Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_1 Provide the following expense account data:
a. A schedule, in comparative form, showing the operating expense account balance for the base period and each of the three most recent calendar years for each account or subaccount included in the utility's annual report. Show the percentage of increase or decrease of each year over the prior year.
b. A listing, with descriptions, of all activities, initiatives or programs undertaken or continued by the utility since its last general rate case for the purpose of minimizing costs or improving the efficiency of its operations or maintenance activities. Include all quantifiable realized and projected savings.

RESPONSE

a. See KPCO_R_KPSC_2_1_Attachment1 for the requested information.

b. Continuous improvement initiatives aimed at offsetting future cost increases or improving process efficiencies over time are a necessary and prudent part of the Company's operations. Several ongoing efforts include the use of drones for storm damage assessment or real estate surveys, using data analytics to identify meter tampering or at-risk meters, and a disciplined O&M optimization process to improve our business. Prudent cost management is not limited to one program – it is many programs, some new and some in existence for years. Due to COVID-19, some of these efforts have been temporarily suspended while others have continued.

Witness: Brian K. West

Witness: Heather M. Whitney

Kentucky Power Company
Case No. 2020-00174
KPSC 2_1(a) and 2_17(a)

Operating Expenses for the Twelve Months Ending						Increase (Decrease) Over Prior 12 Months		
Account	**Descr**	**Test Year**	**2019**	**2018**	**2017**	**Test Year**	**2019**	**2018**
4010001	Operation Exp - Nonassociated	222	164	-	-	35%	n.m.	n.m.
4020000	Maintenance Expense	246	246	-	-	0%	n.m.	n.m.
4030001	Depreciation Exp	85,885,931	84,881,268	82,272,358	81,195,089	1%	3%	1%
4030029	Over/Undr Depr Exp Var Riders	(464,470)	296,618	1,329,191	(884,350)	-257%	-78%	250%
4031001	Depr - Asset Retirement Oblig	242,412	223,101	222,408	222,408	9%	0%	0%
4040001	Amort. of Plant	6,065,261	5,839,732	5,935,606	4,457,974	4%	-2%	33%
4040007	Cloud Implement - Amort Plant	2,724	-	-	-	n.m.	n.m.	n.m.
4060001	Amort of Plt Acq Adj	38,616	38,616	38,616	38,616	0%	0%	0%
4073000	Regulatory Debits	102,932	137,243	137,242	137,242	-25%	0%	0%
4073014	Regulatory Debit - BSDR	6,189,686	6,463,480	7,834,760	2,837,191	-4%	-18%	176%
4081002	FICA	3,263,629	3,300,203	3,310,716	3,079,490	-1%	0%	8%
4081003	Federal Unemployment Tax	18,639	19,434	20,027	19,548	-4%	-3%	2%
408100513	Real Personal Property Taxes	-	-	(9,786)	(127)	n.m.	100%	-7613%
408100514	Real Personal Property Taxes	-	-	(11,384)	-	n.m.	100%	n.m.
408100515	Real Personal Property Taxes	-	-	(34,348)	1,069,007	n.m.	100%	-103%
408100516	Real Personal Property Taxes	211,408	104,327	1,808,350	12,336,988	103%	-94%	-85%
408100517	Real Personal Property Taxes	1,572,860	2,421,371	12,113,582	-	-35%	-80%	n.m.
408100518	Real Personal Property Taxes	11,727,264	14,707,926	-	-	-20%	n.m.	n.m.
408100519	Real Personal Property Taxes	3,710,424	-	-	-	n.m.	n.m.	n.m.
408100600	State Gross Receipts Tax	(71,358)	(71,358)	-	-	0%	n.m.	n.m.
408100610	State Gross Receipts Tax	-	-	-	(208,583)	n.m.	n.m.	100%
408100611	State Gross Receipts Tax	-	-	-	(143,264)	n.m.	n.m.	100%
408100612	State Gross Receipts Tax	-	-	-	(34,114)	n.m.	n.m.	100%
408100613	State Gross Receipts Tax	68,797	68,797	-	-	0%	n.m.	n.m.
408100616	State Gross Receipts Tax	-	-	-	6,729	n.m.	n.m.	-100%
408100617	State Gross Receipts Tax	-	-	(10,999)	35,781	n.m.	100%	-131%
408100618	State Gross Receipts Tax	2,356	1,660	32,669	-	42%	-95%	n.m.
408100619	State Gross Receipts Tax	33,657	40,050	-	-	-16%	n.m.	n.m.
408100620	State Gross Receipts Tax	8,806	-	-	-	n.m.	n.m.	n.m.
4081007	State Unemployment Tax	30,468	33,811	36,782	43,338	-10%	-8%	-15%
408100813	State Franchise Taxes	-	-	-	59,837	n.m.	n.m.	-100%
408100814	State Franchise Taxes	-	-	-	(10,257)	n.m.	n.m.	100%
408100816	State Franchise Taxes	-	-	-	626,959	n.m.	n.m.	-100%
408100817	State Franchise Taxes	-	-	(433,823)	958,000	n.m.	100%	-145%
408100818	State Franchise Taxes	(75,204)	55,796	524,200	-	-235%	-89%	n.m.
408100819	State Franchise Taxes	580,571	580,571	-	-	0%	n.m.	n.m.
408100820	State Franchise Taxes	190,900	-	-	-	n.m.	n.m.	n.m.
408101416	Federal Excise Taxes	-	-	-	1,191	n.m.	n.m.	-100%
408101417	Federal Excise Taxes	-	-	1,635	6,711	n.m.	-100%	-76%
408101418	Federal Excise Taxes	-	586	4,827	-	-100%	-88%	n.m.
408101419	Federal Excise Taxes	3,639	2,666	-	-	36%	n.m.	n.m.
408101420	Federal Excise Taxes	-	-	-	-	n.m.	n.m.	n.m.
408101717	St Lic-Rgstrtion Tax-Fees	-	-	-	40	n.m.	n.m.	-100%
408101718	St Lic-Rgstrtion Tax-Fees	-	-	686	-	n.m.	-100%	n.m.
408101719	St Lic-Rgstrtion Tax-Fees	140	140	-	-	0%	n.m.	n.m.
408101816	St Publ Serv Comm Tax-Fees	-	-	-	563,400	n.m.	n.m.	-100%
408101817	St Publ Serv Comm Tax-Fees	-	-	603,550	603,550	n.m.	-100%	0%
408101818	St Publ Serv Comm Tax-Fees	293,795	587,589	587,589	-	-50%	0%	n.m.
408101819	St Publ Serv Comm Tax-Fees	897,688	598,458	-	-	50%	n.m.	n.m.
408101900	State Sales and Use Taxes	414,000	404,000	-	-	2%	n.m.	n.m.
408101916	State Sales and Use Taxes	-	-	-	43,874	n.m.	n.m.	-100%
408101917	State Sales and Use Taxes	-	-	(4,412)	53,118	n.m.	100%	-108%
408101918	State Sales and Use Taxes	4,711	6,097	48,330	-	-23%	-87%	n.m.
408101919	State Sales and Use Taxes	(30,193)	53,931	-	-	-156%	n.m.	n.m.
408101920	State Sales and Use Taxes	(140,934)	-	-	-	n.m.	n.m.	n.m.
408102016	State Business Occup Taxes	-	-	-	(1)	n.m.	n.m.	100%
408102017	State Business Occup Taxes	-	-	101,112	5,853,348	n.m.	-100%	-98%
408102018	State Business Occup Taxes	39,794	21,860	6,150,861	-	82%	-100%	n.m.
408102019	State Business Occup Taxes	4,750,761	6,300,701	-	-	-25%	n.m.	n.m.
408102020	State Business Occup Taxes	1,570,115	-	-	-	n.m.	n.m.	n.m.
408102216	Municipal License Fees	-	-	-	25	n.m.	n.m.	-100%
408102217	Municipal License Fees	-	-	-	320	n.m.	n.m.	-100%
408102916	Real-Pers Prop Tax-Cap Leases	-	-	(9,395)	(12,809)	n.m.	100%	27%
408102917	Real-Pers Prop Tax-Cap Leases	2	2	(2,290)	285,562	0%	100%	-101%
408102918	Real-Pers Prop Tax-Cap Leases	(505)	(505)	290,326	-	0%	-100%	n.m.
408102919	Real-Pers Prop Tax-Cap Leases	308,756	389,300	-	-	-21%	n.m.	n.m.
408102920	Real-Pers Prop Tax-Cap Leases	105,823	-	-	-	n.m.	n.m.	n.m.
4081033	Fringe Benefit Loading - FICA	(1,282,281)	(1,266,844)	(1,274,127)	(1,130,734)	-1%	1%	-13%
4081034	Fringe Benefit Loading - FUT	(7,473)	(7,290)	(7,107)	(8,438)	-3%	-3%	16%
4081035	Fringe Benefit Loading - SUT	(9,742)	(10,059)	(11,920)	(15,608)	3%	16%	24%
408103616	Real Prop Tax-Cap Leases	-	-	(12,821)	-	n.m.	100%	n.m.
408103617	Real Prop Tax-Cap Leases	-	-	-	24,000	n.m.	n.m.	-100%

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408103618	Real Prop Tax-Cap Leases	-	-	13,000	-	n.m.	-100%	n.m.
408103619	Real Prop Tax-Cap Leases	10,070	13,319	-	-	-24%	n.m.	n.m.
408103620	Real Prop Tax-Cap Leases	3,249	-	-	-	n.m.	n.m.	n.m.
4091001	Income Taxes, UOI - Federal	(7,400,070)	(1,121,992)	1,810,333	(11,894,795)	-560%	-162%	115%
409100212	Income Taxes UOI - State	-	-	7,174	3,858	n.m.	-100%	86%
409100213	Income Taxes UOI - State	-	-	-	(59,837)	n.m.	n.m.	100%
409100214	Income Taxes UOI - State	-	-	-	10,257	n.m.	n.m.	-100%
409100215	Income Taxes UOI - State	-	-	-	(23,449)	n.m.	n.m.	100%
409100216	Income Taxes UOI - State	-	-	-	141,746	n.m.	n.m.	-100%
409100217	Income Taxes UOI - State	-	-	(1,074,731)	(70,827)	n.m.	100%	-1417%
409100218	Income Taxes UOI - State	-	-	723,261	-	n.m.	-100%	n.m.
409100219	Income Taxes UOI - State	1,997,390	1,683,528	-	-	19%	n.m.	n.m.
4101001	Prov Def I/T Util Op Inc-Fed	293,846,753	291,215,227	573,819,795	85,730,448	1%	-49%	569%
4101002	Prov Def I/T Util Op Inc-State	468,801	468,801	3,853,943	801,772	0%	-88%	381%
4111001	Prv Def I/T-Cr Util Op Inc-Fed	(292,675,444)	(289,812,043)	(570,688,061)	(51,837,891)	-1%	49%	-1001%
4111002	Prv Def I/T-Cr UtilOpInc-State	(1,669,710)	(1,669,710)	(2,171,567)	(6,549,074)	0%	23%	67%
4111005	Accretion Expense	758,455	775,812	791,150	774,155	-2%	-2%	2%
4114001	ITC Adj, Utility Oper - Fed	(87)	(61)	(325)	(1,009)	-43%	81%	68%
4116000	Gain From Disposition of Plant	(7,903)	(7,640)	(9,059)	(3,658)	-3%	16%	-148%
4118002	Comp. Allow Gains Title IV SO2	-	(39)	(41)	(39)	100%	5%	-3%
4118006	CSAPR SO2 Gains	-	-	-	-	n.m.	n.m.	n.m.
4118008	Comp Allow Gain CSAPR Seas NOx	(128,130)	(188,060)	(42,600)	(133,710)	32%	-341%	68%
4118010	Emission Allow KY Env Surch	-	-	-	19,799	n.m.	n.m.	-100%
5000000	Oper Supervision & Engineering	4,305,757	4,495,717	3,936,529	4,028,541	-4%	14%	-2%
5000001	Oper Super & Eng-RATA-Affil	63,086	50,407	28,055	61,663	25%	80%	-55%
5010000	Fuel	5,357,817	5,324,268	4,699,095	3,296,158	1%	13%	43%
5010001	Fuel Consumed	53,538,423	58,165,322	66,780,271	86,651,467	-8%	-13%	-23%
5010003	Fuel - Procure Unload & Handle	2,202,038	2,253,587	3,181,237	2,986,836	-2%	-29%	7%
5010005	Fuel - Deferred	2,988,121	2,601,796	(2,946,587)	2,490,507	15%	188%	-218%
5010012	Ash Sales Proceeds	(31,408)	(31,408)	(157)	(8,503)	0%	-19963%	98%
5010013	Fuel Survey Activity	(1,711,458)	(4,245,185)	(2,216,554)	(3,255,470)	60%	-92%	32%
5010019	Fuel Oil Consumed	2,777,090	2,793,125	2,331,356	1,252,509	-1%	20%	86%
5010020	Nat Gas Consumed Steam	20,151,199	24,328,577	19,153,349	16,346,377	-17%	27%	17%
5010021	Transp Gas Consumed Steam	1,162	-	-	-	n.m.	n.m.	n.m.
5010027	Gypsum handling/disposal costs	378,544	371,899	389,374	453,210	2%	-4%	-14%
5010028	Gypsum Sales Proceeds	(573,605)	(808,190)	(597,401)	(650,631)	29%	-35%	8%
5010033	Coal Procurement Sales Net-NA	37,451	(29,646)	(258,639)	-	226%	89%	n.m.
5010034	Gas Transp Res Fees-Steam	6,075,144	6,049,194	6,654,428	6,697,296	0%	-9%	-1%
5010040	Gas Procuremnt Sales Net	1,773	1,773	(41,747)	1,742	0%	104%	-2497%
5020000	Steam Expenses	1,036,946	1,049,329	1,620,762	1,064,797	-1%	-35%	52%
5020002	Urea Expense	692,915	833,079	943,017	984,516	-17%	-12%	-4%
5020003	Trona Expense	278,495	319,877	448,684	545,712	-13%	-29%	-18%
5020004	Limestone Expense	3,030,070	3,062,706	2,945,196	3,676,556	-1%	4%	-20%
5020005	Polymer expense	261,324	153,424	66,771	134,671	70%	130%	-50%
5020007	Lime Hydrate Expense	235,496	156,773	14,431	20,269	50%	986%	-29%
5020015	Environmental Over/Under Consu	-	-	-	(207,661)	n.m.	n.m.	100%
5020025	Steam Exp Environmental	-	192	214	-	-100%	-10%	n.m.
5050000	Electric Expenses	3,170	5,604	1,325	5,875	-43%	323%	-77%
5060000	Misc Steam Power Expenses	7,418,876	9,018,248	7,970,370	7,053,301	-18%	13%	13%
5060002	Misc Steam Power Exp-Assoc	51,788	48,519	41,145	39,362	7%	18%	5%
5060003	Removal Cost Expense - Steam	-	-	(581)	71	n.m.	100%	-923%
5060004	NSR Settlement Expense	-	-	(80,666)	(947,482)	n.m.	100%	91%
5060011	BSRR O/U Recovery-Oper Costs	769	-	-	-	n.m.	n.m.	n.m.
5060012	BS1OR O/U Recovery-Oper Costs	-	-	(26,527)	4,261,276	n.m.	100%	-101%
5060013	Environmental Over/Under O&M E	-	-	-	183,355	n.m.	n.m.	-100%
5070000	Rents	-	1	-	-	-100%	n.m.	n.m.
5090000	Allow Consum Title IV SO2	136,004	171,738	253,866	323,794	-21%	-32%	-22%
5090009	Allow Consumpt CSAPR SO2	1,399	1,839	2,541	3,909	-24%	-28%	-35%
5090013	CSAPR Seasonal NOx Cons. Exp	36,803	36,803	-	-	0%	n.m.	n.m.
5090014	Environmental Over/Under O&M E	-	-	-	34,341	n.m.	n.m.	-100%
5100000	Maint Supv & Engineering	2,067,297	2,070,787	2,241,567	2,530,852	0%	-8%	-11%
5100001	Dresden Maint Sup& Engineer	-	25	-	-	-100%	n.m.	n.m.
5110000	Maintenance of Structures	1,555,134	1,425,776	1,747,703	1,535,143	9%	-18%	14%
5120000	Maintenance of Boiler Plant	11,650,570	12,227,907	15,169,957	11,298,317	-5%	-19%	34%
5120025	Maint of Blr Plt Environmental	(29)	(70)	63	21	59%	-211%	194%
5120034	BSDR O/U Recovery - Maint Cost	(260,031)	(187,911)	(64,682)	(11,892)	-38%	-191%	-444%
5120035	BS1OR O/U Recovery-Maint Costs	-	-	(13,540)	1,288,422	n.m.	100%	-101%
5120037	KY Steam Maint O/U	-	-	-	-	n.m.	n.m.	n.m.
5130000	Maintenance of Electric Plant	4,058,356	4,506,489	5,496,321	3,867,652	-10%	-18%	42%
5140000	Maintenance of Misc Steam Plt	1,682,243	1,569,336	1,636,602	1,561,877	7%	-4%	5%
5140025	Maint MiscStmPlt Environmental	-	(6)	6	-	100%	-201%	n.m.
5550000	Purchased Power	-	-	-	(0)	n.m.	n.m.	100%

