment review to determine whether the care is covered by the Plan, including, but not limited to, whether the care was Medically Necessary; it is possible that Magellan will determine the care was not Medically Necessary and therefore retrospectively not covered by the Plan. Call Magellan at 1-877-705-4357 to Precertify behavioral health services.

Magellan also may review whether your ongoing in-network routine outpatient treatment will be covered by the Plan. If Magellan determines that your in-network routine outpatient treatment is outside usual treatment practices for your condition (for example, ongoing high frequency of sessions, extended duration of treatment inconsistent with your diagnosis), Magellan will contact your Provider to discuss your treatment plan and other alternatives that your Provider may consider that may be more likely to be covered by the Plan. After Magellan's review, if you and your Provider decide to continue with outpatient treatment that is not Medically Necessary, the services will not be covered by the Plan.

Magellan does not practice medicine. Magellan's authority is limited only to whether benefits for your treatment or service are available under the Plan; it cannot supersede the professional judgment of your treating Provider. In all situations, your Provider must use his/her professional judgment to provide care believed to be in your best interest.

## **What Is Not Covered under Your Behavioral Health Benefits Program**

In addition to the circumstances described in the "Limitations and Exclusions" section of this document, the following exclusions apply to the Behavioral Health benefits provided under the HRA Plan:

Benefits are not payable for:

- Aversion therapy.
- Treatment for caffeine-related disorders, nicotine-related disorders or fictitious disorders.\*
- Charges for the following types of mental health/substance abuse treatment: transcendental meditation; rolfing; z therapy; EST; primal; bioenergetic; carbon dioxide; sedative action electrostimulation; confrontation; hyperbaric or normobaric oxygen; poetry/art; megavitamin orthomolecular therapy, guided imagery, narcotherapy with LSA, sensitivity training, education remediation, crystal healing treatment, and hemodialysis.
- Treatment of pain except treatment of pain with psychological or psychosomatic origins as determined to be a covered health service by Magellan.
- Services, treatment or supplies that are not considered a covered health service by Magellan.
- Sex therapy.
- Treatment of paraphilias, such as pedophilia.
- Stress management therapy, but active employees should refer to the description of the separate Employee Assistance Program (EAP), which is available to employees without regard to their participation in the AEP System Comprehensive Medical Plan.
- Consultations for purposes of adjudication of marital and child support custody case.

\* Notwithstanding the exclusion of a diagnosis as set forth above, the Plan will pay for Medically Necessary stabilization of acute behavioral or emotional exacerbations related to or arising from such disorder.

**Note:** If you are an Employee, you and your eligible dependents and your Household Members are eligible to use the Employee Assistance Program (EAP) offered by AEP as a stand-alone program, which is independent of the AEP System Comprehensive Medical Plan, at no cost to you or them. Magellan is the EAP vendor. The EAP offers confidential, professional, short-term counseling and referral services to all AEP employees, their spouses or eligible domestic partners and dependent children, and your household members. EAP services can be accessed by calling Magellan at 1-877-705-4357 or online at [www.magellanhealth.com/member](http://www.magellanhealth.com/member). Please refer to the description of the "Employee Assistance Program" section that immediately follows for more details.

\*\*\*\*\*FOR INFORMATIONAL PURPOSES ONLY (START)\*\*\*\*\*  
(This section describing the Employee Assistance Program is not intended to be considered a part of the formal Summary Plan Description for the AEP System Comprehensive Medical Plan as these benefits are not provided through the AEP System Comprehensive Medical Plan.)

## **The Employee Assistance Program (EAP)**

The Magellan EAP provides confidential, professional, short-term counseling and referral services to all AEP employees, their spouses or eligible domestic partners, and dependent children under age 26. Regardless if you are enrolled in any of AEP's medical plans or waive medical coverage, the Magellan EAP is available to you and your eligible dependents at no charge to you.

EAP services can be accessed by calling Magellan at 1-877-705-4357. The EAP is designed to address a wide range of personal problems and all counseling is confidential, except as required by law. When you contact Magellan, a Magellan representative will arrange for appropriate assistance which may involve referral to an EAP counselor, another behavioral health provider for benefit covered treatment, and/or resources in your community.

You and your eligible dependents are entitled to up to six EAP visits, per problem, per year, as clinically necessary, at no cost to you. The services must be provided by an EAP network provider. If an issue is identified that will require care beyond the scope of counseling within the EAP, a referral will be made. If your EAP counselor determines that a referral to another qualified professional is advisable, benefit coverage will depend on:

- If you are enrolled in one of AEP's medical plans;
- Whether you see in-network or out-of-network providers; and
- Where you receive care.

Though the EAP is able to provide assistance for a wide range of problems, the EAP is not able to provide services for:

- Evaluations required by a state or federal judicial officer or other governmental official or agency.
- Court mandated counseling; evaluations or recommendations to be used in child custody proceedings, child abuse proceedings, criminal proceedings, workers' compensation proceedings or any legal action.
- Evaluations for fitness for duty determination or excuses for leaves of absence or time off..
- Psychological, psychiatric, neurological, education or IQ testing.
- Remedial and social skills education services, such as evaluation or treatment of learning disabilities, learning disorders, academic skill disorders, language disorders, mental retardation, motor skill disorders, or communication disorders; behavioral training; or cognitive rehabilitation.