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5550001	Purch Pwr-NonTrading-Nonassoc	47,645,393	42,376,468	55,623,059	26,669,342	12%	-24%	109%
5550023	Purch Power Capacity -NA	-	-	-	-	n.m.	n.m.	n.m.
5550027	Purch Pwr-Non-Fuel Portion-Aff	55,690,858	57,697,972	57,176,318	54,742,743	-3%	1%	4%
5550029	Purch Power-Assoc-Trnsfr Price	-	-	-	-	n.m.	n.m.	n.m.
5550032	Gas-Conversion-Mone Plant	(1)	-	(4)	(7)	n.m.	100%	40%
5550039	PJM Inadvertent Mtr Res-OSS	(935)	1,890	6,997	14,933	-149%	-73%	-53%
5550040	PJM Inadvertent Mtr Res-LSE	(23,515)	(10,788)	40,477	33,618	-118%	-127%	20%
5550041	PJM Ancillary Serv.-Sync	-	-	377	-	n.m.	-100%	n.m.
5550046	Purch Power-Fuel Portion-Affil	26,285,727	34,386,321	44,784,320	41,214,182	-24%	-23%	9%
5550074	PJM Reactive-Charge	2,914,906	2,931,786	2,075,371	1,723,461	-1%	41%	20%
5550075	PJM Reactive-Credit	(1,411,209)	(1,415,332)	(1,427,033)	(1,764,253)	0%	1%	19%
5550076	PJM Black Start-Charge	1,038,612	1,052,218	817,501	897,185	-1%	29%	-9%
5550078	PJM Regulation-Charge	253,328	248,504	935,094	615,826	2%	-73%	52%
5550079	PJM Regulation-Credit	(96,954)	(108,933)	(874,322)	(575,537)	11%	88%	-52%
5550080	PJM Hourly Net Purch.-FERC	5,326,112	7,294,023	11,162,016	10,512,342	-27%	-35%	6%
5550083	PJM Spinning Reserve-Charge	219,306	247,347	340,176	249,495	-11%	-27%	36%
5550084	PJM Spinning Reserve-Credit	(25,786)	(32,104)	(79,411)	(30,669)	20%	60%	-159%
5550090	PJM 30m Suppl Rserv Charge LSE	37,122	38,697	83,297	106,133	-4%	-54%	-22%
5550099	PJM Purchases-non-ECR-Auction	(126)	(126)	(837)	(2,600)	0%	85%	68%
5550123	PJM OpRes-LSE-Charge	264,964	343,861	641,226	307,948	-23%	-46%	108%
5550124	PJM Implicit Congestion-LSE	6,791,447	8,881,457	9,599,841	2,346,469	-24%	-7%	309%
5550132	PJM FTR Revenue-LSE	(6,859,790)	(8,439,600)	(9,840,719)	(3,065,288)	19%	14%	-221%
5550137	PJM OpRes-LSE-Credit	(114,352)	(123,391)	(195,296)	(124,115)	7%	37%	-57%
5550139	Generation Deactivation expens	3,776	12,636	31,413	27,920	-70%	-60%	13%
5550141	Purchase Power-PPA Deferred	-	-	81,838	(49,604)	n.m.	-100%	265%
5550142	KY Env Sur - Purchase Power	-	-	-	(138,947)	n.m.	n.m.	100%
5550143	BS1OR PJM Over/Under Recovery	-	-	(904,508)	33,209	n.m.	100%	-2824%
5550153	PurchPower-Rockport Def-NonAff	(15,000,000)	(15,000,000)	(14,274,194)	-	0%	-5%	n.m.
5550326	PJM Transm Loss Charges - LSE	6,353,462	7,599,359	10,278,500	7,165,811	-16%	-26%	43%
5550327	PJM Transm Loss Credits-LSE	(1,082,744)	(1,326,436)	(2,346,960)	(1,387,719)	18%	43%	-69%
5550328	PJM FC Penalty Credit	(4,290)	(7,420)	(12,841)	(494)	42%	42%	-2499%
5550329	PJM FC Penalty Charge	15,684	15,684	-	-	0%	n.m.	n.m.
5560000	Sys Control & Load Dispatching	528,484	571,100	599,935	574,325	-7%	-5%	4%
5570000	Other Expenses	581,322	612,638	699,434	1,182,422	-5%	-12%	-41%
5570007	Other Pwr Exp - Wholesale RECs	88,117	85,421	22,526	37,409	3%	279%	-40%
5570008	Other Pwr Exp - Voluntary RECs	-	-	4	776	n.m.	-100%	-99%
5570010	OH Auction Exp - Incremental	-	-	-	4	n.m.	n.m.	-100%
5600000	Oper Supervision & Engineering	3,062,550	3,129,207	2,631,242	2,190,274	-2%	19%	20%
5611000	Load Dispatch - Reliability	-	-	19	1,930	n.m.	-100%	-99%
5612000	Load Dispatch-Mntr&Op TransSys	384,578	396,938	356,979	402,602	-3%	11%	-11%
5614000	PJM Admin-SSC&DS-OSS	108,480	131,447	134,451	178,453	-17%	-2%	-25%
5614001	PJM Admin-SSC&DS-Internal	979,743	995,081	1,073,728	923,868	-2%	-7%	16%
5614007	RTO Admin Default LSE.	130,188	115,710	114,857	-	13%	1%	n.m.
5614008	PJM Admin Defaults OSS	22,756	20,350	17,600	-	12%	16%	n.m.
5614009	GreenHat Settlement	(95,770)	(110,871)	177,615	-	14%	-162%	n.m.
5615000	Reliability,Plng&Stds Develop	109,474	103,815	75,731	77,254	5%	37%	-2%
5616000	Transmission Service Studies	-	-	16	4	n.m.	-100%	338%
5618000	PJM Admin-RP&SDS-OSS	29,388	34,863	38,776	59,685	-16%	-10%	-35%
5618001	PJM Admin-RP&SDS- Internal	290,487	282,621	305,918	289,341	3%	-8%	6%
5620001	Station Expenses - Nonassoc	238,303	223,580	179,061	316,752	7%	25%	-43%
5630000	Overhead Line Expenses	17,505	18,314	24,597	60,752	-4%	-26%	-60%
5640000	Underground Line Expenses	(6)	0	-	-	##########	n.m.	n.m.
5650002	Transmssn Elec by Others-NAC	105,756	112,277	135,945	126,573	-6%	-17%	7%
5650007	Tran Elec by Oth-Aff-Trn Price	-	-	-	-	n.m.	n.m.	n.m.
5650012	PJM Trans Enhancement Charge	(1,140,098)	(3,563,352)	(1,613,399)	4,559,823	68%	-121%	-135%
5650015	PJM TO Serv Exp - Aff	195,641	192,715	-	-	2%	n.m.	n.m.
5650016	PJM NITS Expense - Affiliated	37,573,604	34,901,809	24,822,103	23,168,818	8%	41%	7%
5650019	Affil PJM Trans Enhncement Exp	5,548,943	5,521,482	5,742,520	5,641,332	0%	-4%	2%
5650020	PROVISION RTO Affl Expense	2,554,243	3,337,882	(5,837,690)	2,074,910	-23%	157%	-381%
5650021	PJM NITS Expense - Non-Affilia	287,808	248,444	193,394	-	16%	28%	n.m.
5650050	PJM OATT 205 Trans Cost-Affil	-	-	-	0	n.m.	n.m.	-100%
5650060	PJM trans enhancement refund	684,287	1,134,139	(1,903,735)	-	-40%	160%	n.m.
5660000	Misc Transmission Expenses	839,237	939,588	1,158,946	844,092	-11%	-19%	37%
5660009	PJM OATT LSE Over-Under Adjust	(9,382,251)	(2,673,976)	3,864,304	-	-251%	-169%	n.m.
5660010	GreenHat Settlement	(24,974)	(28,912)	46,316	-	14%	-162%	n.m.
5660011	Misc Transm Exp - Affiliate	649	-	-	-	n.m.	n.m.	n.m.
5670001	Rents - Nonassociated	305	305	3,273	250	0%	-91%	1209%
5670002	Rents - Associated	5,163	-	-	(127,619)	n.m.	n.m.	100%
5680000	Maint Supv & Engineering	34,484	71,496	25,172	18,305	-52%	184%	38%
5690000	Maintenance of Structures	6,119	8,872	7,609	9,237	-31%	17%	-18%
5691000	Maint of Computer Hardware	6,305	6,377	6,414	5,659	-1%	-1%	13%
5692000	Maint of Computer Software	221,006	348,041	293,137	115,352	-37%	19%	154%

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Account	**Descr**	**Test Year**	**2019**	**2018**	**2017**	**Test Year**	**2019**	**2018**
5693000	Maint of Communication Equip	8,382	7,929	6,302	1,246	6%	26%	406%
5700000	Maint of Station Equipment	604,072	481,292	1,125,054	591,135	26%	-57%	90%
5710000	Maintenance of Overhead Lines	6,070,453	5,960,124	5,183,564	2,515,974	2%	15%	106%
5720000	Maint of Underground Lines	229	122	455	242	88%	-73%	89%
5730000	Maint of Misc Trnsmssion Plt	97,043	103,965	67,587	189,288	-7%	54%	-64%
5757000	PJM Admin-MAM&SC- OSS	108,162	126,331	127,295	204,453	-14%	-1%	-38%
5757001	PJM Admin-MAM&SC- Internal	937,019	958,984	1,029,110	975,439	-2%	-7%	6%
5800000	Oper Supervision & Engineering	1,101,195	1,013,963	1,054,364	835,610	9%	-4%	26%
5810000	Load Dispatching	8,951	8,523	1,174	947	5%	626%	24%
5820000	Station Expenses	214,929	216,930	184,604	159,946	-1%	18%	15%
5830000	Overhead Line Expenses	1,131,697	1,108,253	737,448	439,031	2%	50%	68%
5840000	Underground Line Expenses	129,937	123,717	101,611	103,451	5%	22%	-2%
5850000	Street Lighting & Signal Sys E	86,051	83,942	143,662	166,526	3%	-42%	-14%
5860000	Meter Expenses	1,259,918	1,235,139	1,166,911	1,058,210	2%	6%	10%
5870000	Customer Installations Exp	142,580	140,127	122,301	120,930	2%	15%	1%
5880000	Miscellaneous Distribution Exp	4,482,140	4,891,502	4,354,822	3,736,609	-8%	12%	17%
5890001	Rents - Nonassociated	1,343,245	1,348,981	1,570,815	1,498,280	0%	-14%	5%
5890002	Rents - Associated	4,223	3,011	-	-	40%	n.m.	n.m.
5900000	Maint Supv & Engineering	3,943	3,909	2,770	4,019	1%	41%	-31%
5910000	Maintenance of Structures	67,380	65,045	7,509	14,658	4%	766%	-49%
5920000	Maint of Station Equipment	609,780	590,534	426,705	498,193	3%	38%	-14%
5930000	Maintenance of Overhead Lines	29,331,403	29,925,008	30,988,687	37,049,205	-2%	-3%	-16%
5930001	Tree and Brush Control	408,337	417,617	438,777	614,748	-2%	-5%	-29%
5930007	Mnt O/H Line Reliability-Def	-	-	-	57	n.m.	n.m.	-100%
5930010	Storm Expense Amortization	2,066,559	2,066,559	2,084,106	2,429,200	0%	-1%	-14%
5940000	Maint of Underground Lines	71,784	64,244	86,721	73,580	12%	-26%	18%
5950000	Maint of Lne Trnf,Rglators&Dvi	70,093	71,848	23,290	41,392	-2%	208%	-44%
5960000	Maint of Strt Lghtng & Sgnal S	61,411	61,865	60,047	9,201	-1%	3%	553%
5970000	Maintenance of Meters	41,581	45,055	43,492	76,094	-8%	4%	-43%
5980000	Maint of Misc Distribution Plt	53,483	57,031	89,500	62,927	-6%	-36%	42%
9010000	Supervision - Customer Accts	37,114	109,895	120,192	154,377	-66%	-9%	-22%
9020000	Meter Reading Expenses	48,272	10,322	52,656	(630)	368%	-80%	8465%
9020002	Meter Reading - Regular	415,130	407,223	381,616	328,331	2%	7%	16%
9020003	Meter Reading - Large Power	58,323	52,397	47,711	57,437	11%	10%	-17%
9020004	Read-In & Read-Out Meters	-	-	570	4,644	n.m.	-100%	-88%
9030000	Cust Records & Collection Exp	416,490	422,305	415,831	354,572	-1%	2%	17%
9030001	Customer Orders & Inquiries	2,725,456	2,783,054	2,455,882	2,568,911	-2%	13%	-4%
9030002	Manual Billing	18,771	18,689	20,763	24,520	0%	-10%	-15%
9030003	Postage - Customer Bills	533,447	578,014	670,634	691,368	-8%	-14%	-3%
9030004	Cashiering	47,654	48,710	74,383	154,691	-2%	-35%	-52%
9030005	Collection Agents Fees & Exp	52,693	54,297	59,078	64,579	-3%	-8%	-9%
9030006	Credit & Oth Collection Activi	1,149,435	1,145,720	965,316	1,017,174	0%	19%	-5%
9030007	Collectors	276,114	281,956	243,862	252,972	-2%	16%	-4%
9030009	Data Processing	92,425	96,980	77,588	190,562	-5%	25%	-59%
9030014	COVID-19 Credit Card Fees	-	-	-	-	n.m.	n.m.	n.m.
9040007	Uncoll Accts - Misc Receivable	493,529	297,918	74,893	36,559	66%	298%	105%
9050000	Misc Customer Accounts Exp	25,398	28,897	21,177	20,074	-12%	36%	5%
9070000	Supervision - Customer Service	(83,939)	63,903	106,796	110,120	-231%	-40%	-3%
9070001	Supervision - DSM	1	-	37	36	n.m.	-100%	3%
9080000	Customer Assistance Expenses	1,089,686	1,122,917	1,123,073	822,807	-3%	0%	36%
9080004	Cust Assistnce Exp - DSM - Ind	4	0	(149)	148	##########	100%	-200%
9080009	Cust Assistance Expense - DSM	(498,767)	(712,605)	1,451,240	13,361,291	30%	-149%	-89%
9090000	Information & Instruct Advrtis	109,065	68,396	84,694	139,525	59%	-19%	-39%
9100000	Misc Cust Svc&Informational Ex	118,528	122,892	89,945	95,553	-4%	37%	-6%
9100001	Misc Cust Svc & Info Exp - RCS	394	100	67	861	295%	50%	-92%
9110001	Supervision - Residential	698	648	3	-	8%	24829%	n.m.
9110002	Supervision - Comm & Ind	12	12	1	366	0%	1083%	-100%
9120000	Demonstrating & Selling Exp	49,451	46,224	61,239	46,789	7%	-25%	31%
9120001	Demo & Selling Exp - Res	40	40	1	1,366	0%	5891%	-100%
9120003	Demo & Selling Exp - Area Dev	27	-	-	-	n.m.	n.m.	n.m.
9130000	Advertising Expenses	530	530	700	1,610	0%	-24%	-57%
9130001	Advertising Exp - Residential	1,522	1,205	2,148	2,478	26%	-44%	-13%
9200000	Administrative & Gen Salaries	10,517,555	10,503,956	9,522,165	8,824,656	0%	10%	8%
9200003	Admin & Gen Salaries Trnsfr	3,395	-	-	-	n.m.	n.m.	n.m.
9200005	GridSmart Reimbursement Contra	-	-	-	-	n.m.	n.m.	n.m.
9210001	Off Supl & Exp - Nonassociated	929,283	798,466	1,216,843	594,291	16%	-34%	105%
9210002	Off Supl & Exp - Associated	-	-	-	(0)	n.m.	n.m.	100%
9210003	Office Supplies & Exp - Trnsf	554	554	927	20	0%	-40%	4500%
9210004	Office Utilites	113	87	-	54	31%	n.m.	-100%
9210005	Cellular Phones and Pagers	1	-	979	-	n.m.	-100%	n.m.
9210006	O&M Reconciliation	-	-	-	1,427	n.m.	n.m.	-100%
9210007	Dresden Off Supl & Exp Nonasoc	-	-	1	-	n.m.	-100%	n.m.

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9210021	EMP TRAVEL - Airfare	807	741	-	-	9%	n.m.	n.m.
9210022	MEALS & ENT-100 Pct DEDUCTIBLE	582	533	-	-	9%	n.m.	n.m.
9210023	EMP TRAVEL-MILEAGE	96	76	-	-	27%	n.m.	n.m.
9210024	EMP TRAVEL-PARKING	59	55	-	-	7%	n.m.	n.m.
9210025	MEALS & ENT-50 Pct DEDUCTIBLE	104	70	-	-	49%	n.m.	n.m.
9210026	EMP TRAVEL-CAR RENTAL	29	23	-	-	29%	n.m.	n.m.
9210027	EMP TRAVEL-TAXI AND SHUTTLE	22	14	-	-	52%	n.m.	n.m.
9210028	EMP TRAVEL-HOTEL & LODGING	687	475	-	-	45%	n.m.	n.m.
9210030	EMP TRAVEL-OTHER	228	228	-	-	0%	n.m.	n.m.
9210031	SAFETY EQUIPMENT AND SUPPLIES	260	32	-	-	717%	n.m.	n.m.
9210032	Fuel	5	5	-	-	5%	n.m.	n.m.
9210033	FOOD SERVICE-CATERING	261	252	-	-	3%	n.m.	n.m.
9210034	In-House Training & Seminars	800	618	-	-	29%	n.m.	n.m.
9210035	RECRUITING AND SCREENING	4	4	-	-	0%	n.m.	n.m.
9210036	SAFETY TRAINING	475	365	-	-	30%	n.m.	n.m.
9210040	DUES-BUSINESS/PROFESSIONAL	26	20	-	-	26%	n.m.	n.m.
9220000	Administrative Exp Trnsf - Cr	(575,479)	(629,565)	(997,637)	(941,333)	9%	37%	-6%
9220001	Admin Exp Trnsf to Cnstrction	(484,194)	(489,012)	(441,238)	(118,706)	1%	-11%	-272%
9220004	Admin Exp Trnsf to ABD	(262)	(1,822)	(699)	(3,076)	86%	-161%	77%
9230001	Outside Svcs Empl - Nonassoc	3,101,823	3,054,695	2,396,917	1,740,686	2%	27%	38%
9230003	AEPSC Billed to Client Co	256,780	(878,833)	435,203	(57,087)	129%	-302%	862%
9230024	SRV-MAIL/MESSENGER-POSTAGE	2	2	-	-	0%	n.m.	n.m.
9230025	SRV-CONSULTING	4,090	4,090	-	-	0%	n.m.	n.m.
9230034	SRV-SOFTWARE LICENSING	20	220	-	-	-91%	n.m.	n.m.
9230035	Development Project Expense	6	6	-	-	0%	n.m.	n.m.
9240000	Property Insurance	919,174	834,323	614,421	657,371	10%	36%	-7%
9250000	Injuries and Damages	1,290,680	1,361,216	4,891,709	1,420,618	-5%	-72%	244%
9250001	Safety Dinners and Awards	-	23	472	3,004	-100%	-95%	-84%
9250002	Emp Accdent Prvntion-Adm Exp	3,777	5,141	3,983	4,396	-27%	29%	-9%
9250004	Injuries to Employees	-	-	-	34	n.m.	n.m.	-100%
9250005	Dresden Injuries and Damages	-	-	-	(0)	n.m.	n.m.	100%
9250006	Wrkrs Cmpnstn Pre&Slf Ins Prv	256,879	214,481	(670,515)	827,572	20%	132%	-181%
9250007	Prsnal Injries&Prop Dmage-Pub	6,668	4,589	62,367	483,228	45%	-93%	-87%
9250010	Frg Ben Loading - Workers Comp	(37,053)	239	(248,203)	(360,276)	-15597%	100%	31%
9260000	Employee Pensions & Benefits	20,465	14,080	21,288	12,495	45%	-34%	70%
9260001	Edit & Print Empl Pub-Salaries	7,146	8,662	19,571	20,756	-18%	-56%	-6%
9260002	Pension & Group Ins Admin	29,816	27,923	44,020	29,131	7%	-37%	51%
9260003	Pension Plan	2,235,662	2,175,592	2,114,352	2,247,263	3%	3%	-6%
9260004	Group Life Insurance Premiums	159,075	149,610	150,293	151,940	6%	0%	-1%
9260005	Group Medical Ins Premiums	4,700,951	4,499,420	4,461,844	4,343,851	4%	1%	3%
9260006	Physical Examinations	-	-	-	69	n.m.	n.m.	-100%
9260007	Group L-T Disability Ins Prem	456,833	458,585	387,576	306,042	0%	18%	27%
9260009	Group Dental Insurance Prem	185,223	153,065	229,132	184,094	21%	-33%	24%
9260010	Training Administration Exp	10,118	10,403	2,758	2,462	-3%	277%	12%
9260012	Employee Activities	26,185	26,755	35,316	18,954	-2%	-24%	86%
9260014	Educational Assistance Pmts	49,822	49,928	28,196	21,702	0%	77%	30%
9260021	Postretirement Benefits - OPEB	198,642	191,541	238,130	(599,149)	4%	-20%	140%
9260027	Savings Plan Contributions	1,757,680	1,789,821	1,847,416	1,709,998	-2%	-3%	8%
9260036	Deferred Compensation	(1,003)	2,191	(1,930)	14,913	-146%	214%	-113%
9260037	Supplemental Pension	2,364	2,106	6,587	6,254	12%	-68%	5%
9260040	SFAS 112 Postemployment Benef	(116,981)	(65,010)	(57,587)	(78,454)	-80%	-13%	27%
9260042	SERP Pension - Non-Service	3,362	3,062	4,007	2,665	10%	-24%	50%
9260043	OPEB - Non-Service	(3,230,919)	(2,979,354)	(3,762,227)	(1,665,392)	-8%	21%	-126%
9260050	Frg Ben Loading - Pension	(910,544)	(860,048)	(855,908)	(909,300)	-6%	0%	6%
9260051	Frg Ben Loading - Grp Ins	(2,183,196)	(2,128,973)	(2,001,593)	(1,864,044)	-3%	-6%	-7%
9260052	Frg Ben Loading - Savings	(694,603)	(687,220)	(694,270)	(607,412)	-1%	1%	-14%
9260053	Frg Ben Loading - OPEB	(147,257)	(144,680)	(130,371)	657,507	-2%	-11%	-120%
9260055	IntercoFringeOffset- Don't Use	(570,666)	(508,196)	(450,341)	(471,924)	-12%	-13%	5%
9260057	Postret Ben Medicare Subsidy	-	-	-	(0)	n.m.	n.m.	100%
9260058	Frg Ben Loading - Accrual	(56,498)	(30,410)	(31,949)	4,026	-86%	5%	-894%
9260060	Amort-Post Retirerment Benefit	216,620	216,620	216,620	216,620	0%	0%	0%
9260062	Pension Plan - Non-Service	(648,606)	(840,074)	(293,618)	41,530	23%	-186%	-807%
9270000	Franchise Requirements	125,087	124,522	124,655	140,369	0%	0%	-11%
9280000	Regulatory Commission Exp	498	512	1,172	576	-3%	-56%	104%
9280001	Regulatory Commission Exp-Adm	(0)	14	-	0	-101%	n.m.	-100%
9280002	Regulatory Commission Exp-Case	1,032,844	939,595	(596,230)	4,096,808	10%	258%	-115%
9280005	Reg Com Exp-FERC Trans Cases	16,233	15,845	14,430	21,148	2%	10%	-32%
9301000	General Advertising Expenses	59,820	57,289	23,667	11,521	4%	142%	105%
9301001	Newspaper Advertising Space	2,432	3,116	8,177	389,557	-22%	-62%	-98%
9301002	Radio Station Advertising Time	31,000	38,000	15,300	-	-18%	148%	n.m.
9301003	TV Station Advertising Time	9,600	10,800	4,700	-	-11%	130%	n.m.
9301009	Fairs, Shows, and Exhibits	1,452	1,452	-	-	0%	n.m.	n.m.

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9301010	Publicity	620	501	866	897	24%	-42%	-3%
9301012	Public Opinion Surveys	81,782	104,823	91,107	87,015	-22%	15%	5%
9301014	Video Communications	31	-	-	(954)	n.m.	n.m.	100%
9301015	Other Corporate Comm Exp	9,494	9,406	9,091	13,639	1%	3%	-33%
9302000	Misc General Expenses	235,526	248,803	209,268	215,204	-5%	19%	-3%
9302003	Corporate & Fiscal Expenses	27,166	23,888	27,376	11,123	14%	-13%	146%
9302004	Research, Develop&Demonstr Exp	212	179	1,329	163	18%	-87%	714%
9302006	Assoc Bus Dev - Materials Sold	65,180	44,620	34,172	9,559	46%	31%	257%
9302007	Assoc Business Development Exp	105,756	102,775	85,709	52,366	3%	20%	64%
9310001	Rents - Real Property	83,380	106,828	133,518	158,102	-22%	-20%	-16%
9310002	Rents - Personal Property	74,150	55,992	149,761	163,206	32%	-63%	-8%
9310005	Int on Regulated Fin Leases	59,046	30,608	-	-	93%	n.m.	n.m.
9350000	Maintenance of General Plant	4,973	4,939	34	99	1%	14372%	-66%
9350001	Maint of Structures - Owned	710,406	676,029	894,192	599,432	5%	-24%	49%
9350002	Maint of Structures - Leased	119,045	104,608	57,428	89,865	14%	82%	-36%
9350012	Maint of Data Equipment	12,040	10,481	7,873	(21,583)	15%	33%	136%
9350013	Maint of Cmmncation Eq-Unall	1,430,037	1,384,818	1,458,296	1,174,204	3%	-5%	24%
9350014	Maint Supv & Eng-Cmmun Eq	-	-	-	-	n.m.	n.m.	n.m.
9350015	Maint of Office Furniture & Eq	795,967	457,797	662,318	741,778	74%	-31%	-11%
9350016	Maintenance of Video Equipment	19	34	18	117	-43%	84%	-84%
9350017	Maint of Misc General Property	3	3	-	-	0%	n.m.	n.m.
9350019	Maint of Gen Plant-SCADA Equ	1,139	1,190	1,251	478	-4%	-5%	162%
9350024	Maint of DA-AMI Comm Equip	15,318	12,806	19,225	24,292	20%	-33%	-21%
Electric Operations & Maintenance Expense (A)		**382,213,240**	**400,749,421**	**420,209,995**	**440,678,863**	**-5%**	**-5%**	**-5%**
Reclass (C)		798,195	818,150	789,532	657,059	-2%	4%	20%
Total Utility Operating Expenses (B)		**504,469,680**	**529,148,400**	**549,614,813**	**570,354,719**	**-5%**	**-4%**	**-4%**

(A) Subtotal of accounts included in Electric Operations and Maintenance Expenses reported on pages 320-323 of Kentucky Power's FERC Form 1.
(B) Total of accounts reported in Total Utility Operating Expenses.
(C) Reclass for FERC Form 1 reporting purposes primarily represents income tax effect on factored accounts receivable expenses (21%).
n.m. Not meaningful.

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_2 Provide the capital structure at the end of the five most recent calendar years and each of the other periods shown in Schedule A1 and Schedule A2.

RESPONSE

The capital structure at the end of the five most recent calendar years and each of the other periods shown in Schedule A1 and Schedule A2 have been provided in attachment KPCO_R_KPSC_2_2_Attachment1.

Witness: Franz D. Messner

Kentucky Power Company
Case No. 2020-00174
Calculation of Average Capital Structure
12 Months Ended for the Periods as Shown
"000 Omitted"
Schedule A1

Line No.	Type of Capital	2015 5th Year Amount	2015 5th Year Ratio	2016 4th Year Amount	2016 4th Year Ratio	2017 3rd Year Amount	2017 3rd Year Ratio	2018 2nd Year Amount	2018 2nd Year Ratio	2019 1st Year Amount	2019 1st Year Ratio	Latest Available Quarter 3/31/2020 Amount	Latest Available Quarter 3/31/2020 Ratio
1	Long-term Debt	866,451	55.96%	867,164	56.41%	867,188	56.05%	867,128	53.27%	867,553	49.21%	992,617	55.01%
2	Short-term Debt	18,692	1.21%	1,807	0.12%	9,641	0.62%	27,871	1.71%	113,175	6.42%	10,685	0.59%
3	Preferred & Preference Stock	-	0.00%	-	0.00%	-	0.00%	-	0.00%	-	0.00%	-	0.00%
4	Common Equity	663,074	42.83%	668,401	43.48%	670,263	43.32%	732,879	45.02%	782,180	44.37%	801,038	44.40%
5	Other (Itemize by Type)	-	0.00%	-	0.00%	-	0.00%	-	0.00%	-	0.00%	-	0.00%
6	Total Capitalization	1,548,217	100.00%	1,537,372	100.00%	1,547,092	100.00%	1,627,878	100.00%	1,762,908	100.00%	1,804,340	100.00%

Kentucky Power Company
Case No. 2020-00174
Calculation of Average Test Year Capital Structure
12-Months Ended December 31, 2019
"000 Omitted"
Schedule A2

Line No.	Item (a)	Total Capital (b)	Long-term Debt (c)	Short-term Debt (d)	Preferred Stock (e)	Common Stock (f)	Retained Earnings (g)	Total Common Equity (h)
1	Balance Beginning of Test Year	1,627,878	867,128	27,871	-	50,450	156,506	732,879
2	1st Month	1,625,246	867,163	14,476	-	50,450	167,233	743,606
3	2nd Month	1,630,974	867,199	18,930	-	50,450	168,472	744,845
4	3rd Month	1,655,630	867,234	34,765	-	50,450	177,267	753,631
5	4th Month	1,661,090	867,269	38,650	-	50,450	178,806	755,171
6	5th Month	1,667,776	867,305	44,492	-	50,450	179,615	755,979
7	6th Month	1,694,902	867,340	71,439	-	50,450	179,768	756,123
8	7th Month	1,705,171	867,375	74,507	-	50,450	186,934	763,289
9	8th Month	1,721,572	867,411	87,137	-	50,450	190,669	767,024
10	9th Month	1,724,076	867,446	86,863	-	50,450	193,422	769,767
11	10th Month	1,733,200	867,482	94,085	-	50,450	195,287	771,633
12	11th Month	1,752,977	867,517	106,345	-	50,450	202,769	779,114
13	12th Month	1,762,908	867,553	113,175	-	50,450	204,806	782,180
14	Total (L1 through L13)	21,963,400	11,275,424	812,735	-	655,850	2,381,552	9,875,241
15	Average Balance (L14/13)	1,689,492	867,340	62,518	-	50,450	183,196	759,634
16	Average Capitalization Ratios	100.00%	51.34%	3.70%	0.00%	2.99%	10.84%	44.96%
17	End-of-period Capitalization Ratios	100.00%	49.21%	6.42%	0.00%	2.86%	11.62%	44.37%

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
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DATA REQUEST

KPSC 2_3 Provide the following:
a. A list of all outstanding issues of long-term debt as of the end of the latest calendar year together with the related information as shown in Schedule B1.
b. An analysis of short-term debt as shown in Schedule B2 as of the end of the latest calendar year.

RESPONSE

A list of all outstanding issues of long-term debt as of the end of the latest calendar year and analysis of short-term debt as of the end of the latest calendar year as shown in Schedule B1 and B2, respectively, are attached as KPCO_R_KPSC_2_3_Attachment1 and KPCO_R_KPSC_2_3_Attachment2.

Witness: Franz D. Messner

Kentucky Power Company
Case No. 2020-00174
Schedule of Outstanding Long-Term Debt
For the Year Ended December 31, 2019
Schedule B2

Line No.	Type of Debt Issue (a)	Date of Issue (b)	Date of Maturity (c)	Amount Outstanding (d)	Coupon Interest Rate [1] (e)	Cost Rate at Issue [2] (f)	Cost Rate at Maturity [3] (g)	Bond Rating at time of Issue [4] (h)	Type of Obligation (i)	Annualized Cost Col. (d) x Col. (g); (j)
1	Senior Unsecured Notes - Series D	6/13/2003	12/1/2032	$75,000,000	5.625%	5.625%	5.694%	Baa2/BBB/BBB	Senior Unsecured	4,270,500
2	Senior Unsecured Notes - Series A	6/18/2009	6/18/2021	$40,000,000	7.250%	7.250%	7.319%	n/a	Senior Unsecured	2,927,597
3	Senior Unsecured Notes - Series B	6/18/2009	6/18/2029	$30,000,000	8.030%	8.030%	8.080%	n/a	Senior Unsecured	2,424,000
4	Senior Unsecured Notes - Series C	6/18/2009	6/18/2039	$60,000,000	8.130%	8.130%	8.181%	n/a	Senior Unsecured	4,908,600
5	Senior Unsecured Notes - Series A	9/30/2014	9/30/2026	$120,000,000	4.180%	4.180%	4.237%	n/a	Senior Unsecured	5,084,400
6	Senior Unsecured Notes - Series B	12/30/2014	12/30/2026	$80,000,000	4.330%	4.330%	4.386%	n/a	Senior Unsecured	3,508,800
7	Senior Unsecured Notes - Series F	9/12/2017	9/12/2024	$65,000,000	3.130%	3.130%	3.182%	n/a	Senior Unsecured	2,068,325
8	Senior Unsecured Notes - Series G	9/12/2017	9/12/2027	$40,000,000	3.350%	3.350%	3.388%	n/a	Senior Unsecured	1,355,400
9	Senior Unsecured Notes - Series H	9/12/2017	9/12/2029	$165,000,000	3.450%	3.450%	3.483%	n/a	Senior Unsecured	5,747,432
10	Senior Unsecured Notes - Series I	9/12/2017	9/12/2047	$55,000,000	4.120%	4.120%	4.139%	n/a	Senior Unsecured	2,276,434
11	Pollution Control Revenue Bond - Series 2014A	6/19/2017	6/19/2020	$65,000,000	2.000%	2.000%	2.361%	n/a	Pollution Control Bond	1,534,561
12	Local Bank Term Credit Facility [5]	11/5/2018	10/26/2022	$75,000,000	3.175%	3.175%	3.359%	n/a	Credit Agreement	2,518,982
	Total Long-term Debt and Annualized Cost			$870,000,000						38,625,030
	Annualized Cost Rate [Total Col. (j) / Total Col. (d)]			4.440%						

[1] Nominal Rate

[2] Nominal Rate plus Discount or Premium Amortization

[3] Nominal Rate plus Discount or Premium Amortization and Issuance Cost

[4] Standard and Poor's, Moody's,etc.

[5] Variable rate (as of 12/31/2019) term credit facility

Kentucky Power Company
Case No. 2020-00174
Schedule of Outstanding Long-Term Debt
For the Test Year Ended March 30, 2020
Schedule B1

Line No.	Type of Debt Issue (a)	Date of Issue (b)	Date of Maturity (c)	Amount Outstanding (d)	Coupon Interest Rate [1] (e)	Cost Rate at Issue [2] (f)	Cost Rate at Maturity [3] (g)	Bond Rating at time of Issue [4] (h)	Type of Obligation (i)	Annualized Cost Col. (d) x Col. (g) (j)	Actual Test Year Interest Cost [5] (k)
1	Senior Unsecured Notes - Series D	6/13/2003	12/1/2032	$75,000,000	5.625%	5.625%	5.694%	Baa2/BBB/BBB	Senior Unsecured	$4,270,500	$4,270,500
2	Senior Unsecured Notes - Series A	6/18/2009	6/18/2021	$40,000,000	7.250%	7.250%	7.319%	n/a	Senior Unsecured	$2,927,597	$2,927,597
3	Senior Unsecured Notes - Series B	6/18/2009	6/18/2029	$30,000,000	8.030%	8.030%	8.080%	n/a	Senior Unsecured	$2,424,000	$2,424,000
4	Senior Unsecured Notes - Series C	6/18/2009	6/18/2039	$60,000,000	8.130%	8.130%	8.181%	n/a	Senior Unsecured	$4,908,600	$4,908,600
5	Senior Unsecured Notes - Series A	9/30/2014	9/30/2026	$120,000,000	4.180%	4.180%	4.237%	n/a	Senior Unsecured	$5,084,400	$5,084,400
6	Senior Unsecured Notes - Series B	12/30/2014	12/30/2026	$80,000,000	4.330%	4.330%	4.386%	n/a	Senior Unsecured	$3,508,800	$3,508,800
7	Senior Unsecured Notes - Series F	9/12/2017	9/12/2024	$65,000,000	3.130%	3.130%	3.182%	n/a	Senior Unsecured	$2,068,325	$2,068,325
8	Senior Unsecured Notes - Series G	9/12/2017	9/12/2027	$40,000,000	3.350%	3.350%	3.388%	n/a	Senior Unsecured	$1,355,400	$1,355,400
9	Senior Unsecured Notes - Series H	9/12/2017	9/12/2029	$165,000,000	3.450%	3.450%	3.483%	n/a	Senior Unsecured	$5,747,432	$5,747,432
10	Senior Unsecured Notes - Series I	9/12/2017	9/12/2047	$55,000,000	4.120%	4.120%	4.139%	n/a	Senior Unsecured	$2,276,434	$2,276,434
11	Pollution Control Revenue Bond - Series 2014A	6/19/2017	6/19/2020	$65,000,000	2.000%	2.000%	2.361%	n/a	Pollution Control Bond	$1,534,561	$1,534,561
12	Local Bank Term Credit Facility [6]	11/5/2018	10/26/2022	$75,000,000	2.365%	2.365%	2.546%	n/a	Credit Agreement	$1,909,203	$1,909,203
13	Local Bank Term Credit Facility [6]	3/5/2020	3/6/2022	$125,000,000	1.670%	1.670%	1.683%	n/a	Credit Agreement	$2,103,421	$2,103,421
	Total Long-term Debt and Annualized Cost			$995,000,000						$40,118,673	$40,118,673
	Annualized Cost Rate [Total Col. (j) / Total Col. (d)]			4.032%							
	Actual Test Year Cost Rate			4.032%							

[1] Nominal Rate

[2] Nominal Rate plus Discount or Premium Amortization

[3] Nominal Rate plus Discount or Premium Amortization and Issuance Cost

[4] Standard and Poor's, Moody's, etc.