- Medical care, including services for a condition that requires psychiatric treatment (for example, a psychosis).
- Inpatient treatment.
- Services by providers who are not part of Magellan's EAP counselor network.
- EAP sessions that were not accessed through Magellan's toll-free telephone number or Magellan's on-line self-referral service for the particular episode of care.
- Medication, medication management. If you have a mental health or substance abuse condition for which medication is required, you must see a doctor to prescribe the medication and oversee your use of the medication.
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), obtaining any kind of insurance coverage.
- Testimony in legal proceedings, creation of records for legal proceedings or other preparation for legal proceedings.
- Guidance on workplace issues when you sue, or threaten to sue, a Participating AEP System Company or other AEP affiliate.
- Acupuncture.
- Biofeedback & hypnotherapy.
- Group counseling.

### **Reimbursement of Claims**

Magellan pays EAP counselors directly. You do not have to file EAP claims. There are no copays, coinsurance, or deductibles. You should not make any payment to a provider for EAP services. You should not make any agreement with an EAP counselor to pay the counselor for EAP sessions. However, you will be responsible to pay for services that you obtain (i) without having Magellan open an EAP case with a particular EAP counselor, or (ii) your completing an electronic referral request through Magellan's online EAP self-referral process.

### **Claim Determinations**

If you are receiving an ongoing course of EAP counseling, Magellan will notify you in advance if it intends to terminate or reduce the number of EAP sessions that can be provided so that you will have an opportunity to appeal the decision before the termination or reduction takes effect.

Because Magellan pays all EAP counselors directly, you should not make any payment to a counselor for EAP sessions. In the event that you mistakenly pay a counselor for EAP sessions, Magellan will make a determination on your request for reimbursement within 15 days after receipt of the claim (if EAP services have not yet been received) or within 30 days after receipt of the claim (if the EAP services have already been received). Magellan will notify you of its determination telephonically, and, if you consent to written notice, in writing, within the 15 day or 30 day period, as applicable.

EAP services do not include urgent care services. Therefore, if Magellan determines that you need urgent care, Magellan will make an appropriate referral to your benefit plan and/or emergency resources in the community. Magellan does not make determinations relating to urgent care under the EAP.

**Termination of EAP Participation**

- Your employment with all Participating AEP System Companies terminates. Your EAP participation will end on the last day of the pay period in which your employment ends (except as provided under any applicable law).
- Death. Your eligible dependents will be covered through the end of the month following your death.
- Change in employment status that affects your eligibility to participate in the EAP. Coverage ends on the last day of the pay period in which your employment status changes.
- Retirement. Coverage continues through the end of the month in which you retire.
- Divorce. Coverage for your ex-spouse continues through the last day of the month in which the divorce is final.
- The EAP ends. Coverage for you and your eligible dependents ends on the date the EAP is terminated.

**Assignment of Benefits**

You may not assign, transfer, or convey any of the benefits provided by the EAP.

**Confidentiality**

Discussions with the EAP counselor are confidential. The EAP will not share information identifying your use of the EAP without your permission, except as required or permitted by law. You will have an opportunity to evaluate the services provided by the EAP by completing a confidential survey.

\*\*\*\*\* FOR INFORMATIONAL PURPOSES ONLY (END) \*\*\*\*\*

**Limitations and Exclusions**

These limitations and exclusions apply even if a qualified practitioner has performed or prescribed a Medically Necessary procedure, treatment or supply. This does not prevent your qualified practitioner from providing or performing the procedure, treatment or supply. Regardless, the procedure, treatment or supply will not be a covered expense. Additional limitations and exclusions are set forth in other sections of this SPD.

<b>ACT OF WAR/MILITARY DUTY:</b>
Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services (directly related to military service) provided or available from the Veterans' Administration or military facilities except as required by law.
<b>CUSTODIAL/CONVALESCENT CARE:</b>
Services for Custodial Care.
Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
<b>DENTAL SERVICES:</b>
Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered.

<b>ELIGIBILITY:</b>
Charges for treatment received before coverage under this option began or after coverage terminated.
<b>EXPERIMENTAL/INVESTIGATIONAL:</b>
Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are in the applicable Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated.
Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the applicable Claims Administrator.
<b>GOVERNMENT AGENCY/LAWS/PLANS:</b>
Services that can be provided through a government program for which you as a member of the community are eligible for participation, but only to the extent allowed by law. Such programs include, but are not limited to, school speech and reading programs.
Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
Except to the extent otherwise required by law (such as the Medicare Secondary Payer rules), services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the <u>primary payer whether or not the Member has enrolled Medicare Part B.</u>
Court-ordered services, or those required by court order as a condition of parole or probation (unless Medically Necessary and approved by the Plan).
<b>MEDICATIONS:</b>
Nonprescription drugs, medications or supplies (except insulin).
<b>MEDICALLY NECESSARY:</b>
Care, supplies, or equipment not Medically Necessary, as determined by the applicable Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy <u>guidelines.</u>
Vitamins, minerals and food supplement, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific illness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.
Services for Hospital confinement primarily for diagnostic studies.
Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an injury or to correct a congenital defect.
<b>MISCELLANEOUS:</b>
Donor Search/Compatibility Fee (except as explicitly provided under the Plan).
Hearing aids, hearing devices or examinations for prescribing or fitting them.
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.
Contraceptive Drugs, except for any above stated covered contraceptive services.