[5] Sum of Accrued Interest Amortization of Discount or Premium and Issuance Cost

[6] Variable rate (as of 3/31/2020) term credit facility

Kentucky Power Company
Case No. 2020-00174
Schedule of Short-Term Debt
For the Test Year Ended March 30, 2020
Schedule B2

Line No.	Type of Debt Issue (a)	Date of Issue (b)	Date of Maturity (c)	Amount Outstanding (d)	Nominal Interest Rate (e)	Interest Expense (f)	Average Balance (g)	Effective Interest Rate (h)	Annualized Interest Cost Col. (d) x Col. (e) (i)
1	Advances from Affiliates	N/A	N/A	10,685,291	2.24%	1,797,951	80,620,853	2.24%	239,514

Total Short-term Debt 10,685,291

Annualized Cost Rate [Total Col. (i) / Total Col.(d)] 2.24%

Actual Interest Paid or Accrued on Short-term Debt During the Test Year [Report in Col. (f) of this Schedule] 1,797,951

Average Short-term Debt - [Report in Col. (g) of this Schedule] 80,620,853

Test Year Interest Cost Rate 2.23%
[Actual Interest / Average Short-term Debt]
[Report in Col. (h) of this Schedule]

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_4 Provide the utility's internal accounting manuals, directives, and policies and procedures.

RESPONSE

See Kentucky Power Application Section II, Volume 4, Exhibit R, Pages 80-89 for a description of the Company's Organization and Summary of Significant Accounting Policies included in Kentucky Power's most recent, externally published, Annual Report. See KPCO_R_KPSC_2_4_ConfidentialAttachment1 for Kentucky Power's internal accounting policies and procedures. KPCO_R_KPSC_2_4_PublicAttachment1 has been redacted in its entirety.

Witness: Heather M. Whitney

KPCO_R_KPSC_2_4_PublicAttachment1 has been redacted in its entirety.

DATA REQUEST

KPSC 2_5 Provide the utility's long-term construction planning program.

RESPONSE

Generation Planning:
Within Kentucky Power's generation fleet, the Company identifies and prioritizes expenditures that are recognized through resource expansion, environmental rule compliance, and capital and maintenance planning processes. Kentucky Power utilizes the Integrated Resource Planning (IRP) process to identify new generation needs and potential retirements within the next 15 years. The IRP is updated on a 3-year basis. Environmental planning considers project development and implementation based on existing and expected state and federal environmental requirements. Capital and maintenance planning is performed on an annual basis for each site to sustain a 10 year look ahead. Every year the Fossil Hydro Organization utilizes the information from these three planning processes to develop an overall 10-year plan.

Distribution Planning:
Kentucky Power Company's approach to long term construction planning is realized through an annual process that identifies where system improvements are necessary in order to maintain reliable electric service to our customers. The process ensures that system capacity and reliability improvements are reviewed regularly through a comprehensive analysis of comparing existing and anticipated customer loading as compared to existing system equipment capabilities and by also reviewing system historical reliability performance. This analysis and review leads to the identification of system improvement opportunities that are vetted out through various stakeholder groups and are proposed for funding consideration.

Transmission Planning:
Planning and operation of the system is integrated through the coordinated efforts of the AEP Transmission Department (AEP Transmission), a business unit of AEPSC, and PJM. AEP Transmission works closely with neighboring utilities, other interconnected entities, and PJM to plan and operate the transmission grid. RTOs align the transmission planning and operating requirements set out in each RTO's protocols and operating criteria, as further defined through North American Electric Reliability Corporation requirements.
The PJM RTEP process is a 24-month planning process that identifies reliability issues over a 15-year horizon. The 24-month planning process consists of overlapping 18-month planning cycles to identify and develop shorter lead-time transmission upgrades and one

24-month planning cycle to provide sufficient time for the identification and development of longer lead-time transmission upgrades that may be required to satisfy planning criteria.

Witness: Everett G. Phillips

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_6 Provide the following concerning the utility's construction projects.
a. For each project started during the last five calendar years, provide the information requested in the format contained in Schedule C1. For each project, include the amount of any cost variance and delay encountered, and explain in detail the reasons for such variances and delays.
b. Using the data included in Schedule C1, calculate the annual Slippage Factor associated with those construction projects. The Slippage Factor should be calculated as shown in Schedule C2.
c. In determining the capital additions reflected in the base period and forecasted test period, explain whether the utility recognized a Slippage Factor.

RESPONSE

a. Please refer to KPCO_R_KPSC_ 2_6_Attachment1, Schedule C1 tab, for the requested information.
b. Please refer to KPCO_R_KPSC_ 2_6_Attachment1, Schedule C2 tab, for the requested information.
c. Please refer to KPSC 2-11 for the Company's reconciliation of capitalization to net investment rate base for the historical test year. CWIP per books as of the end of the historical test year is reflected in the Company's jurisdictional capitalization.

Witness: Everett G. Phillips

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_7 Provide the information shown in Schedule D for each construction project in progress, or planned to be in progress, during the 12 months preceding the historical test year and the historical test year.

RESPONSE

Please refer to KPCO_R_KPSC_ 2_7_Attachment1 for the requested information.

Witness: Everett G. Phillips

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_8 Provide, in the format provided in Schedule E, an analysis of the utility's Construction Work in Progress (CWIP) as defined in the Uniform System of Accounts for each project identified in Schedule D.

RESPONSE

Please refer to KPCO_R_KPSC_ 2_8_Attachment1 for the requested information.

Witness: Everett G. Phillips

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_9 Provide a calculation of the rate or rates used to capitalize interest during construction for the three most recent calendar years. Explain each component entering into the calculation of the rate(s).

RESPONSE

Please see KPCO_R_KPSC_2_9_Attachment1 for the requested information.

Witness: Heather M. Whitney

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_10 Provide the following monthly account balances and a calculation of the average (13-month) account balances for the test year for the total company and Kentucky operations:
a. Plant in service (Account No. 101);
b. Plant purchased or sold (Account No. 102);
c. Property held for future use (Account No. 105);
d. Completed construction not classified (Account No. 106);
e. Construction work in progress (Account No. 107);
f. Depreciation reserve (Account No. 108);
g. Materials and supplies (include all accounts and subaccounts);
h. Computation and development of minimum cash requirements;
i. Balance in accounts payable applicable to amounts included in utility plant in service (if actual is indeterminable, give a reasonable estimate);
j. Balance in accounts payable applicable to amounts included in plant under construction (if actual is indeterminable, give a reasonable estimate); and
k. Balance in accounts payable applicable to prepayments by major category or subaccount.

RESPONSE

Please refer to KPCO_R_KPSC_ 2_10_Attachment1 for the requested information.

Witness: Heather M. Whitney

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_11 Provide a reconciliation and detailed explanation of each difference, if any, in the utility's capitalization and net investment rate base for historical test year.

RESPONSE

Please see KPCO_R_KPSC_2_11_Attachment1 for the requested information.

Witness: Jaclyn N. Cost

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_12 Provide the journal entries relating to the purchase of utility plant acquired as an operating unit or system by purchase, merger, consolidation, liquidation, or otherwise currently included in rate base. Also, provide a schedule showing the calculation of the acquisition adjustment at the date of purchase or each item of utility plant, the amortization period, and the unamortized balance at the beginning of the test year.

RESPONSE

Please see KPCO_R_KPSC_2_12_Attachment1 for the journal entries related to the transfer to Kentucky Power on December 31, 2013 of a 50% undivided interest in the Mitchell Plant.

Witness: Heather M. Whitney

Kentucky Power Company
Final Accounting Entries
As of February 28, 2017

Entry 1: To record the receipt of AGR's contribution of its 50% undivided interest in the assets and related liabilities of Mitchell Units 1&2 to Newco Kentucky Inc. (subsequently merged with and into KPCo), in accordance with CFR 18 Part 101, Electric Plant Instructions 5.A.

(in whole dollars)

Account	Account Description	Debit	Credit
102	Electric Plant Purchased or Sold	682,307,653	
124	Other Investments	2,633,823	
129	Special Funds	12,742,889	
151	Fuel Stock	32,979,440	
152	Fuel Stock Expenses Undistributed	1,040,933	
154	Plant Materials and Operating Supplies	10,532,759	
158.1	Allowances	3,158,670	
182.3	Regulatory Assets	33,362,092	
183	Preliminary Survey & Investigation Charges	1,587,320	
186	Miscellaneous Deferred Debits	4,474,549	
190	Accumulated Deferred Income Tax	21,825,285	
208	Donations Received from Stockholders		375,898,268
219	Accumulated Other Comprehensive Income	5,220,772	
224	Other Long-term Debt		200,000,000
228.2	Accumulated Provision for Injuries and Damages		10,240
228.3	Accum. Provision for Pension and Benefits		882,414
230	Asset Retirement Obligations		16,421,465
236	Taxes Accrued		4,175,000
237	Interest Accrued		59,375
242	Miscellaneous Current and Accrued Liabilities		1,104,515
253	Other Deferred Credits		355,702
281	Accum. Deferred Income Taxes-Accelerated Amort Property		61,534,011
282	Accum. Deferred Income Taxes-Other Property		93,123,611
283	Accum. Deferred Income Taxes-Other		58,301,584
	Total	811,866,185	811,866,185

Entry 2: To clear the balance in Account 102 to the appropriate electric plant accounts, in accordance with CFR 18 Part 101, Electric Plant instructions 5.B.

(in whole dollars)

Account	Account Description	Debit	Credit
101	Electric Plant in Service	917,141,782	
107	Construction Work in Progress	75,252,819	
102	Electric Plant Purchased or Sold		682,307,653
108	Accum Provision for Depreciation of Plant		310,086,948
	Total	992,394,601	992,394,601

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_13 Provide a copy of the utility's most recent depreciation study. If no such study exists, provide a copy of the utility's most recent depreciation schedule. The schedule should include a list of all facilities by account number, service life, and accrual rate for each plant item, the methodology that supports the schedule and the date the schedule was last updated.

RESPONSE

Please see KPCO_R_KPSC_2_13_Attachment1 and KPCO_R_KPSC_2_13_Attachment2 for copies of the Company's most recent depreciation studies.

Witness: Brian K. West

KENTUCKY POWER COMPANY

DEPRECIATION STUDY REPORT

FOR

BIG SANDY UNIT 1

ELECTRIC PLANT IN SERVICE

AT

DECEMBER 31, 2016

DEPRECIATION STUDY REPORT

Table of Contents

I. INTRODUCTION

This report presents the results of a depreciation study of Kentucky Power Company's ("Kentucky Power" or "Company") depreciable Big Sandy Unit 1 electric utility plant in service at December 31, 2016 (the "Study"). The study was prepared by Jason A. Cash, Staff Accountant – Accounting Policy and Research at American Electric Power Service Corporation ("AEPSC"). The purpose of the Study was to develop updated annual depreciation accrual rates for Unit 1 of Kentucky Power's Big Sandy Plant.

The proposed depreciation rates are based on the Average Remaining Life Method of computing depreciation. Further explanation of this method is contained in Section II of this report.

The definition of depreciation used in the Study is the same used by the Federal Energy Regulatory Commission ("FERC") and the National Association of Regulatory Utility Commissioners and in preparing the Company's most recent depreciation study in Case No. 2014-00396:

> Depreciation, as applied to depreciable electric plant, means the loss in service value not restored by current maintenance, incurred in connection with the consumption or prospective retirement of electric plant in the course of service from causes which are known to be in current operation and against which the utility is not protected by insurance. Among the causes to be given consideration are wear and tear, decay, action of the elements, inadequacy, obsolescence, changes in the art, changes in demand and requirements of public authorities.
>
> Service value means the difference between original cost and the net salvage value (net salvage value means the salvage value of the property retired less the cost of removal) of the electric plant. (FERC Accounting and Reporting Requirements for Public Utilities and Licensees, ¶15.001.)

Schedule I of this report shows the proposed depreciation accrual rates for Big Sandy Unit 1. Schedule II compares depreciation expense of Big Sandy Unit 1 using rates approved by the Commission and rates recommended by the depreciation study. A comparison of Kentucky

Power's current rates and accruals for Big Sandy Unit 1 and the Study rates and accruals is shown below based on total Company depreciable plant balances at December 31, 2016:

Table 1 - Depreciation Rates and Accruals
Based on Depreciable Plant In Service at December 31, 2016

	Existing		Study		
Functional Plant Group	Rates	Accruals	Rates	Accruals	Difference
Big Sandy Unit 1	3.78%	5,886,810	5.78%	9,003,728	3,116,918

Based on Big Sandy Unit 1 Depreciable Plant In-Service as of December 31, 2016, the Company proposes an increase in depreciation rates that result in an increase in annual depreciation expense of $3,116,918. The depreciation rate changes are necessary because of changes in investment and the service life of Big Sandy Unit 1 after it was converted to use natural gas in 2016. Big Sandy Unit 1's current depreciation rates are based on a 1991 settlement agreement in Case No. 91-066 and were made effective on April 1, 1991.

II. DISCUSSION OF METHODS AND PROCEDURES USED IN THE STUDY

1. Group Method

All of the depreciable property included in the Study was considered using the group plan method. Under the group plan method, depreciation expense is accrued upon the basis of the original cost of all property included in each depreciable plant account. Upon retirement of any depreciable property, its full cost, less any net salvage realized, is charged to the accrued depreciation reserve regardless of the age of the particular item retired. Also, under the group plan method, the amount in each primary plant account are considered as a separate group for depreciation accounting purposes and an annual depreciation rate for each account is determined. The annual accruals by primary account were then summed, to arrive at the total accrual for each functional group. The total accrual divided by the original cost yields the functional group accrual rate.

2. Annual Depreciation Rates Using the Average Remaining Life Method

Kentucky Power's current depreciation rates are based on the Average Remaining Life Method. The Average Remaining Life Method recovers the original cost of the plant, adjusted for net salvage, less accumulated depreciation, over the average remaining life of the plant. By this method, the annual depreciation rate for each account is determined on the following basis:

$$\text{Annual Depreciation Expense} = \frac{(\text{Orig. Cost})\ (\text{Net Salvage Ratio}) - \text{Accumulated Depreciation}}{\text{Average Remaining Life}}$$

$$\text{Annual Depreciation Rate} = \frac{\text{Annual Depreciation Expense}}{\text{Original Cost}}$$

3. Life Span Analysis

For Kentucky Power's Big Sandy Unit 1, a life span analysis was used to arrive at the historically realized mortality characteristics and service life of the depreciable plant investment. The life-span method of analysis is particularly suited to specific location property, such as generating plants, where all of the surviving investments are likely to be retired in total at a future date. The key elements in the life span analysis are the age of the surviving investments, the projected retirement date of the facility and the expected interim retirements. Interim retirements are those retirements that are expected to occur between the date of the depreciation study and the expected final retirement date of the generating plant. Examples of interim retirements include fans, pumps, motors, a set of boiler tubes, a turbine rotor, etc. The interim retirement history for each primary production plant account was analyzed and the results of those analyses were used to project future interim retirements. The age of Big Sandy's surviving investments at December 31, 2016 was obtained from the accounting records of Kentucky

Power. AEPSC engineering and Kentucky Power operational personnel provided the estimated retirement date used in the life-span analysis for Big Sandy Unit 1.

Big Sandy Unit 1

At December 31, 2016, Kentucky Power's depreciable investment in Steam Production Plant includes Big Sandy Unit 1. Big Sandy Unit 1 is located on Highway 23 near Louisa, Kentucky and was originally placed in service in 1963. Kentucky Power converted Big Sandy Unit 1 from a coal fired unit to a natural gas fired unit in 2016. Following the conversion to natural gas, Big Sandy Unit 1's capacity is 285 MW. The anticipated retirement date for Big Sandy Unit 1 as a natural gas unit is 2031. Additionally, since the last depreciation study performed for Kentucky Power (property investment dated December 31, 2013), Kentucky Power retired Big Sandy Unit 2 and the coal related assets of Big Sandy Unit 1 in 2015.

III. NET SALVAGE

1. Net Salvage - Steam Production Plant

The net salvage analysis for steam production plant included a review of the experienced functional interim retirement, salvage and removal history for Steam Production Plant for the period 2001-2016.

While the net salvage characteristics include interim retirements for the plants, the most significant net salvage amounts for generating plants occurs at the end of their life. Therefore, to assist in establishing total net salvage applicable to Kentucky Power's Big Sandy Unit 1, Kentucky Power relied on a conceptual demolition costs estimate prepared by Sargent & Lundy for the Big Sandy Plant. The Sargent & Lundy demolition cost estimates are based on 2013 price levels which were inflated to retirement date in the depreciation study. The terminal net salvage amount provided by Sargent & Lundy in the dismantling study was for the entire Big Sandy Plant, which included both Units 1 and 2. A portion of the terminal net salvage amount

was allocated to Unit 1 based on the generating capacity of each unit. These estimates were incorporated into the calculation of net salvage ratios for Big Sandy's Production Plant.

2. Net Salvage – Ratios

The net salvage ratios shown on Schedule I of this report may be explained as follows:

a. Where the ratio is shown as unity (1.00), it was assumed that the net salvage in that particular account would be zero.

b. Where the ratio is less than unity, it was assumed that the salvage exceeded the removal costs. For example, if the net salvage were 20%, the net salvage ratio would be expressed as .80.

c. Where the ratio is greater than unity, it was assumed that the salvage was less than the cost of removal. For example, if the net salvage were minus 5%, the net salvage ratio would be expressed as 1.05.

IV. STUDY RESULTS

Steam Production Plant

Depreciation rates for Big Sandy Unit 1 were calculated by plant account with the expectation that the total cost including interim net salvage would be recovered by 2031, which is the estimated retirement date for the unit. A comparison of the Big Sandy Unit 1 steam production depreciation accruals is provided on Schedule II using the currently approved depreciation rates and the study depreciation rates. The original cost and accumulated depreciation amounts used for Big Sandy Plant are the plant's original cost and accumulated depreciation on Kentucky Power's books at December 31, 2016.

Depreciation rates for the Big Sandy Plant increased from 3.78% to 5.78%. As a result, depreciation expense increased by $3,116,918. The increase in steam production depreciation expense due to the change in depreciation rates was primarily because of the changes in investment and the service life of Big Sandy Unit 1 after it was converted to use natural gas in 2016.

SCHEDULE I – EXPLANATION OF COLUMN HEADINGS

Schedule I shows the determination of the recommended annual depreciation accrual rate by primary plant accounts by the straight line remaining life method. An explanation of the schedule follows:

Column I	-	Account number.
Column II	-	Account title.
Column III	-	Original Cost at December 31, 2016
Column IV	-	Net Salvage Ratio.
Column V	-	Total to be Recovered (Column III) * (Column IV).
Column VI	-	Calculated Depreciation Requirement.
Column VII	-	Accumulated Depreciation.
Column VIII	-	Remaining to be Recovered (Column V - Column VII).
Column IX	-	Average Remaining Life.
Column X	-	Recommended Annual Accrual Amount.
Column XI	-	Recommended Annual Accrual Percent or Depreciation Rate (Column X/Column III).

KENTUCKY POWER COMPANY

DEPRECIATION STUDY REPORT

OF

ELECTRIC PLANT IN SERVICE

AT

DECEMBER 31, 2013

DEPRECIATION STUDY REPORT

Table of Contents

I. INTRODUCTION

This report presents the results of a depreciation study of Kentucky Power Company's (KPCo) depreciable electric utility plant in service at December 31, 2013. The study was prepared by David A. Davis, Manager – Property Accounting Policy and Research at American Electric Power Service Corporation (AEPSC). The purpose of the depreciation study was to develop appropriate annual depreciation accrual rates for each of the primary plant accounts that comprise the functional groups for which KPCo computes its annual depreciation expense.

The recommended depreciation rates are based on the Average Remaining Life Method of computing depreciation. Further explanation of this method is contained in Section II of this report.

The definition of depreciation used in my Study is the same as that used by the Federal Energy Regulatory Commission (FERC) and the National Association of Regulatory Utility Commissioners:

> "Depreciation, as applied to depreciable electric plant, means the loss in service value not restored by current maintenance, incurred in connection with the consumption or prospective retirement of electric plant in the course of service from causes which are known to be in current operation and against which the utility is not protected by insurance. Among the causes to be given consideration are wear and tear, decay, action of the elements, inadequacy, obsolescence, changes in the art, changes in demand and requirements of public authorities."
>
> "Service value means the difference between original cost and the

net salvage value (net salvage value means the salvage value of the property retired less the cost of removal) of the electric plant." (FERC Accounting and Reporting Requirements for Public Utilities and Licensees, ¶15.001.)

Schedule I of this report shows the recommended depreciation accrual rates by primary plant accounts and composited to functional plant classifications. Schedule II compares depreciation expense using rates approved by the Commission and rates recommended by the depreciation study. Schedule III shows a comparison of the current mortality characteristics that were used to compute the recommended depreciation rates and the mortality characteristics used to determine the existing depreciation rates and accruals for Transmission, Distribution and General Plant Functions. A comparison of KPCo's current functional group composite depreciation rates and accruals to recommended functional group rates and accruals based on December 31, 2013 depreciable plant balances follows:

Table 1 - Depreciation Rates and Accruals
Based on Depreciable Plant In Service at December 31, 2013

	Existing		Study		
Functional Plant Group	Rates	Accruals	Rates	Accruals	Difference
Steam Production (1)	3.80%	54,851,796	3.36%	48,418,617	(6,433,179)
Transmission	1.71%	8,478,288	2.66%	13,169,805	4,691,517
Distribution	3.52%	24,312,736	4.48%	30,971,933	6,659,197
General	2.54%	858,462	4.42%	1,492,241	633,779
Total Depreciable Plant	3.32%	88,501,282	3.50%	94,052,596	5,551,314

Note: (1) Includes Big Sandy and Mitchell plants. The Company is not recommending a change in depreciation rates for Big Sandy Plant due to the planned retirement of Unit 2 in 2015 and the coal related portions of Unit 1 in 2016.

Based on Total Company Depreciable Plant In-Service as of December 31, 2013, I am recommending an increase in depreciation rates that result in an increase in annual depreciation expense of $5,551,314. The depreciation rate changes are necessary because of changes in average service lives and net salvage estimates used to calculate KPCo's recommended depreciation rates that takes into account the December 31, 2013 transfer of a 50% undivided interest in the Mitchell generating station from AEP affiliate Ohio Power Company as approved by the Kentucky Public Service Commission (or Commission) in Case No. 2012-00578. KPCo's current approved depreciation rates with the exception of Mitchell Plant rates are based on a 1991 settlement agreement in Case No. 91-066 and were made effective on April 1, 1991. The Stipulation and Settlement Agreement in Case No. 2012-00578 ordered Kentucky Power to use the current Ohio Power Company depreciation rates for Mitchell Plant until such rates are changed in a base rate case.

II. DISCUSSION OF METHODS AND PROCEDURES USED IN THE STUDY

1. Group Method

All of the depreciable property included in this report was considered on a group plan. Under the group plan, depreciation expense is accrued upon the basis of the original cost of all property included in each depreciable plant account. Upon retirement of any depreciable property, its full cost, less any net salvage realized, is charged to the accrued depreciation reserve regardless of the age of the particular item retired. Also, under this plan, the dollars in each primary plant account are considered as a separate group for depreciation accounting purposes and an annual depreciation rate for each account is determined. The annual accruals by primary account were then summed, to arrive at the total accrual for each functional group. The total accrual divided by the original cost yields the functional group accrual rate.

2. Annual Depreciation Rates Using the Average Remaining Life Method

KPCo's current depreciation rates are based on the Average Remaining Life Method. The Average Remaining Life Method recovers the original cost of the plant, adjusted for net salvage, less accumulated depreciation, over the average remaining life of the plant. By this method, the annual depreciation rate for each account is determined on the following basis:

$$\text{Annual Depreciation Expense} = \frac{(\text{Orig. Cost})\ (\text{Net Salvage Ratio}) - \text{Accumulated Depreciation}}{\text{Average Remaining Life}}$$

$$\text{Annual Depreciation Rate} = \frac{\text{Annual Depreciation Expense}}{\text{Original Cost}}$$

3. Methods of Life Analysis

Depending upon the type of property and the nature of the data available from the property accounting records, one of three life analyses was used to arrive at the historically realized mortality characteristics and service lives of the depreciable plant investments. These methods are identified and described as follows:

Life Span Analysis

The life span analysis was employed for Mitchell Plant. The life-span method of analysis is particularly suited to specific location property, such as generating plants, where all of the surviving investments are likely to be retired in total at a future date. The key elements in the life span

analysis are the age of the surviving investments, the projected retirement date of the facility and the expected interim retirements. Interim retirements are those retirements that are expected to occur between the date of the depreciation study and the expected final retirement date of the generating plant. Examples of interim retirements include fans, pumps, motors, a set of boiler tubes, a turbine rotor, etc. The interim retirement history for each primary production plant account was analyzed and the results of those analyses were used to project future interim retirements. The age of Mitchell Plant's surviving investments at December 31, 2013 was obtained from the accounting records of affiliate Ohio Power Company (OPCo). American Electric Power Service Corporation (AEPSC) provided the retirement date used in the life-span analysis for Mitchell Plant.

The Company is not recommending any revision to Big Sandy Plant's depreciation rates in this filing since Unit 2 is planned for retirement at the end of May 2015 and the coal related portions of Unit 1 are planned for retirement in April 2016. KPCo expects to repower Big Sandy Unit 1 to use natural gas in 2016.

The order in the Mitchell transfer Case No. 2012-00578 allows Kentucky Power to recover the coal-related retirement costs of Big Sandy Unit 1, the retirement costs of Big Sandy Unit 2 and other site related retirement costs that will not continue in use. New depreciation rates will be required for Big Sandy Unit 1 after it is repowered to use natural gas in 2016.

Steam Production Plant

At December 31st, 2013, KPCo's depreciable investment in Steam

Production Plant includes the Big Sandy Generating plant and a 50% undivided interest in Mitchell Generation Plant. The Big Sandy plant is located highway 23 near Louisa, Kentucky and includes two generating units. The Mitchell Plant is located on the Ohio River near Moundsville, West Virginia and also consists of two generating units. All generating units at the Big Sandy and Mitchell plants are currently coal fired.

The generating units and their capacities are as follows (also shown on Schedule IV – Estimated Generation Plant Retirement Dates):

Plant	Unit	Rating	Commercial Operating Date
Big Sandy	1	260 MW	1963
Big Sandy	2	800 MW	1969
Mitchell	1	770 MW	1971
Mitchell	2	790 MW	1971

AEPSC evaluated each of the generating units and determined the following retirement dates for the units:

Plant	Unit	Retirement Date
Big Sandy	2	2015
Big Sandy	1	2016 coal related portion
Big Sandy	1	2031 repowered to use natural gas
Mitchell Plant	1,2	2040

Since KPCo's last depreciation study (property investment dated December 31, 2008), AEP has reevaluated the expected retirement dates for its generation plant including Big Sandy Units 1-2. The reevaluation for these two Big Sandy units indicated that their current estimated retirement

dates should be 2015 for Big Sandy Unit 2, 2016 for the coal related portion of Big Sandy Unit 1 and 2031 for Big Sandy Unit 1 after it is repowered to use natural gas. AEP previously estimated individual unit retirement dates of 2023 for Unit 1 and 2029 for Unit 2. According to AEP, the earlier Big Sandy Unit 2 and the coal related portion of Unit 1 retirement dates are because it is not economically feasible to equip the units with necessary environmental controls, not because they have reached the end of their service lives.

Current plans are for the Mitchell Plant to operate for a total life of 69 years or until 2040.

Actuarial Analysis – Transmission, Distribution and General Plant

This method of analyzing past experience represents the application to industrial property of statistical procedures developed in the life insurance field for investigating human mortality. It is distinguished from other methods of life estimation by the requirement that it is necessary to know the age of the property at the time of its retirement and the age of survivors, or plant remaining in service; that is, the installation date must be known for each particular retirement and for each particular survivor.

The application of this method involves the statistical procedure known as the "annual rate method" of analysis. This procedure relates the retirements during each age interval to the exposures at the beginning of that interval, the ratio of these being the annual retirement ratio. Subtracting each retirement ratio from unity yields a sequence of annual survival ratios from which a survivor curve can be determined. This is

accomplished by the consecutive multiplication of the survivor ratios. The length of this curve depends primarily upon the age of the oldest property. Normally, if the period of years from the inception of the account to the time of the study is short in relation to the expected maximum life of the property, an incomplete or stub survivor curve results.

While there are a number of acceptable methods of smoothing and extending this stub survivor curve in order to compute the area under it from which the average life is determined, the well-known Iowa Type Curve Method was used in this study.

By this procedure, instead of mathematically smoothing and projecting the stub survivor curve to determine the average life of the group, it was assumed that the stub curve would have the same mortality characteristics as the type curve selected. The selection of the appropriate type curve and average life is accomplished by plotting the stub curve, superimposing on it Iowa curves of the various types and average lives drawn to the same scale, and then determining which Iowa type curve and average life best matches the stub.

The Actuarial Method of Life Analysis was used for the following accounts:

352.0 Transmission Structures & Improvements

353.0 Transmission Station Equipment

361.0 Distribution Structures & Improvements

362.0 Distribution Station Equipment

390.0 General Structures & Improvements

The result of the actuarial analysis for the above accounts is detailed in the depreciation study work papers.

Simulated Plant Record Analysis – Transmission and Distribution Plant

The "Simulated Plant Record" (SPR) method designates a class of statistical techniques that provide an estimate of the age distribution, mortality dispersion and average service life of property accounts whose recorded history provides no indication of the age of the property units when retired from service. For each such account, the available property records usually reveal only the annual gross additions, annual retirements and balances with no indication of the age of either plant retirements or annual plant balances. For this study, the "Balances method" of analysis was used.

The SPR Balances Method is a trial and error procedure that attempts to duplicate the annual balance of a plant account by distributing the actual annual gross additions over time according to an assumed mortality distribution. Specifically, the dollars remaining in service at any date are estimated by multiplying each year's additions by the successive proportion surviving at each age as given by the assumed survivor characteristics. For a given year, the balance indicated is the accumulation of survivors from all vintages and this is compared with the actual book balance. This process is repeated for a different survivor curves and average life combinations until a pattern is discovered which produces a series of "simulated balances" most nearly equaling the actual balances shown in a company's books.

This determination is based on the distribution producing the minimum sum of squared differences between the simulated balance and the actual balances over a test period of years.

The iterative nature of the simulated methods makes them ideally suited for computerized analysis. For each analysis of a given property account, the computer program provides a single page summary containing the results of each analysis indicating the "best fit" based on criteria selected by the user.

The results of my analysis using the Balance Method is shown in the depreciation study work papers. The analysis also shows the value of the Index of Variation of the difference that is calculated according to the the Balances Method where a lower value for the Index of Variation indicates better agreement with the actual data.

The SPR Method of Life Analysis was utilized for the following accounts:

354.0 Transmission Towers & Fixtures

355.0 Transmission Poles & Fixtures

356.0 Transmission Overhead Conductor & Devices

364.0 Distribution Poles, Towers & Fixtures

365.0 Distribution OH Conductor & Devices

366.0 Distribution Underground Conduit

367.0 Distribution Underground Conductor & Devices

368.0 Distribution Line Transformers

369.0 Distribution Services

370.0 Distribution Meters

371.0 Installation on Customers Premises

373.0 Street Lighting & Signal Systems

Vintage Year Accounting – General Equipment

In 1998, the Company began using a vintage year accounting method for general plant accounts 391 to 398 in accordance with Federal Energy Regulatory Commission Accounting Release Number 15 (AR-15). This accounting method requires the amortization of vintage groups of property over their useful lives. AR-15 also requires that property be retired when it meets its average service life.

As a result, my recommendation for these accounts is that the current useful life approved by the Commission be retained and used to continue amortization of the account balances.

4. Final Selection of Average Life and Curve Type

The final selection of average life and curve type for each depreciable plant account analyzed by the Actuarial and SPR Methods was primarily based on the results of the mortality analyses of past retirement history.

III. NET SALVAGE

1. Net Salvage - Steam Production Plant

The net salvage analysis for steam production plant included a review of the plant's experienced functional interim retirement, salvage and removal history for the period 2001-2013. No interim retirements were estimated for Big Sandy Plant in this depreciation study since Unit 2 is estimated to retire in 2015, the coal

related portions of Unit 1 are estimated to retire in 2016 and the repowered Unit 1 (to use natural gas) is expected to retire in 2031.

While a standard type of analysis was used by the depreciation study to determine the net salvage characteristics applicable to interim retirements for the plants, the most significant net salvage amounts for generating plants occurs at the end of their life. Therefore, to assist in establishing total net salvage applicable to Big Sandy and Mitchell plants, the Company contracted with Sargent & Lundy (S&L) to prepare conceptual demolition cost estimates. The S&L cost estimates to demolish the plants are based on current (2013) price levels which were inflated to retirement dates in the depreciation study. These estimates were incorporated into the calculation of a net salvage ratio for Steam Production Plant. S&L's demolition costs do not include Asset Retirement Obligation (ARO) amounts associated with the removal of asbestos or any cost associated with the final disposition of Big Sandy or Mitchell Plant landfills and ash ponds. The costs to remove asbestos and cover ash ponds are included separately in the cost of service through the accounting for asset retirement obligations.

2. Net Salvage – Transmission, Distribution and General Plant

The net salvage percentages used in this report for Transmission, Distribution and General Plant are expressed as percent of original cost and are based on the Company's experience combined with the judgment of the analyst. KPCo maintains salvage and removal costs in its depreciation ledger at the functional plant level, rather than by primary plant accounts. To determine gross salvage, gross removal and net salvage percentages for individual plant accounts, original cost retirements, salvage and removal were taken from the Company's account history in its PowerPlant software which detailed these

amounts by account for the period 2000 to 2013. Gross salvage and cost of removal percentages were calculated using the data from this fourteen year time period for each account. The salvage and removal percentages for each account were then netted to determine a net salvage percentage for each account.

The net salvage percents were converted to net salvage ratios (1 minus the net salvage percentage) and appear in Column IV on Schedule I and were used to determine the total amount to be recovered through depreciation. The same net salvage was also reflected in the determination of the calculated depreciation requirement, which was used to allocate accumulated depreciation at the functional group to the accounts comprising each group.

5. Net Salvage – Ratios

The net salvage ratios shown on Schedule I of this report may be explained as follows:

a. Where the ratio is shown as unity (1.00), it was assumed that the net salvage in that particular account would be zero.

b. Where the ratio is less than unity, it was assumed that the salvage exceeded the removal costs. For example, if the net salvage were 20%, the net salvage ratio would be expressed as .80.

c. Where the ratio is greater than unity, it was assumed that the salvage was less than the cost of removal. For example, if the net salvage were minus 5%, the net salvage ratio would be expressed as 1.05.

IV. CALCULATION OF DEPRECIATION REQUIREMENT AT DECEMBER 31, 2013

The accumulated depreciation by functional group was allocated to individual plant accounts based on the calculation of a depreciation requirement (theoretical reserve) for each plant account using the average service life, curve type and net salvage amount recommended in this study.

V. STUDY RESULTS

Production, Transmission, Distribution and General plant results are discussed below. In addition, Transmission, Distribution and General Plant average service life, retirement dispersion pattern and net salvage percentages used to calculate each primary plant account depreciation rate are shown on Schedule III where the mortality characteristics and net salvage values for the current rates are also shown. The changes to the mortality characteristics follow trends shown by historical retirement experience. Gross salvage and gross cost of removal percentages were largely based on the history of each account for the period 2000-2013.

Steam Production Plant

Depreciation rates for Mitchell Plant were calculated by plant account with the expectation that the total cost including net salvage would be recovered by 2040 which is the estimated retirement date for Mitchell Plant. New depreciation rates for Big Sandy Plant were not recommended by the depreciation study. The comparison of steam production depreciation accruals on Schedule II using the currently approved depreciation rates and the study depreciation rates includes

Mitchell Plant. The original cost and accumulated depreciation amounts used for Mitchell Plant are 50% of the plant's original cost and accumulated depreciation on KPCo's books at December 31, 2013.

The decrease in steam production depreciation expense due to a change in depreciation rates was primarily due to the longer life estimate for Mitchell Plant in this proceeding (2040 retirement date) versus a previously estimated 2031 retirement date. The depreciation study doesn't recommend any changes to the Big Sandy Plant's depreciation rates.

Terminal demolition costs are included in the steam production depreciation rates. The estimates of demolition costs were developed by Sargent & Lundy. S&L estimated demolition cost in 2013 dollars for Big Sandy Plant and Mitchell Plant (KPCo's 50% share) was $28,831,786 and $21,185,697, respectively.