<b>MISCELLANEOUS (cont'd):</b>
In-vitro Fertilization and Artificial Insemination.
Hair transplants, hair pieces or wigs (except when necessitated by disease) wig maintenance, or prescriptions or medications related to hair growth.
Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided under "Covered Services."
Christian Science Practitioner.
Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state, or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.
For any charges for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided under the Plan.
Respite care.
<b>SPECIAL CHARGES/SERVICES:</b>
Services or supplies provided by a member of your family or household.
Charges or any portion of a charge in excess of the maximum allowable amount as determined by the Claims Administrator.
Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
Administrative Charges - Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provider their test results; specific medical reports including those not directly related to the treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.
Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies. Nutritional supplies (such as diet foods or over-the-counter diet pills) that do not require a prescription.
<b>SURGERY:</b>
Reversal of vasectomy or tubal ligation.
Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.

<b>THERAPIES:</b>
Services for outpatient therapy or rehabilitation other than those specifically noted. Excluded forms of therapy include, but are not limited to: primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy, and boot camp therapy.
<b>VISION CARE:</b>
Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.
Vision Surgeries - Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
<b>WEIGHT REDUCTION PROGRAMS:</b>
Services for weight reduction programs, services and supplies. Weight loss programs, including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss).

### Coverage Regarding Approved Clinical Trials

Notwithstanding the foregoing limitations and exclusions, the Claims Administrator will not

- Deny any Qualified Individual the right to participate in an Approved Clinical Trial provided through a Network Provider;
- Deny, limit, or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the clinical trial; nor
- Discriminate against any Qualified Individual who participates in an Approved Clinical Trial.

For this purpose, the following definitions apply:

- “Routine Patient Costs” include items and services typically provided under the Plan for a Member not enrolled in a clinical trial. However, such items and services do not include (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.
- “Qualified Individual” is a Member who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other life-threatening disease or condition and either —
  - The referring health care professional is a Network Provider and has concluded that the Member’s participation in the clinical trial would be appropriate; or
  - The Member provides medical and scientific information establishing that the Member’s participation in the clinical trial would be appropriate.
- “Approved Clinical Trial” is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the federal Food and Drug Administration; or is exempt from investigational new drug application requirements.
- “Life-Threatening Disease or Condition” is a disease or condition likely to result in death unless the disease or condition is interrupted.

## Filing Claims & Claims Appeals

When you use Network Providers (including participating pharmacies), your Providers may file claims for you. If you use an Out-of-Network Provider (or nonparticipating pharmacy), 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, receipt or other documentation 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 or receipt or other documentation from the pharmacy 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 applicable Claims Administrator's 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. No request for an adjustment of a claim can be submitted later than two years after the claim has been paid.**

You may file claims for plan benefits, and appeal adverse claim decisions, either by yourself or through an authorized representative. In order to process your claim, the Claims Administrator may need information from the Provider of the service. As a claimant, you agree to authorize your physician, hospital, or other provider to release necessary information. The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

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 Identification Card. Member Services representatives are available to take your call during regular business hours, Monday through Friday.

### **Benefit Determinations for Anthem Medical Benefit Claims**

For general medical benefits, the Medical Claims Administrator performs all internal levels of appeal.

### **Benefit Determinations for Magellan Behavioral Health Claims**

For behavioral health benefits, the Behavioral Health Claims Administrator performs all internal levels of appeal.

### **Benefit Determinations for Express Scripts Prescription Drug Claims**

For prescription drug benefits, the Prescription Drug Claims Administrator 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. For example, Certain prescription drugs require pre-certification by the Prescription Drug Claims Administrator before they can be filled. 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, within five days after the improper claim is received.

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 (Internal).”

### **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 (Internal)."

### **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 Identification 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:

#### For Medical Claims

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

#### For Behavioral Health Claims

Magellan Healthcare, Inc., Appeals Department; P.O. Box 2128; Maryland Heights, MO 63043  
(Fax number 888-656-3820)

#### For Prescription Drug Claims

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

**You must include your Member Identification Number when submitting an appeal.**

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 30 days after receipt of your request for a first-level appeal.
- For first-level appeals of post-service claims, not later than 60 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.

**Voluntary 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. The filing of a second-level appeal is voluntary and you are not required to undertake it before pursuing legal action. If you choose not to file for voluntary second-level appeal, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

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 30 days after receipt of your request for a second-level appeal.
- For appeals of post-service claims, not later than 60 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**

See also the "Expedited External Reviews" section if you receive an adverse benefit determination to your urgent care appeal and you want to request an expedited external review.