Transmission Plant

The depreciation rates for Transmission plant increased from 1.71% to 2.66% due to increases in the net salvage ratio for five accounts (accounts 352, 353, 354, 355 and 356) and decreases in the average service life for two accounts (accounts 354, and 355). The increase was partially offset by an increase in the average service life for account 352.

Distribution Plant

The depreciation rates for Distribution plant increased from 3.52% to 4.48% due to increases in the net salvage ratio for nine accounts (accounts 361, 362, 364, 365, 367, 368, 369, 371 and 373) and a decrease in the average service life for one account (account 370). The increase was partially offset by a decrease in the net salvage ratio for account 370 and by increases in the

average service life for five accounts (accounts 361, 362, 366, 369 and 373).

General Plant

The depreciation rates for General plant increased from 2.54% to 4.42% due to increases in the net salvage ratio for three accounts (accounts 391, 394 and 398) and a reduction in the average service life for account 390. The increase was partially offset by a decrease in the net salvage ratio for account 397.

SCHEDULE I – EXPLANATION OF COLUMN HEADINGS

Schedule I shows the determination of the recommended annual depreciation accrual rate by primary plant accounts by the straight line remaining life method. An explanation of the schedule follows:

Column I	-	Account number.
Column II	-	Account title.
Column III	-	Original Cost at December 31, 2013
Column IV	-	Net Salvage Ratio.
Column V	-	Total to be Recovered (Column III) * (Column IV).
Column VI	-	Calculated Depreciation Requirement.
Column VII	-	Allocated Accumulated Depreciation – accumulated depreciation (book reserve) spread to each account on the basis of the Calculated Depreciation Requirement shown in Column VI.
Column VIII	-	Remaining to be Recovered (Column V - Column VII).
Column IX	-	Average Remaining Life.
Column X	-	Recommended Annual Accrual Amount.
Column XI	-	Recommended Annual Accrual Percent or Depreciation Rate (Column X/Column III).

KENTUCKY POWER COMPANY
SCHEDULE I - CALCULATION OF DEPRECIATION RATES BY THE REMAINNG LIFE METHOD
BASED ON PLANT IN SERVICE AT DECEMBER 31, 2013
AVERAGE LIFE GROUP (ALG) METHOD ACCRUAL RATES

Acct. No.	Account Title	Original Cost	Net Salvg. Ratio	Total to be Recovered	Calculated Depreciation Requirement	Accumulated Depreciation	Remaining to Be Recovered	Avg. Remain Life	Annual Accrual Amount	Annual Accrual Percent
(I)	(II)	(III)	(IV)	(V)	(VI)	(VII)	(VIII)	(IX)	(X)	(XI)
STEAM PRODUCTION PLANT										
Big Sandy Plant (1)										
311	Structures & Improvements	43,291,665	**(1)**	**(1)**	**(1)**	30,726,379	**(1)**	**(1)**	1,636,425	3.78%
312	Boiler Plant Equipment	362,456,070	**(1)**	**(1)**	**(1)**	177,325,748	**(1)**	**(1)**	13,700,839	3.78%
312	Boiler Plant Equip SCR Catalyst **(2)**	8,147,622	**(1)**	**(1)**	**(1)**	5,742,300	**(1)**	**(1)**	389,456	4.78%
314	Turbogenerator Units	109,522,949	**(1)**	**(1)**	**(1)**	61,149,688	**(1)**	**(1)**	4,139,967	3.78%
315	Accessory Electrical Equip.	16,513,202	**(1)**	**(1)**	**(1)**	12,896,303	**(1)**	**(1)**	624,199	3.78%
316	Misc. Power Plant Equip.	8,709,178	**(1)**	**(1)**	**(1)**	5,351,493	**(1)**	**(1)**	329,207	3.78%
	Total	548,640,686				293,191,911			20,820,093	3.79%
Mitchell Plant (3)										
311	Structures & Improvements	42,000,197	1.07	44,940,211	18,282,178	16,183,402	28,756,809	25.01	1,149,812	2.74%
312	Boiler Plant Equipment	765,644,984	1.07	819,240,133	245,324,500	238,518,432	580,721,701	24.25	23,947,287	3.13%
312	Boiler Plant Equip SCR Catalyst **(2)**	8,190,115	1.00	8,190,115	4,023,394	2,378,493	5,811,622	4.07	1,023,764	12.50%
314	Turbogenerator Units	53,295,697	1.07	57,026,396	29,106,660	33,613,523	23,412,873	23.84	982,084	1.84%
315	Accessory Electrical Equip.	17,080,672	1.07	18,276,319	9,466,086	11,043,285	7,233,034	25.81	280,242	1.64%
316	Misc. Power Plant Equip.	7,693,412	1.07	8,231,951	3,289,590	3,072,520	5,159,431	23.96	215,335	2.80%
	Total	893,905,077	1.07	955,905,125	309,492,408	304,809,655	651,095,470	23.59	27,598,524	3.09%
	Total Steam Prod. Plant	**1,442,545,763**	**0.66**	**955,905,125**	**309,492,408**	**598,001,566**	**651,095,470**	**13.45**	**48,418,617**	**3.36%**
TRANSMISSION PLANT										
350.1	Land Rights	26,456,147	1.00	26,456,147	8,498,622	7,016,166	19,439,981	50.91	381,850	1.44%
352	Structures & Improvements	6,636,668	1.10	7,300,335	3,172,075	2,618,754	4,681,581	33.93	137,978	2.08%
353	Station Equipment	170,843,671	1.03	175,968,981	34,476,675	28,462,741	147,506,240	40.20	3,669,309	2.15%
354	Towers & Fixtures	94,517,543	1.10	103,969,297	56,679,229	46,792,396	57,176,901	23.20	2,464,522	2.61%
355	Poles & Fixtures	74,696,720	1.61	120,261,719	28,658,583	23,659,527	96,602,192	32.75	2,949,685	3.95%
356	OH Conductor & Devices	122,537,908	1.27	155,623,143	70,585,347	58,272,803	97,350,340	27.32	3,563,336	2.91%
357	Undergrnd Conduit	11,590	1.00	11,590	4,345	3,587	8,003	23.13	346	2.99%
358	Undergrnd Conductor	106,066	1.00	106,066	49,568	40,922	65,144	23.44	2,779	2.62%
	Total Transmission Plant	495,806,313	**1.19**	589,697,279	202,124,444	166,866,896	422,830,383	32.11	13,169,805	2.66%
DISTRIBUTION PLANT										
360.1	Land Rights	5,343,520	1.00	5,343,520	1,411,791	1,371,633	3,971,887	55.18	71,981	1.35%
361	Structures & Improvements	4,372,006	1.12	4,896,647	1,354,850	1,316,312	3,580,335	50.63	70,716	1.62%
362	Station Equipment	83,664,562	1.07	89,521,081	18,549,279	18,021,648	71,499,433	26.16	2,733,159	3.27%
364	Poles, Towers, & Fixtures	180,551,331	1.30	234,716,730	68,606,654	66,655,150	168,061,580	19.82	8,479,394	4.70%
365	OH Conductor & Devices	179,538,721	0.94	168,766,398	33,083,601	32,142,543	136,623,855	20.90	6,537,027	3.64%
366	Underground Conduit	6,377,091	1.00	6,377,091	1,464,955	1,423,285	4,953,806	34.66	142,926	2.24%
367	Underground Conductor	9,812,956	1.13	11,088,640	1,655,544	1,608,452	9,480,188	37.43	253,278	2.58%
368	Line Transformers	119,012,919	1.01	120,203,048	28,150,578	27,349,840	92,853,208	19.15	4,848,731	4.07%
369	Services	53,900,363	1.38	74,382,501	17,054,558	16,569,444	57,813,057	15.41	3,751,658	6.96%
370	Meters	24,723,287	0.97	23,981,588	10,273,269	9,981,048	14,000,540	9.72	1,440,385	5.83%
371	Installations on Custs. Prem.	20,056,550	1.32	26,474,646	7,344,863	7,135,939	19,338,707	7.95	2,432,542	12.13%
373	Street Lighting & Signal Sys.	3,349,341	1.24	4,153,183	1,231,600	1,196,567	2,956,616	14.07	210,136	6.27%
	Total Distribution Plant	690,702,647	**1.11**	769,905,074	190,181,542	184,771,861	585,133,213	18.89	30,971,931	4.48%

KENTUCKY POWER COMPANY
SCHEDULE I - CALCULATION OF DEPRECIATION RATES BY THE REMAINNG LIFE METHOD
BASED ON PLANT IN SERVICE AT DECEMBER 31, 2013
AVERAGE LIFE GROUP (ALG) METHOD ACCRUAL RATES

Acct. No.	Account Title	Original Cost	Net Salvg. Ratio	Total to be Recovered	Calculated Depreciation Requirement	Accumulated Depreciation	Remaining to Be Recovered	Avg. Remain Life	Annual Accrual Amount	Annual Accrual Percent
(I)	(II)	(III)	(IV)	(V)	(VI)	(VII)	(VIII)	(IX)	(X)	(XI)
GENERAL PLANT										
389.1	Land Rights	37,384	1.00	37,384	11,898	6,909	30,475	51.13	596	1.59%
390	Structures & Improvements	19,811,669	1.00	19,811,669	9,535,669	5,537,254	14,274,415	18.15	786,469	3.97%
391	Office Furniture & Equipment	1,683,333	1.00	1,683,333	377,310	219,100	1,464,233	27.15	53,931	3.20%
392	Transportation Equipment	14,768	1.00	14,768	1,742	1,012	13,756	26.46	520	3.52%
393	Stores Equipment	164,548	1.00	164,548	60,496	35,129	129,419	18.97	6,822	4.15%
394	Tools Shop & Garage Equip.	3,553,696	1.09	3,873,529	1,042,908	605,604	3,267,925	21.92	149,084	4.20%
395	Laboratory Equipment	141,765	1.00	141,765	89,929	52,221	89,544	10.97	8,163	5.76%
396	Power Operated Equipment	5,931	1.00	5,931	2,728	1,584	4,347	13.50	322	5.43%
397	Communication Equipment	7,318,955	0.97	7,099,386	2,872,871	1,668,243	5,431,143	13.10	414,591	5.66%
398	Miscellaneous Equipment	1,065,616	1.03	1,097,584	464,407	269,676	827,908	11.54	71,743	6.73%
Total General Plant		33,797,665	**1.00**	33,929,897	14,459,958	8,396,732	25,533,165	17.11	1,492,241	4.42%
Total Depreciable Plant		2,662,852,388		2,349,437,375	716,258,352	958,037,055	1,684,592,231		94,052,594	3.53%

N/A = Not Applicable

Notes:

(1) The Company plans to retire Big Sandy Unit 2 at the end of May 2015 and the coal related portions of Unit 1 in 2016. Since the Commission authorized (Case No. 2012-00578) the Company to recover the coal-related portion of Big Sandy Unit 1, the retirement costs of Big Sandy Unit 2 and any other site related retirement costs, this depreciation recommends that the existing approved depreciation rates for Big Sandy Plant be retained until a future proceeding that includes the remaining portion of Big Sandy Unit 1 and the cost to re-power this unit to use natural gas.

(2) An annualized depreciation rate for Big Sandy Plant's SCR Catalyst was calculated using currently approved rates and included in the above analysis. A separate depreciation rate was calculated for Mitchell Plant's SCR Catalyst using AEP Air Emmissions Control estimated average life for the catalyst.

(3) Mitchell Plant cost at December 31, 2013. At December 31, 2013 the Mitchell Plant was jointly owned 50% by Kentucky Power Company and 50% by AEP Generating Resources and therefore the cost shown above is 50% of the total Mitchell Plant depreciable plant in service. The Mitchell Plant cost includes 50% of the investment in the gypsum plant underloader located at the Mountaineer Generating Station.

KENTUCKY POWER COMPANY
SCHEDULE II - COMPARE DEPRECIATION EXPENSE USING CURRENT AND STUDY RATES
ANNUAL DEPRECIATION RATES AND ACCRUALS BY THE REMAINNG LIFE METHOD
BASED ON PLANT IN SERVICE AT DECEMBER 31, 2013

ACCT. NO. (1)	ACCOUNT TITLE (2)	ORIGINAL COST (3)	CURRENT APPROVED RATE (4)	ANNUAL ACCRUAL (5)	STUDY RATE (6)	STUDY ACCRUAL (7)	DIFFERENCE (DECREASE) (8)
STEAM PRODUCTION PLANT							
BIG SANDY PLANT (a)							
311	Structures & Improvements	43,291,665	3.78%	1,636,425	3.78%	1,636,425	0
312	Boiler Plant Equipment	362,456,070	3.78%	13,700,839	3.78%	13,700,839	0
312	Boiler Plant Equip SCR Catalyst	8,147,622	4.78%	389,456	4.78%	389,456	0
314	Turbogenerator Units	109,522,949	3.78%	4,139,967	3.78%	4,139,967	0
315	Accessory Electrical Equipment	16,513,202	3.78%	624,199	3.78%	624,199	0
316	Misc. Power Plant Equip.	8,709,178	3.78%	329,207	3.78%	329,207	0
	Total	548,640,686	3.79%	20,820,093	3.79%	20,820,093	0
MITCHELL PLANT - (b)							
311	Structures & Improvements	42,000,197	2.87%	1,205,406	2.74%	1,149,812	(55,594)
312	Boiler Plant Equipment	765,644,984	3.90%	29,860,154	3.13%	23,947,287	(5,912,867)
312	Boiler Plant Equip SCR Catalyst **(c)**	8,190,115	10.00%	819,012	12.50%	1,023,764	204,752
314	Turbogenerator Units	53,295,697	2.86%	1,524,257	1.84%	982,084	(542,173)
315	Accessory Electrical Equipment	17,080,672	2.39%	408,228	1.64%	280,242	(127,986)
316	Misc. Power Plant Equip.	7,693,412	2.79%	214,646	2.80%	215,335	689
	Total	893,905,077	3.81%	34,031,703	3.09%	27,598,524	(6,433,179)
	Total Steam Production Plant	**1,442,545,763**	**3.80%**	**54,851,796**	**3.36%**	**48,418,617**	**(6,433,179)**
TRANSMISSION PLANT							
350.1	Land Rights	26,456,147	1.71%	452,400	1.44%	381,850	(70,550)
352	Structures & Improvements	6,636,668	1.71%	113,487	2.08%	137,978	24,491
353	Station Equipment	170,843,671	1.71%	2,921,427	2.15%	3,669,309	747,882
354	Towers & Fixtures	94,517,543	1.71%	1,616,250	2.61%	2,464,522	848,272
355	Poles & Fixtures	74,696,720	1.71%	1,277,314	3.95%	2,949,685	1,672,371
356	OH Conductor & Devices	122,537,908	1.71%	2,095,398	2.91%	3,563,336	1,467,938
357	Underground Conduit	11,590	1.71%	198	2.99%	346	148
358	Underground Conductor & Devices	106,066	1.71%	1,814	2.62%	2,779	965
	Total Transmission Plant	**495,806,313**	**1.71%**	**8,478,288**	**2.66%**	**13,169,805**	**4,691,517**
DISTRIBUTION PLANT							
360.1	Land Rights	5,343,520	3.52%	188,092	1.35%	71,981	(116,111)
361	Structures & Improvements	4,372,006	3.52%	153,895	1.62%	70,716	(83,179)
362	Station Equipment	83,664,562	3.52%	2,944,993	3.27%	2,733,159	(211,834)
364	Poles, Towers, & Fixtures	180,551,331	3.52%	6,355,407	4.70%	8,479,394	2,123,987
365	Overhead Conductor & Devices	179,538,721	3.52%	6,319,763	3.64%	6,537,027	217,264
366	Underground Conduit	6,377,091	3.52%	224,474	2.24%	142,926	(81,548)
367	Underground Conductor	9,812,956	3.52%	345,416	2.58%	253,278	(92,138)
368	Line Transformers	119,012,919	3.52%	4,189,255	4.07%	4,848,731	659,476
369	Services	53,900,363	3.52%	1,897,293	6.96%	3,751,658	1,854,365
370	Meters	24,723,287	3.52%	870,260	5.83%	1,440,385	570,125
371	Installations on Custs. Prem.	20,056,550	3.52%	705,991	12.13%	2,432,542	1,726,551
373	Street Lighting & Signal Sys.	3,349,341	3.52%	117,897	6.27%	210,136	92,239
	Total Distribution Plant	**690,702,647**	**3.52%**	**24,312,736**	**4.48%**	**30,971,933**	**6,659,197**

KENTUCKY POWER COMPANY
SCHEDULE II - COMPARE DEPRECIATION EXPENSE USING CURRENT AND STUDY RATES
ANNUAL DEPRECIATION RATES AND ACCRUALS BY THE REMAINNG LIFE METHOD
BASED ON PLANT IN SERVICE AT DECEMBER 31, 2013

ACCT. NO. (1)	ACCOUNT TITLE (2)	ORIGINAL COST (3)	CURRENT APPROVED RATE (4)	ANNUAL ACCRUAL (5)	STUDY RATE (6)	STUDY ACCRUAL (7)	DIFFERENCE (DECREASE) (8)
GENERAL PLANT							
389.1	Land Rights	37,384	2.54%	950	1.59%	596	(354)
390	Structures & Improvements	19,811,669	2.54%	503,216	3.97%	786,469	283,253
391	Office Furniture & Equipment	1,683,333	2.54%	42,757	3.20%	53,931	11,174
392	Transportation Equipment	14,768	2.54%	375	3.52%	520	145
393	Stores Equipment	164,548	2.54%	4,180	4.15%	6,822	2,642
394	Tools Shop & Garage Equipment	3,553,696	2.54%	90,264	4.20%	149,084	58,820
395	Laboratory Equipment	141,765	2.54%	3,601	5.76%	8,163	4,562
396	Power Operated Equipment	5,931	2.54%	151	5.43%	322	171
397	Communication Equipment	7,318,955	2.54%	185,901	5.66%	414,591	228,690
398	Miscellaneous Equipment	1,065,616	2.54%	27,067	6.73%	71,743	44,676
	Total General Plant	**33,797,665**	**2.54%**	**858,462**	**4.42%**	**1,492,241**	**633,779**
	Total Depreciable Plant	**2,662,852,388**	**3.32%**	**88,501,282**	**3.53%**	**94,052,596**	**5,551,314**

Notes:

(a) The depreciation study recommends that the current approved depreciation rates for Big Sandy Plant remain in effect until the next base case which will reflect the retirement of Big Sandy Unit 2 in 2015, the coal related portions of Unit 1 in 2016 and the cost to re-power Unit 1 to burn natural gas. Therefore there is no change in depreciation expense due to a change in depreciation rates for Big Sandy Plant.