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

- The adverse determination on first-level appeal involved medical judgment (such as those based on medical necessity, appropriateness, health care setting, or level of care; or a determination that a treatment is experimental or investigational; among others); 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 to participate in the plan is not eligible for external review.

If upon your first-level 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 first-level appeal.

### **Preliminary Review**

Within 5 business days 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 mandatory internal appeals process (unless Deemed Exhaustion applies – generally upon the failure of the Claims Administrator to make its determination on your claim or your appeal within the required timeframes), 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 first-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 first-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.

## Coordination of Benefits (COB)

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the SPD, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the SPD, Plan has the meaning listed in the "Definitions" section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance and Deductible under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowable Amount.

## COB Definitions

**Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non-group insurance contracts and subscriber contracts; Health Maintenance Organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non-group closed panel plans; group-type contracts; medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.
2. Plan does not include: Accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

**This Plan** means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

**Allowable expense** is a health care expense, including Deductibles and Coinsurance that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non-Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount that is subject to the Primary high-Deductible health plan's Deductible, if the applicable Claims Administrator has been advised by you that all Plans covering you are high-Deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.



**Closed panel plan** is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

**Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

## Order of Benefit Determination Rules

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

**Rule 1 - Non-Dependent or Dependent.** The Plan that covers you other than as a Dependent, for example as an Employee, Member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an Employee, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

**Rule 2 - Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
  - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
  - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
  - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
  - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The Plan covering the custodial parent;
    - The Plan covering the Spouse of the custodial parent;
    - The Plan covering the non-custodial parent; and then
    - The Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

**Rule 3 - Active Employee or Retired or Laid-off Employee.** The Plan that covers you as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off Employee is the Secondary Plan. The same would hold true if you are a Dependent of an active Employee and you are a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

**Rule 4 - COBRA.** If you are covered under COBRA or under a right of continuation provided by other Federal law and are covered under another Plan, the Plan covering you as an Employee, Member, subscriber or retiree or covering you as a Dependent of an Employee, Member, subscriber or retiree is the Primary Plan and the COBRA or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an Employee or as a retired Employee and is covered under his or her own Plan as an Employee, Member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Dependent of an Employee, Member or subscriber or retired Employee and is covered under the other plan as a Dependent of an Employee, Member, subscriber or retiree).

**Rule 5 - Longer or Shorter Length of Coverage.** The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

**Rule 6** - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

### **Effect on the Benefits of this Plan**

When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, we start with this Plan's Allowable expense, deduct the Primary Plan's payment and then deduct any Deductibles or Coinsurance.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

### **Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The applicable Claims Administrator may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The applicable Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the applicable Claims Administrator any facts the Claims Administrator needs to apply those rules and determine benefits payable.

### **Facility of Payment**

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, this Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

### **Right of Recovery**

If the amount of the payments made by this Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## When a Covered Person Qualifies for Medicare

When you are eligible for the Medicare program and Medicare is allowed by Federal law to be the primary payer, the benefits described in this SPD will be reduced by the amount of benefits allowed under Medicare for the same Covered Services. This reduction will be made whether or not you actually receive the benefits from Medicare. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

- **If You Are Under Age 65 With End Stage Renal Disease (ESRD)**  
If you are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), this Plan will be primary and Medicare will be secondary. This includes the Medicare “three month waiting period” and the additional **30 months** after the Medicare effective date. After 33 months, this Plan will be secondary and Medicare will be primary.
- **If You Are Under Age 65 With Other Disability**  
If you are under age 65 and eligible for Medicare only because of a disability other than ESRD, this Plan will be primary and Medicare will be secondary. This is the case **only** if you are the actively employed Subscriber or the enrolled Spouse or child of the actively employed Subscriber.
- **If You Are Age 65 or Older**  
If you are age 65 or older and eligible for Medicare only because of age, this Plan will be primary and Medicare will be secondary. This can be the case **only** if you are an actively employed Subscriber or the enrolled Spouse of the actively employed Subscriber.

## Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

## Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source.

## Recovery

A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, Workers’ Compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

## Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

## Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery, whichever is less, from any future benefit under the Plan if:
  1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

## **Your Duties**

- You must notify the applicable Claims Administrator promptly of how, when and where an accident or incident resulting in personal Injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to you.
- You must promptly notify the applicable Claims Administrator if you retain an attorney or if a lawsuit is filed on your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal Injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

## **General Information**

### **Workers' Compensation**

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent Employer liability or indemnification law.

## **Other Government Programs**

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

## **Right of Recovery**

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

## **Modifications or Changes in Coverage**

The Plan Sponsor may change the benefits described in this SPD and the Member will be informed of such changes as required by law. This SPD shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer without the consent or concurrence of any Member.

## **Fraud**

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage, in addition to any other consequences that may be applicable by law or the Employer's policies.

## **Unauthorized Use of Identification Card**

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements in connection with enrollment and/or claims for services or payment may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

## **Assignment**

You authorize each Claims Administrator, on behalf of the Plan, to make payments directly to Providers for Covered Services. Each Claims Administrator also reserves the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person's custodial parent or designated representative. Any payments made by a Claims Administrator will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable federal law.

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

## **Acts Beyond Reasonable Control (Force Majeure)**

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

## **Conformity with Law**

Any provision of the Plan which is in conflict with the applicable Federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

## **Clerical Error**

Clerical error, whether of a Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or maintain or otherwise continue benefits otherwise validly terminated or otherwise not in force.

## **Policies and Procedures**

Each Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

## **Waiver**

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

## **Reservation of Discretionary Authority**

Each Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the SPD. This includes, without limitation, the power to act within its scope of benefits to determine all questions arising under the Plan, to resolve Member appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the SPD of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Medical Benefits portions of this SPD, Express Scripts has complete discretion to interpret the Prescription Drug Benefits portions of this SPD, and Magellan Behavioral Health has complete discretion to interpret the Behavioral Health Benefits portions of this SPD. Each Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable appeals procedures.



## **When Coverage Ends**

### **Generally**

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

- You stop paying required contributions;
- You terminate employment (if you are covered as an Employee);
- You are no longer eligible;
- This Plan ends;
- You die; or
- You enroll in a Medicare Part D prescription drug benefit other than AEP's and you were not automatically enrolled due to the federal low income subsidy.

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

Should you or any covered family Members be receiving covered care in the Hospital at the time your coverage terminates for reasons other than the termination of this Plan, or failure to pay the required contributions, benefits for Hospital Inpatient care will be provided until the date you are discharged from the Hospital.

### **Continuing Coverage as an AEP Retiree**

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

### **Continuing Coverage as a Surviving Dependent**

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

### **Continuing 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 AEP System Companies (generally referred to in these sections as the "Company"). You and your spouse should take the time to read this notice carefully.

When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### **Qualified Beneficiaries**

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

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

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

Although COBRA laws do not establish health benefit continuation rights for other categories of eligible dependent (such as domestic partners while they remain eligible or lose coverage under circumstances that are similar to the COBRA qualifying events described below), AEP offers COBRA-like coverage to them under the medical plan.

### **COBRA Qualifying Events**

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

*Spouse or Domestic Partner.* 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 six (6) reasons:

- Your death;
- A surviving spouse's remarriage within 36 months of your death;
- The termination of your employment (for reasons other than gross misconduct) or reduction in your hours;
- Your divorce, legal separation or termination of domestic partnership;

- You become eligible for benefits under Medicare Part A, Part B, or both; or
- A filing under Title 11 of the Federal Bankruptcy Code with respect to the employer. With regard to this qualifying event, the loss of coverage may include the substantial elimination of coverage within one year before or after the filing.

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

- Your death;
- The termination of your employment (for reasons other than gross misconduct) or reduction in your hours;
- Your divorce, legal separation or termination of domestic partnership;
- You become eligible for benefits under Medicare Part A, Part B, or both;
- Your dependent ceases to be a “dependent child” under the Plan; or
- 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”).

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

#### *Obligation to Notify the Company of Certain Qualifying Events*

Under COBRA, you or your family member has the responsibility to inform the Company of a divorce, 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.

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

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

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

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

### **Notice of Election**

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

Under COBRA, you and each qualified beneficiary have 60 days from the latter of the date you would lose coverage because of one of the qualifying events previously described, or the date you are notified of your rights to continue coverage, to inform the Company that you want continuation coverage. As mentioned 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 contributions for the continuation coverage in a timely manner. (See the section on "Conditions on Continuation Coverage.")

### **Duration of Continuation of Coverage**

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

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

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

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

COBRA generally requires that a plan offer conversion health plan coverage to a qualified beneficiary who uses continuation coverage for the maximum coverage period, but only if conversion coverage is otherwise generally available under the Plan. Because the 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:

- The Company no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid in a timely fashion;
- 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);
- 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
- 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.

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

### **Conditions on Continuation 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. If you or your dependents are entitled to up to 29 months of continuation coverage due to disability, the premium increases to as much as 150% of the full cost beginning with the 19th month of continuation coverage. The AEP Benefits Center can provide you with current cost information.

You must pay for the coverage in monthly installments. Your first payment must be in full and received no later than 45 days after the date you elect continuation coverage. For payment after that first payment, you will have a grace period of at least 30 days to pay the premiums. As a general matter, coverage will be suspended for 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.

### **Other Coverage Options Besides COBRA Continuation Coverage**

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **If You Have Questions**

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Continuation of Coverage During Military Leave (USERRA)**

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

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

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

## For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under this Plan is available from the AEP Benefits Center.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact the AEP Benefits Center.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## Life Events and Your Coverage

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

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

## You Begin Working at AEP

As a new employee of a Participating AEP System Company, you must indicate your medical plan election within 31 days of your hire date. If you do not enroll within 31 days, you will be defaulted into the Basic HSA Plan option covering yourself only. Unless you experience a qualifying change in family or employment status, you will not be able to make changes to your benefit elections until the next Annual Enrollment period.