(b) The current approved rates for Mitchell Generating Plant are from AEP affiliated company, Ohio Power Company as per the Order in Case No. 2012-00578.

(c) The depreciation rate was revised for the SCR catalyst at Mitchell Generating Station using AEP Generation's estimated average life for the catalyst of 8 years.

KENTUCKY POWER COMPANY
SCHEDULE III - COMPARISON OF MORTALITY CHARACTERISTICS
DEPRECIATION STUDY AS OF DECEMBER 31, 2013

(1)		(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
		Existing Rates (See note, below)					Current Study Rates				
		Average Service Life (Years)	Iowa Curve	Salvage Factor	Cost of Removal Factor	Net Salvage Factor	Average Service Life (Years)	Iowa Curve	Salvage Factor	Cost of Removal Factor	Net Salvage Factor
TRANSMISSION PLANT											
350.1	Rights of Way	75	R4.0	N/A	N/A	0%	75	R4.0	0%	0%	0%
352.0	Structures & Improvements	55	S1.5	N/A	N/A	0%	60	S3.0	0%	10%	-10%
353.0	Station Equipment	50	R0.5	N/A	N/A	25%	50	L0.5	8%	11%	-3%
354.0	Towers & Fixtures	55	R4.0	N/A	N/A	0%	51	S6.0	3%	13%	-10%
355.0	Poles & Fixtures	45	R3.0	N/A	N/A	0%	43	L3.0	2%	63%	-61%
356.0	Overhead Conductor & Devices	50	R3.0	N/A	N/A	10%	50	S6.0	6%	33%	-27%
357.0	Underground Conduit	37	R2.0	N/A	N/A	0%	37	R2.0	0%	0%	0%
358.0	Underground Conductor and Devices	44	R1.0	N/A	N/A	0%	44	R1.0	0%	0%	0%
DISTRIBUTION PLANT											
360.1	Rights of Way	75	R4.0	N/A	N/A	0%	75	R4.0	0%	0%	0%
361.0	Structures & Improvements	65	L0.5	N/A	N/A	0%	70	R2.0	4%	16%	-12%
362.0	Station Equipment	25	L0.0	N/A	N/A	25%	33	R0.5	10%	17%	-7%
364.0	Poles, Towers, & Fixtures	28	L0.0	N/A	N/A	25%	28	R0.5	18%	48%	-30%
365.0	Overhead Conductor & Devices	26	R1.5	N/A	N/A	25%	26	L0.0	30%	24%	6%
366.0	Underground Conduit	37	R2.0	N/A	N/A	0%	45	R3.0	0%	0%	0%
367.0	Underground Conductor	44	R1.0	N/A	N/A	0%	44	R0.5	1%	14%	-13%
368.0	Line Transformers	25	R1.5	N/A	N/A	15%	25	L0.0	29%	30%	-1%
369.0	Services	18	R2.0	N/A	N/A	0%	20	L0.0	1%	39%	-38%
370.0	Meters	27	R0.5	N/A	N/A	0%	17	R4.0	22%	19%	3%
371.0	Installations on Custs. Prem.	11	L0.0	N/A	N/A	30%	11	L0.0	1%	33%	-32%
373.0	Street Lighting & Signal Sys.	15	L0.0	N/A	N/A	15%	20	L0.0	1%	25%	-24%
GENERAL PLANT											
389.1	Rights of Way	75	R4.0	N/A	N/A	0%	75	R4.0	0%	0%	0%
390.0	Structures & Improvements	45	L3.0	N/A	N/A	0%	35	L2.0	1%	1%	0%
391.0	Office Furniture & Equipment	35	R0.5	N/A	N/A	10%	35	SQ	0%	0%	0%
392.0	Transportation Equipment	30	R3.0	N/A	N/A	0%	30	SQ	0%	0%	0%
393.0	Stores Equipment	30	R1.0	N/A	N/A	0%	30	SQ	0%	0%	0%
394.0	Tools Shop & Garage Equipment	30	R0.5	N/A	N/A	0%	30	SQ	0%	9%	-9%
395.0	Laboratory Equipment	30	L5.0	N/A	N/A	0%	30	SQ	0%	0%	0%
396.0	Power Operated Equipment	N/A	N/A	N/A	N/A	N/A	25	SQ	0%	0%	0%
397.0	Communication Equipment	22	L3.0	N/A	N/A	0%	22	SQ	6%	3%	3%
398.0	Miscellaneous Equipment	20	S5.0	N/A	N/A	0%	20	SQ	0%	3%	-3%

Note: Kentucky Power Company's existing depreciation rates are from Case No. 91-066. No detail of Cost of Removal % and Salvage Factor % is available from the order from that Case.

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_14 Provide the utility's cash account balances at the beginning of the test year and at the end of each month during the test year for total company and Kentucky operations.

RESPONSE

Please refer to KPCO_R_KPSC_ 2_14_Attachment1 for the requested information.

Witness: Heather M. Whitney

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_15 Provide the average number of customers on the utility's system (actual and projected) by rate schedule for the test year and two most recent calendar years.

RESPONSE

Please see KPCO_R_KPSC_2_15_Attachment1, KPCO_R_KPSC_2_15_Attachment2, and KPCO_R_KPSC_2_15_Attachment3 for the requested data. There are no customer number projections with respect to the Company's filed case.

Witness: Alex E. Vaughan

TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
011	RSW-LMWH	186,272.82	4,611.55	181,661.27	1,678,345	0	0.0	78	0	0	11.10	10.82	0.00
012	RSW-A	26,299.90	662.01	25,637.89	240,746	0	0.0	10	0	0	10.92	10.65	0.00
013	RSW-B	3,917.76	107.26	3,810.50	36,543	0	0.0	2	0	0	10.72	10.43	0.00
015	RS	112,656,945.82	2,612,032.09	110,044,913.73	936,402,523	60,183	8,585.7	64,571	0	0	12.03	11.75	0.00
017	RS EMP	1,094,460.43	24,441.96	1,070,018.47	9,416,046	0	0.0	466	0	0	11.62	11.36	0.00
022	RSW-RS	139,980,196.94	3,146,831.65	136,833,365.29	1,181,642,088	52,964	18,198.5	69,668	0	0	11.85	11.58	0.00
028	AORH-W ON	11,447.22	244.20	11,203.02	106,403	72,021	0.0	7	0	0	10.76	10.53	0.00
030	RSW-ONPK	163,914.08	3,897.72	160,016.36	1,452,157	884,220	0.0	67	0	0	11.29	11.02	0.00
032	RS LM-ON	210,366.85	4,876.48	205,490.37	1,942,721	1,276,669	0.0	84	0	0	10.83	10.58	0.00
034	AORH-ON	1,647.97	21.82	1,626.15	14,808	8,738	0.0	2	0	0	11.13	10.98	0.00
036	RS-TOD-ON	12,243.05	345.67	11,897.38	112,723	74,118	0.0	5	0	0	10.86	10.55	0.00
093	OL 175 MV	105,801.31	1,888.84	103,912.47	620,080	0	0.0	0	697	732	17.06	16.76	104.43
094	OL 100 HP	2,781,700.46	31,341.34	2,750,359.12	10,304,425	0	0.0	0	20,042	21,650	27.00	26.69	57,283.55
095	OL 400 MV	20,830.56	458.25	20,372.31	152,422	0	0.0	0	59	81	13.67	13.37	40.48
097	OL 200 HP	321,678.81	5,325.28	316,353.53	1,757,376	0	0.0	0	1,342	1,762	18.30	18.00	10,918.79
098	OL 400 HP	64,211.75	1,378.79	62,832.96	430,469	0	0.0	0	77	214	14.92	14.60	3,452.28
099	OL175 MVP	1,540.48	24.24	1,516.24	7,700	0	0.0	0	4	9	20.01	19.69	0.00
103	OL 250 HP	488.37	7.79	480.58	2,452	0	0.0	0	1	2	19.92	19.60	0.00
107	OL 200HPF	377,421.20	5,342.59	372,078.61	1,769,358	0	0.0	0	1,263	1,774	21.33	21.03	10,367.28
109	OL400 HPF	1,248,686.35	24,769.53	1,223,916.82	8,189,932	0	0.0	0	1,740	4,154	15.25	14.94	35,563.81
110	OL 250 MH	35,517.84	494.71	35,023.13	162,140	0	0.0	0	72	137	21.91	21.60	1,991.51
111	OL100 HPP	164,712.06	1,142.14	163,569.92	380,038	0	0.0	0	198	792	43.34	43.04	1,468.02
113	OL 150 HP	3,307,860.43	45,503.44	3,262,356.99	15,190,834	0	0.0	0	19,422	21,903	21.78	21.48	154,237.81
116	OL 400 MH	299,309.00	5,535.76	293,773.24	1,758,142	0	0.0	0	290	934	17.02	16.71	8,653.67
120	OL 250HPP	579.69	6.29	573.40	1,935	0	0.0	0	2	2	29.96	29.63	0.00
122	OL150 HPP	22,651.26	141.63	22,509.63	46,526	0	0.0	0	15	67	48.69	48.38	0.00
126	OL 400HPP	357.13	4.06	353.07	1,467	0	0.0	0	0	1	24.34	24.07	0.00
130	OL 250MON	911.25	11.32	899.93	3,423	0	0.0	0	3	3	26.62	26.29	0.00
131	OL 1000MH	49,798.40	1,197.54	48,600.86	393,236	0	0.0	0	43	87	12.66	12.36	779.89
136	OL 400MON	308.51	5.38	303.13	1,549	0	0.0	0	1	1	19.92	19.57	0.00
204	GS-MTRD	238,699.53	4,028.70	234,670.83	1,228,707	0	0.0	468	0	0	19.43	19.10	0.00
211	GS SEC	23,603,544.83	404,086.02	23,199,458.81	140,883,662	118,202	175,199.2	22,670	0	0	16.75	16.47	0.00
213	GS-UMR	457,327.25	6,679.45	450,647.80	2,344,032	0	0.0	600	0	0	19.51	19.23	0.00
214	GS - AF	182,207.38	4,256.20	177,951.18	1,347,532	0	27,719.0	87	0	0	13.52	13.21	0.00
215	GS SEC	59,506,659.19	1,360,838.32	58,145,820.87	448,093,898	0	1,854,791.7	6,394	0	0	13.28	12.98	0.00
217	GS PRI	416,886.88	8,405.80	408,481.08	2,755,859	0	17,704.0	23	0	0	15.13	14.82	0.00
218	GS M SEC	28,133.56	642.68	27,490.88	214,119	0	751.2	1	0	0	13.14	12.84	0.00
220	GSCC PRI	714,426.55	16,889.93	697,536.62	5,645,798	0	16,498.5	53	0	0	12.65	12.35	0.00
223	GS LM ON	115,055.30	2,095.32	112,959.98	958,623	602,021	0.0	43	0	0	12.00	11.78	0.00
225	GS LM TOD	37,248.02	766.92	36,481.10	254,065	153,807	0.0	31	0	0	14.66	14.36	0.00
227	EXP GSTOD	239,090.03	4,547.18	234,542.85	1,483,815	992,328	0.0	224	0	0	16.11	15.81	0.00
229	GS-TOD	481,238.64	11,709.96	469,528.68	3,911,355	2,436,624	463.2	86	0	0	12.30	12.00	0.00
236	GSCC SUB	115,784.37	2,550.68	113,233.69	838,022	0	2,331.3	6	0	0	13.82	13.51	0.00
240	LGS SEC	45,155,873.44	1,239,502.54	43,916,370.90	388,936,137	0	1,096,890.1	560	0	0	11.61	11.29	0.00
242	LGS M SEC	860,880.88	22,766.87	838,114.01	7,800,503	0	18,110.0	7	0	0	11.04	10.74	0.00
244	LGS PRI	8,917,601.48	249,943.17	8,667,658.31	79,387,889	113,750	296,047.0	60	0	0	11.23	10.92	0.00
246	LGS M PRI	69,017.38	2,083.17	66,934.21	676,075	0	1,914.0	1	0	0	10.21	9.90	0.00
248	LGS SUB	1,697,058.39	60,947.59	1,636,110.80	19,397,183	0	58,975.0	16	0	0	8.75	8.43	0.00
250	LGS TRAN	477,594.47	14,641.00	462,953.47	5,594,238	0	15,477.0	2	0	0	8.54	8.28	0.00
251	LGS-LM-TD	189,686.86	4,231.83	185,455.03	1,635,537	867,020	0.0	7	0	0	11.60	11.34	0.00

TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
256	LGSSECTOD	397,744.06	12,599.60	385,144.46	4,016,296	2,252,464	7,966.0	5	0	0	9.90	9.59	0.00
257	LGSPRITOD	291,217.45	9,411.34	281,806.11	3,449,480	1,957,700	4,914.0	1	0	0	8.44	8.17	0.00
260	PS SEC	13,369,345.64	331,357.15	13,037,988.49	108,038,008	0	402,989.0	158	0	0	12.37	12.07	0.00
264	PS PRI	236,470.06	6,431.75	230,038.31	2,259,540	0	7,549.0	1	0	0	10.47	10.18	0.00
321	CS-IRP	53,460.29	2,679.68-	56,139.97	910,340	0	3,822.0	0	0	0	5.87	6.17	0.00
330	CS-IRP PR	707,262.22	13,720.46	693,541.76	4,252,976	0	27,159.0	1	0	0	16.63	16.31	0.00
331	CS-IRP ST	12,095,591.56	600,479.44	11,495,112.12	204,949,717	0	416,333.0	3	0	0	5.90	5.61	0.00
332	CS-IRP TR	375,435.31	7,887.20	367,548.11	4,116,000	0	13,776.0	0	0	0	9.12	8.93	0.00
356	IGS SEC	1,566,240.62	49,973.09	1,516,267.53	16,532,300	0	33,680.0	4	0	0	9.47	9.17	0.00
358	IGS PRI	28,692,309.19	1,050,243.29	27,642,065.90	323,054,331	0	732,309.0	40	0	0	8.88	8.56	0.00
359	IGS SUB	20,069,602.80	709,022.84	19,360,579.96	239,013,800	0	735,747.0	18	0	0	8.40	8.10	0.00
360	IGS	1,452,747.10	37,046.38	1,415,700.72	12,354,234	0	55,971.0	1	0	0	11.76	11.46	0.00
371	IGS	73,069,187.82	3,785,124.57	69,284,063.25	1,307,864,919	0	1,974,153.0	5	0	0	5.59	5.30	0.00
372	IGS	17,298,542.89	1,074,763.79	16,223,779.10	318,770,518	0	456,642.0	2	0	0	5.43	5.09	0.00
528	SL	1,636,835.67	21,241.66	1,615,594.01	8,453,335	0	0.0	55	0	0	19.36	19.11	0.00
540	MW	221,697.63	6,637.53	215,060.10	1,986,738	0	2,885.0	10	0	0	11.16	10.82	0.00
Grand Total		578,189,782.44	17,057,525.07	561,132,257.37	5,847,628,188	11,922,829	8,485,550.4	166,602	45,270	54,306	9.89	9.60	284,861.52