Coverage begins on your first day of work whether you elect coverage or are defaulted into coverage.

## **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 will be requested by the AEP Benefits Center in order to enroll your new spouse. A marriage event does NOT allow you to change your medical plan option.

Coverage is effective on the date of your marriage if you enroll yourself, your eligible 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 option.

## **Your Domestic Partnership Ends**

You must notify the AEP Benefits Center of the loss of dependent eligibility due to termination of a domestic partnership. The AEP Benefits Center can help you make changes to your medical 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 the names of former 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 to change your medical plan option.



## **You Are Unable to Work Due to an Illness or Injury**

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

## **You Die**

In the event you die, your survivors must contact the AEP Benefits Center to make decisions about whether to continue coverage for themselves if they were enrolled in medical coverage at the time of your death.

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

Your death does NOT allow your surviving dependents to change the medical plan option in which they were enrolled, except surviving spouse who is over age 65 may elect among the plan options then available.

## **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 medical plan. 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 dependent on the last day of the month in which he or she no longer meets any other requirement to be considered an eligible dependent. The child may continue coverage through COBRA.

## **Birth/Adoption/Placement for Adoption/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 months 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 medical plan 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 Begin a Family Medical Leave of Absence (FMLA)**

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

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

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

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

COBRA eligibility does not begin until your FMLA leave ends.

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

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

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

## **You Begin a Paid Military Leave of Absence**

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

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

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

## **You Terminate Employment before Qualifying for AEP Retiree Benefits**

If your employment with a Participating Company terminates for any reason prior to both reaching age 55 and at least 10 years of service, your medical coverage ends on the last day of the month in which your employment ends. You and your dependents may be eligible to continue medical coverage through COBRA. Under COBRA you pay the full cost of that coverage, plus an administrative charge.

## **You Terminate Employment After Becoming Retiree Benefits Eligible**

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

See section titled "Enrolling for Coverage."

If you elect retiree medical coverage, contributions will either be deducted from your monthly pension check (if applicable) or you will be billed monthly for your contributions.

## **You are Rehired at AEP**

As a rehired employee of a Participating AEP System Company, you must indicate your medical plan election within 31 days of your rehire date. If you do not enroll or waive within 31 days, you may be enrolled in the default coverage then applicable (see “Enrolling for Coverage” section). Unless you experience a qualifying change in status, you will not be able to make changes to your benefit elections until the next Annual Enrollment period.

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

## **You Return from an Unpaid Leave of Absence**

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

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

## **You Return After Retirement**

If you return to work with a Participating AEP System 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.

## **Coverage or Employer Contributions Lost Under Another Medical Plan**

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

- Lost eligibility under a prior medical plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact;
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior medical plan; or
- Lost Employer contributions towards the cost of the other 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 a birth or adoption). You also may be required to provide proof of the qualifying status change(s).

## **Medicaid or CHIP Coverage (Loss of Eligibility or Qualify for Premium Assistance)**

You may request enrollment in the AEP Comprehensive Medical Plan 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.

### **Newly Eligible Because of Change In AEP Employment Status**

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

## **Definitions**

### **Accidental Injury**

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

### **Ambulance Services**

A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

### **Authorized Service(s)**

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance or Deductible. For more information, see the "Claims Payment" section.

### **Behavioral Health Care**

Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

### **Benefit Period**

One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's coverage becomes effective. It does not continue after a Member's coverage ends.

## **Blue Distinction Bariatric Surgery Providers**

**Blue Distinction Center (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

**Blue Distinction Center+ (BDC+) Facility:** Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

**Designated Bariatric Surgery Provider:** A Provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for Bariatric Surgery Procedures.

**PAR Bariatric Surgery Provider:** Hospitals participating in the Medical Claims Administrator's networks; also known as "Network" or "PAR" (are NOT designated as either Blue Distinction Center+ or Blue Distinction Center).

**Non-PAR Bariatric Surgery Provider:** Any Provider that does not hold a contractual agreement with Blue Cross Blue Shield Plans to provide Bariatric Surgery services; also known as "Out-of-Network" or "non-PAR."

## **Blue Distinction Cardiac Providers**

**Blue Distinction Center (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

**Blue Distinction Center+ (BDC+) Facility:** Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

**Designated Cardiac Provider:** A Provider who has achieved designation as a Blue Distinction+ or Blue Distinction Center for Cardiac Procedures.

**PAR Cardiac Provider:** Hospitals participating in the Medical Claims Administrator's networks; also known as "Network" or "PAR" (are NOT designated as either Blue Distinction Center+ or Blue Distinction Center).

**Non-PAR Cardiac Provider:** Any Provider that does not hold a contractual agreement with Blue Cross Blue Shield Plans to provide Cardiac services; also known as "Out-of-Network" or "non-PAR."

## **Blue Distinction Orthopedic Surgery Providers**

**Blue Distinction (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

**Blue Distinction+ (BDC+) Facility:** Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

**Designated Orthopedic Provider:** A Provider who has achieved designation as a Blue Distinction+ or Blue Distinction Center for Knee/Hip Replacement or Spine Surgery.

**PAR Orthopedic Provider:** Hospitals participating in the Medical Claims Administrator's networks; also known as "Network" or "PAR" (are NOT designated as either Blue Distinction+ or Blue Distinction).

**Non-PAR Orthopedic Provider:** Any Provider that does not hold a contractual agreement with Blue Cross Blue Shield Plans to provide orthopedic services; also known as "Out-of-Network" or "non-PAR."

## **Centers of Excellence (COE) Network**

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Medical Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

## **Claims Administrator**

The company the Plan Sponsor chose to administer benefits with respect to a designated portion of its Comprehensive Medical Plan. Community Insurance Company was chosen to administer the Medical benefits portion of the Plan. Express Scripts Inc. was chosen to administer the Prescription Drug benefits portion of the Plan. Magellan Behavioral Health Services was chosen to administer the Behavioral Health benefits portion of the Plan. Each Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

## **Coinsurance**

If a Member's coverage payable by the Plan is limited to a certain percentage, for example 85%, then the remaining 15% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

## **Combined Limit**

The maximum total of Network and Out-of-Network benefits available for designated health services in the "Schedule of Benefits" section.

## **Complications of Pregnancy**

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, and cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, and Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

## **Congenital Anomaly**

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

## **Coordination of Benefits**

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

## **Cosmetic Surgery**

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

## **Covered Dependent**

Any Dependent in a Subscriber's family who meets all the requirements of the "Eligibility" section of this SPD, has enrolled in the Plan, and whose coverage under the Plan has not ended.

## **Covered Services**

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

## **Covered Transplant Procedure**

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Medical Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.



## **Custodial Care**

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

## **Deductible**

The portion of a bill representing Covered Services that must be paid before the medical expenses will be subjected to the Coinsurance provisions. It usually is applied on a calendar year basis.

## **Dependent**

The Spouse (same or opposite sex) and same sex Domestic Partner and all children until attaining age limit, each to the extent stated in the "Eligibility" section. Children include natural children, legally adopted children, foster children and stepchildren. Also included are your children (or children of your Spouse (same or opposite sex) and eligible same sex Domestic Partner) and children for whom you have legal responsibility resulting from a qualified medical child support order.

Mentally, intellectually or physically disabled children remain covered no matter what age to the extent stated in the "Eligibility" section.

## **Detoxification**

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

## **Developmental Delay**

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

## **Domestic Partner**

Your same sex Domestic Partner who meets all the requirements stated in the “Eligibility” section  
Domestic Partner eligibility ends on the date a Domestic Partner no longer meets all the requirements  
stated in the “Eligibility” section.

## **Durable Medical Equipment**

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the  
treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d)  
not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

## **Elective Surgical Procedure**

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member  
to a later point in time.

## **Emergency Medical Condition**

(“Emergency services,” “emergency care,” or “Medical Emergency”) Emergency Medical Condition  
means a medical condition manifesting itself by acute symptoms of sufficient severity (including  
severe pain) such that a prudent layperson, who possesses an average knowledge of health and  
medicine, could reasonably expect the absence of immediate medical attention to result in[one of the  
following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the  
woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

## **Employee**

A person who is classified by the Employer as its employee and is eligible for Plan coverage under  
the employment regulations of the Employer. The Employee is also called the Subscriber.

## **Employer**

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor  
or adopting the Plan as a participating Employer by being classified on the records of the Plan  
Sponsor as a Participating AEP System Company.

## **Experimental/Investigative**

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 applicable 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; or
- 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; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- 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; or
- Documents of an IRB or other similar body performing substantially the same function; or
- 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; or
- 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 within the scope of its Plan benefit determinations pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

### **Freestanding Ambulatory Facility**

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

### **Group Health Plan or Plan**

An employee welfare benefit plan (as defined in Section 3(1) of ERISA), established by an employer. References in this SPD to the Plan may be construed as reference to the American Electric Power System Comprehensive Medical Plan unless the contexts suggests otherwise.

### **Home Health Care**

Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

### **Home Health Care Agency**

A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

### **Hospice**

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

### **Hospice Care Program**

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

## **Hospital**

An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or disabled children.

## **Identification Card or ID Card**

The latest card given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective.

## **Ineligible Charges**

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

## **Ineligible Provider**

A Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

## **Infertile or Infertility**

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

## **Injury**

Bodily harm from a non-occupational accident.

## **Inpatient**

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

## **Intensive Care Unit**

A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

## **Late Enrollees**

Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders pursuant to a qualified medical child support order that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued.

## **Maternity Care**

Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

## **Maximum Allowed Amount**

The maximum amount that the Plan will allow for Covered Services you receive.

For example, the Claims Administrator may determine that a claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code. Likewise, when multiple procedures are performed on the same day by the same Provider, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider. For Covered Services performed by a Network Provider, the Maximum Allowed Amount is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have Coinsurance.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the applicable Claims Administrator:

- An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established at its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or
- An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
- An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Unlike Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges.

## **Medical Facility**

A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this SPD. The facility must be licensed, accredited, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the applicable Claims Administrator.

## **Medical Necessity or Medically Necessary**

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 applicable 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; or,
- Not otherwise subject to an exclusion under this SPD.

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.

## **Member**

Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

## **Network Provider**

A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the applicable Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

## **Non-Covered Services**

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

## **Out-of-Network Provider**

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the applicable Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

## **Out-of-Pocket Maximum**

The maximum amount of a Member's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.



## **Physical Therapy**

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

## **Physician**

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

## **Plan**

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

## **Plan Administrator**

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. **The Plan Administrator is not a Claims Administrator.**

## **Plan Sponsor**

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. **The Plan Sponsor is not a Claims Administrator.**

## **Precertification**

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

## **Primary Care Physician**

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

## **Provider**

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. Providers that deliver Covered Services are described throughout this SPD. If you have a question if a Provider is covered, please call the number on the back of your Identification Card.

## **QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order**

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- Provides for child support payment related to health benefits with respect to the child of a group health plan Member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- Enforces a state law relating to medical child support payment with respect to a group health plan.

## **Retail Health Clinic**

A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

## **Semiprivate Room**

A Hospital room which contains two or more beds.

## **Skilled Convalescent Care**

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

## **Skilled Nursing Facility**

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

## **SPD**

This SPD in conjunction with any amendment constitutes the entire Plan. If there is any conflict between either this SPD and any amendment, the amendment shall control.

## **Specialist (Specialty Care Physician\Provider or SCP)**

A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

## **Spouse**

For the purpose of this Plan, a Spouse is defined as shown in the “Eligibility” section of this SPD.

## **Therapeutic Equivalent**

Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

## **Transplant Providers**

**Network Transplant Provider:** A Provider that has been designated as a “Center of Excellence” for Transplants by the Medical Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

**Out-of-Network Transplant Provider:** Any Provider that has NOT been designated as a “Center of Excellence” for Transplants by the Medical Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

**Blue Distinction Center (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).

**Blue Distinction Center+ (BDC+) Facility:** Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

**Designated Transplant Provider:** A Provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for Transplant Procedures.

**PAR Transplant Provider:** Hospitals participating in the Medical Claims Administrator’s networks; also known as “Network” or “PAR” (are NOT designated as either Blue Distinction Center+ or Blue Distinction Center).

**Non-PAR Transplant Provider:** Any Provider that does not hold a contractual agreement with Blue Cross Blue Shield Plans to provide Transplant services; also known as “Out-of-Network” or “non-PAR.”

## **Urgent Care**

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

## **Utilization Review**

A function performed by a Claims Administrator or by an organization or entity selected by a Claims Administrator to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.

## **You and Your**

Refer to the Subscriber, Member and each Covered Dependent.

## **Health Benefits Coverage Under Federal Law**

### **Choice of Primary Care Physician**

The Plan generally allows you to select your own Primary Care Physician (PCP).

### **Access to Obstetrical and Gynecological (ObGyn) Care**

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Medical Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Precertification for certain services or following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to the Medical Claims Administrator's website, [www.anthem.com](http://www.anthem.com).

### **Statement of Rights Under the Newborns' and Mother's Health Protection Act**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider (e.g., your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain Precertification. For information on Precertification, contact your Plan Administrator.

Also, under Federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

## **Statement of Rights Under the Women's Cancer Rights Act of 1998**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the "Schedule of Benefits" section.

If you would like more information on WHCRA benefits, call your Plan Administrator.

## **Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")**

If you or your Spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your Employer or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

## **Special Enrollment Notice**

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health benefit coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards you or your Dependents' other coverage). However, you must request enrollment within 31 days after you or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage (or within 90 days after a birth, adoption, or placement for adoption).

Eligible Employees and Dependents may also enroll under two additional circumstances:

- The Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Employee or Dependent becomes eligible for a subsidy (state premium assistance program).

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the AEP Benefits Center.

## Health Insurance Portability and Accountability Act ("HIPAA")

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

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

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

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

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

## Plan Administration

**Note: This section is not a part of your SPD. No Claims Administrator is responsible for any statements contained herein that are not set forth in the earlier sections of this SPD.**

- **Plan Name:** American Electric Power System Comprehensive Medical Plan
- **Type of Plan:** The Plan is an Employee welfare benefit plan providing group medical benefits.
- **Type of Administration:** The HRA Plan option (including the associated medical, behavioral health and prescription drug benefits) 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.

- **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). 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 Administrators identified in this Summary Plan Description (or including any additional or replacement claims administrators as may be identified from time to time). 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 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.

## Your Legal Rights

Participants in the AEP Comprehensive Medical Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### Receive Information About Your Plans and Benefits

- Examine, without charge, at the plan administrator's office and other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of 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 may be ordered 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.

### **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, 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 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.