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
010	011	RSW-LMWH	56,918.62	1,445.53	55,473.09	507,702	0	0.0	30	0	0	11.21	10.93	0.00
	015	RS	57,223,477.27	1,357,598.83	55,865,878.44	466,912,369	6,771	4,703.8	37,896	0	0	12.26	11.96	0.00
	022	RSW-RS	21,239,797.07	487,718.75	20,752,078.32	175,451,684	0	569.9	12,811	0	0	12.11	11.83	0.00
	036	RS-TOD-ON	2,191.73	49.27	2,142.46	16,994	10,438	0.0	2	0	0	12.90	12.61	0.00
	093	OL 175 MV	55,152.85	992.65	54,160.20	325,612	0	0.0	0	384	387	16.94	16.63	64.07
	094	OL 100 HP	1,094,998.61	12,437.16	1,082,561.45	4,087,958	0	0.0	0	8,093	8,591	26.79	26.48	18,618.92
	095	OL 400 MV	1,501.59	31.80	1,469.79	11,325	0	0.0	0	4	6	13.26	12.98	0.00
	097	OL 200 HP	64,397.02	1,100.12	63,296.90	365,477	0	0.0	0	340	366	17.62	17.32	1,120.49
	098	OL 400 HP	375.14	7.73	367.41	2,751	0	0.0	0	2	1	13.64	13.36	0.00
	107	OL 200HPF	52,044.70	763.63	51,281.07	253,676	0	0.0	0	215	254	20.52	20.22	888.66
	109	OL400 HPF	51,229.30	1,075.23	50,154.07	351,037	0	0.0	0	112	178	14.59	14.29	799.87
	110	OL 250 MH	3,034.98	46.91	2,988.07	15,271	0	0.0	0	12	13	19.87	19.57	0.00
	111	OL100 HPP	5,544.44	40.59	5,503.85	13,290	0	0.0	0	16	28	41.72	41.41	54.01
	113	OL 150 HP	921,417.93	12,889.83	908,528.10	4,288,913	0	0.0	0	5,654	6,190	21.48	21.18	36,997.53
	116	OL 400 MH	4,913.15	91.09	4,822.06	29,788	0	0.0	0	10	16	16.49	16.19	152.20
	122	OL150 HPP	359.85	2.75	357.10	795	0	0.0	0	1	1	45.26	44.92	0.00
	131	OL 1000MH	278.02	7.56	270.46	2,193	0	0.0	0	0	1	12.68	12.33	0.00
	136	OL 400MON	308.51	5.38	303.13	1,549	0	0.0	0	1	1	19.92	19.57	0.00
Total 010			80,777,940.78	1,876,304.81	78,901,635.97	652,638,384	17,209	5,273.7	50,739	14,844	16,033	12.38	12.09	58,695.75
020	011	RSW-LMWH	129,354.20	3,166.02	126,188.18	1,170,643	0	0.0	48	0	0	11.05	10.78	0.00
	012	RSW-A	26,299.90	662.01	25,637.89	240,746	0	0.0	10	0	0	10.92	10.65	0.00
	013	RSW-B	3,917.76	107.26	3,810.50	36,543	0	0.0	2	0	0	10.72	10.43	0.00
	015	RS	55,433,468.55	1,254,433.26	54,179,035.29	469,490,154	53,412	3,881.9	26,675	0	0	11.81	11.54	0.00
	017	RS EMP	1,094,460.43	24,441.96	1,070,018.47	9,416,046	0	0.0	466	0	0	11.62	11.36	0.00
	022	RSW-RS	118,740,399.87	2,659,112.90	116,081,286.97	1,006,190,404	52,964	17,628.6	56,857	0	0	11.80	11.54	0.00
	028	AORH-W ON	11,447.22	244.20	11,203.02	106,403	72,021	0.0	7	0	0	10.76	10.53	0.00
	030	RSW-ONPK	163,914.08	3,897.72	160,016.36	1,452,157	884,220	0.0	67	0	0	11.29	11.02	0.00
	032	RS LM-ON	210,366.85	4,876.48	205,490.37	1,942,721	1,276,669	0.0	84	0	0	10.83	10.58	0.00
	034	AORH-ON	1,647.97	21.82	1,626.15	14,808	8,738	0.0	2	0	0	11.13	10.98	0.00
	036	RS-TOD-ON	10,051.32	296.40	9,754.92	95,729	63,680	0.0	3	0	0	10.50	10.19	0.00
	093	OL 175 MV	27,247.62	489.71	26,757.91	160,776	0	0.0	0	184	189	16.95	16.64	40.36
	094	OL 100 HP	1,431,440.99	16,153.96	1,415,287.03	5,308,562	0	0.0	0	10,456	11,152	26.96	26.66	33,052.68
	095	OL 400 MV	999.48	23.91	975.57	7,508	0	0.0	0	4	4	13.31	12.99	0.00
	097	OL 200 HP	91,638.69	1,565.90	90,072.79	516,867	0	0.0	0	484	521	17.73	17.43	1,974.55
	098	OL 400 HP	3,708.66	106.45	3,602.21	27,192	0	0.0	0	10	12	13.64	13.25	78.82
	107	OL 200HPF	74,572.93	1,075.23	73,497.70	357,179	0	0.0	0	319	359	20.88	20.58	2,232.71
	109	OL400 HPF	75,667.32	1,556.47	74,110.85	511,876	0	0.0	0	198	260	14.78	14.48	2,047.35
	110	OL 250 MH	2,393.71	36.32	2,357.39	11,965	0	0.0	0	10	10	20.01	19.70	34.02
	111	OL100 HPP	20,292.83	142.44	20,150.39	48,031	0	0.0	0	83	101	42.25	41.95	449.01
	113	OL 150 HP	1,878,372.09	26,071.93	1,852,300.16	8,733,592	0	0.0	0	11,547	12,593	21.51	21.21	78,015.43
	116	OL 400 MH	5,573.36	105.68	5,467.68	34,516	0	0.0	0	13	19	16.15	15.84	40.34
	120	OL 250HPP	199.57	2.05	197.52	713	0	0.0	0	1	1	27.99	27.70	0.00
	122	OL150 HPP	1,134.34	7.35	1,126.99	2,451	0	0.0	0	4	4	46.26	45.98	0.00
	130	OL 250MON	308.61	3.51	305.10	1,200	0	0.0	0	1	1	29.72	29.43	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	131	OL 1000MH	2,138.11	52.15	2,085.96	17,678	0	0.0	0	1	4	12.09	11.80	0.00
	211	GS SEC	481.56	21.87	459.69	3,623	0	0.0	0	0	0	13.29	12.69	0.00
Total 020			179,441,498.02	3,998,674.96	175,442,823.06	1,505,900,083	2,411,704	21,510.5	84,220	23,315	25,227	11.92	11.65	117,965.27
211	093	OL 175 MV	13,678.39	236.01	13,442.38	78,157	0	0.0	0	76	92	17.50	17.20	0.00
	094	OL 100 HP	174,505.17	1,880.63	172,624.54	621,351	0	0.0	0	1,066	1,306	28.08	27.78	3,733.10
	095	OL 400 MV	7,696.98	168.99	7,527.99	56,278	0	0.0	0	25	30	13.68	13.38	0.00
	097	OL 200 HP	92,312.45	1,515.38	90,797.07	490,829	0	0.0	0	311	491	18.81	18.50	3,784.99
	098	OL 400 HP	27,753.09	605.17	27,147.92	193,773	0	0.0	0	35	97	14.32	14.01	473.92
	099	OL175 MVP	1,369.09	21.46	1,347.63	6,844	0	0.0	0	3	8	20.00	19.69	0.00
	103	OL 250 HP	488.37	7.79	480.58	2,452	0	0.0	0	1	2	19.92	19.60	0.00
	107	OL 200HPF	138,309.53	1,952.41	136,357.12	639,675	0	0.0	0	413	642	21.62	21.32	3,751.04
	109	OL400 HPF	557,127.31	11,059.71	546,067.60	3,651,323	0	0.0	0	767	1,856	15.26	14.96	14,272.94
	110	OL 250 MH	14,700.72	202.63	14,498.09	66,293	0	0.0	0	32	56	22.18	21.87	906.13
	111	OL100 HPP	39,545.35	276.38	39,268.97	89,652	0	0.0	0	34	187	44.11	43.80	708.06
	113	OL 150 HP	335,851.32	4,381.56	331,469.76	1,456,179	0	0.0	0	1,597	2,099	23.06	22.76	21,699.42
	116	OL 400 MH	168,475.50	3,147.11	165,328.39	987,502	0	0.0	0	148	520	17.06	16.74	5,122.39
	122	OL150 HPP	7,519.41	45.76	7,473.65	15,390	0	0.0	0	2	22	48.86	48.56	0.00
	126	OL 400HPP	357.13	4.06	353.07	1,467	0	0.0	0	0	1	24.34	24.07	0.00
	130	OL 250MON	602.64	7.81	594.83	2,223	0	0.0	0	2	2	27.11	26.76	0.00
	131	OL 1000MH	26,150.75	634.87	25,515.88	206,496	0	0.0	0	23	46	12.66	12.36	394.62
	204	GS-MTRD	223,928.90	3,907.49	220,021.41	1,193,856	0	0.0	413	0	0	18.76	18.43	0.00
	211	GS SEC	16,914,845.78	285,501.74	16,629,344.04	98,256,813	36,023	98,678.2	17,191	0	0	17.21	16.92	0.00
	213	GS-UMR	365,022.87	5,882.76	359,140.11	1,795,865	0	0.0	464	0	0	20.33	20.00	0.00
	214	GS - AF	10,268.31	259.20	10,009.11	60,667	0	1,553.9	10	0	0	16.93	16.50	0.00
	215	GS SEC	28,508,338.49	668,453.41	27,839,885.08	215,209,058	0	875,182.9	3,120	0	0	13.25	12.94	0.00
	217	GS PRI	82,065.41	1,903.96	80,161.45	641,394	0	2,151.6	6	0	0	12.79	12.50	0.00
	220	GSCC PRI	90,790.67	2,082.94	88,707.73	747,825	0	1,983.6	4	0	0	12.14	11.86	0.00
	223	GS LM ON	7,611.55	189.33	7,422.22	57,579	34,516	0.0	4	0	0	13.22	12.89	0.00
	225	GS LM TOD	1,423.02	13.89	1,409.13	7,008	3,951	0.0	2	0	0	20.31	20.11	0.00
	227	EXP GSTOD	109,877.31	2,035.87	107,841.44	657,974	409,673	0.0	108	0	0	16.70	16.39	0.00
	229	GS-TOD	168,941.76	4,345.41	164,596.35	1,390,884	896,085	463.2	34	0	0	12.15	11.83	0.00
	236	GSCC SUB	10,942.98	170.05	10,772.93	56,319	0	224.0	1	0	0	19.43	19.13	0.00
	240	LGS SEC	12,799,819.21	371,718.39	12,428,100.82	113,770,207	0	279,092.0	164	0	0	11.25	10.92	0.00
	244	LGS PRI	1,391,475.13	45,059.78	1,346,415.35	14,038,252	0	34,525.0	12	0	0	9.91	9.59	0.00
	248	LGS SUB	336,867.43	13,958.43	322,909.00	4,243,066	0	9,400.0	3	0	0	7.94	7.61	0.00
	256	LGSSECTOD	397,744.06	12,599.60	385,144.46	4,016,296	2,252,464	7,966.0	5	0	0	9.90	9.59	0.00
	356	IGS SEC	1,566,240.62	49,973.09	1,516,267.53	16,532,300	0	33,680.0	4	0	0	9.47	9.17	0.00
	358	IGS PRI	6,975,116.74	294,061.03	6,681,055.71	92,151,375	0	161,990.0	8	0	0	7.57	7.25	0.00
	359	IGS SUB	1,367,128.07	71,120.33	1,296,007.74	21,467,039	0	38,958.0	3	0	0	6.37	6.04	0.00
Total 211			72,934,891.51	1,859,384.43	71,075,507.08	594,859,661	3,632,712	1,545,848.4	21,556	4,535	7,456	12.26	11.95	54,846.61
212	093	OL 175 MV	2,144.59	38.89	2,105.70	12,250	0	0.0	0	14	14	17.51	17.19	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	094	OL 100 HP	41,438.00	438.90	40,999.10	145,554	0	0.0	0	243	306	28.47	28.17	1,285.39
	095	OL 400 MV	4,207.23	86.95	4,120.28	30,840	0	0.0	0	9	16	13.64	13.36	0.00
	097	OL 200 HP	27,667.94	435.64	27,232.30	146,651	0	0.0	0	110	147	18.87	18.57	1,255.92
	098	OL 400 HP	5,051.34	106.23	4,945.11	33,082	0	0.0	0	12	17	15.27	14.95	344.27
	099	OL175 MVP	171.39	2.78	168.61	856	0	0.0	0	1	1	20.02	19.70	0.00
	107	OL 200HPF	49,922.97	692.95	49,230.02	231,793	0	0.0	0	157	232	21.54	21.24	1,298.43
	109	OL400 HPF	217,347.03	4,336.47	213,010.56	1,418,865	0	0.0	0	299	721	15.32	15.01	6,377.65
	110	OL 250 MH	10,410.68	137.93	10,272.75	45,246	0	0.0	0	9	38	23.01	22.70	922.88
	111	OL100 HPP	3,894.74	26.73	3,868.01	9,000	0	0.0	0	5	19	43.27	42.98	0.00
	113	OL 150 HP	93,460.73	1,203.62	92,257.11	394,569	0	0.0	0	396	567	23.69	23.38	8,029.84
	116	OL 400 MH	56,989.35	1,031.81	55,957.54	332,994	0	0.0	0	65	180	17.11	16.80	1,747.16
	131	OL 1000MH	11,944.57	287.36	11,657.21	94,741	0	0.0	0	7	21	12.61	12.30	128.50
	211	GS SEC	3,207,183.24	58,005.00	3,149,178.24	21,511,825	6,025	44,235.8	2,249	0	0	14.91	14.64	0.00
	215	GS SEC	18,600,820.96	411,284.96	18,189,536.00	139,262,563	0	608,216.8	2,122	0	0	13.36	13.06	0.00
	217	GS PRI	130,006.20	3,088.49	126,917.71	1,061,987	0	3,056.5	5	0	0	12.24	11.95	0.00
	220	GSCC PRI	53,581.80	904.24	52,677.56	427,869	0	1,452.0	1	0	0	12.52	12.31	0.00
	223	GS LM ON	98,786.38	1,737.57	97,048.81	823,106	511,812	0.0	35	0	0	12.00	11.79	0.00
	225	GS LM TOD	32,151.22	689.27	31,461.95	222,288	135,464	0.0	26	0	0	14.46	14.15	0.00
	227	EXP GSTOD	129,212.72	2,511.31	126,701.41	825,841	582,655	0.0	116	0	0	15.65	15.34	0.00
	229	GS-TOD	285,626.29	6,817.57	278,808.72	2,326,302	1,423,547	0.0	41	0	0	12.28	11.99	0.00
	240	LGS SEC	16,066,199.73	436,748.92	15,629,450.81	140,580,327	0	374,343.0	200	0	0	11.43	11.12	0.00
	242	LGS M SEC	168,972.38	4,640.78	164,331.60	1,549,802	0	3,393.0	1	0	0	10.90	10.60	0.00
	244	LGS PRI	887,318.22	26,069.64	861,248.58	8,967,797	0	22,587.0	6	0	0	9.89	9.60	0.00
	248	LGS SUB	210,522.61	9,242.03	201,280.58	2,747,332	0	6,581.0	1	0	0	7.66	7.33	0.00
	251	LGS-LM-TD	98,261.51	2,136.48	96,125.03	821,805	422,240	0.0	4	0	0	11.96	11.70	0.00
	358	IGS PRI	975,547.26	41,568.07	933,979.19	12,009,552	0	23,400.0	2	0	0	8.12	7.78	0.00
Total 212			41,468,841.08	1,014,270.59	40,454,570.49	336,034,837	3,081,743	1,087,265.1	4,808	1,328	2,279	12.34	12.04	21,390.04
213	093	OL 175 MV	900.79	14.99	885.80	5,157	0	0.0	0	6	6	17.47	17.18	0.00
	094	OL 100 HP	5,238.17	58.25	5,179.92	19,043	0	0.0	0	25	40	27.51	27.20	9.54
	095	OL 400 MV	1,030.80	22.31	1,008.49	7,539	0	0.0	0	3	4	13.67	13.38	0.00
	097	OL 200 HP	5,689.27	90.07	5,599.20	30,306	0	0.0	0	20	30	18.77	18.48	233.17
	098	OL 400 HP	4,876.47	103.97	4,772.50	31,788	0	0.0	0	5	16	15.34	15.01	343.79
	107	OL 200HPF	20,150.29	284.16	19,866.13	93,108	0	0.0	0	47	93	21.64	21.34	568.46
	109	OL400 HPF	133,714.40	2,579.93	131,134.47	861,780	0	0.0	0	99	435	15.52	15.22	5,449.58
	110	OL 250 MH	1,056.39	15.22	1,041.17	4,754	0	0.0	0	3	4	22.22	21.90	64.18
	111	OL100 HPP	6,031.96	40.87	5,991.09	13,959	0	0.0	0	4	29	43.21	42.92	0.00
	113	OL 150 HP	10,945.30	129.85	10,815.45	41,876	0	0.0	0	30	60	26.14	25.83	1,732.44
	116	OL 400 MH	25,625.89	463.95	25,161.94	149,811	0	0.0	0	20	80	17.11	16.80	828.31
	131	OL 1000MH	637.09	11.76	625.33	4,536	0	0.0	0	1	1	14.05	13.79	64.47
	211	GS SEC	326,788.64	5,698.78	321,089.86	2,144,494	0	3,855.6	252	0	0	15.24	14.97	0.00
	214	GS - AF	112,039.21	2,660.93	109,378.28	817,381	0	19,139.6	57	0	0	13.71	13.38	0.00
	215	GS SEC	2,597,044.21	56,169.79	2,540,874.42	19,531,468	0	80,040.7	212	0	0	13.30	13.01	0.00
	223	GS LM ON	5,376.92	107.04	5,269.88	55,340	41,040	0.0	1	0	0	9.72	9.52	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	240	LGS SEC	2,491,669.06	63,755.33	2,427,913.73	21,012,413	0	65,078.1	36	0	0	11.86	11.55	0.00
	260	PS SEC	13,369,345.64	331,357.15	13,037,988.49	108,038,008	0	402,989.0	158	0	0	12.37	12.07	0.00
	264	PS PRI	236,470.06	6,431.75	230,038.31	2,259,540	0	7,549.0	1	0	0	10.47	10.18	0.00
	358	IGS PRI	388,683.55	12,336.29	376,347.26	4,055,704	0	10,475.0	1	0	0	9.58	9.28	0.00
	359	IGS SUB	196,309.54	6,382.51	189,927.03	1,916,336	0	6,518.0	1	0	0	10.24	9.91	0.00
Total 213			19,939,623.65	488,714.90	19,450,908.75	161,094,341	41,040	595,645.0	719	263	798	12.38	12.07	9,293.94
216	093	OL 175 MV	5,026.40	88.55	4,937.85	28,685	0	0.0	0	23	34	17.52	17.21	0.00
	094	OL 100 HP	24,592.82	268.58	24,324.24	87,858	0	0.0	0	116	184	27.99	27.69	455.90
	095	OL 400 MV	3,560.69	82.02	3,478.67	25,888	0	0.0	0	9	14	13.75	13.44	0.00
	097	OL 200 HP	23,833.63	367.43	23,466.20	122,066	0	0.0	0	56	122	19.53	19.22	1,749.07
	098	OL 400 HP	21,885.25	437.53	21,447.72	137,897	0	0.0	0	13	69	15.87	15.55	2,211.48
	107	OL 200HPF	36,573.49	491.65	36,081.84	166,252	0	0.0	0	94	167	22.00	21.70	1,580.28
	109	OL400 HPF	136,872.91	2,645.39	134,227.52	893,013	0	0.0	0	192	450	15.33	15.03	4,478.00
	110	OL 250 MH	2,285.57	31.99	2,253.58	10,750	0	0.0	0	6	9	21.26	20.96	64.30
	111	OL100 HPP	69,008.93	481.87	68,527.06	158,896	0	0.0	0	37	331	43.43	43.13	256.94
	113	OL 150 HP	52,527.02	628.63	51,898.39	212,241	0	0.0	0	146	304	24.75	24.45	6,279.79
	116	OL 400 MH	26,153.45	484.38	25,669.07	153,664	0	0.0	0	21	82	17.02	16.70	699.21
	120	OL 250HPP	380.12	4.24	375.88	1,222	0	0.0	0	1	1	31.11	30.76	0.00
	122	OL150 HPP	10,900.60	69.71	10,830.89	22,286	0	0.0	0	6	32	48.91	48.60	0.00
	131	OL 1000MH	4,560.96	110.71	4,450.25	36,063	0	0.0	0	6	8	12.65	12.34	64.28
	204	GS-MTRD	11,627.68	96.18	11,531.50	27,112	0	0.0	43	0	0	42.89	42.53	0.00
	211	GS SEC	2,301,487.95	40,549.84	2,260,938.11	14,263,407	76,154	22,345.1	2,017	0	0	16.14	15.85	0.00
	213	GS-UMR	92,090.79	796.50	91,294.29	548,108	0	0.0	135	0	0	16.80	16.66	0.00
	214	GS - AF	59,899.86	1,336.07	58,563.79	469,484	0	7,025.5	19	0	0	12.76	12.47	0.00
	215	GS SEC	7,769,937.92	178,527.75	7,591,410.17	58,918,671	0	226,337.9	720	0	0	13.19	12.88	0.00
	217	GS PRI	134,112.97	1,611.81	132,501.16	521,412	0	10,387.8	4	0	0	25.72	25.41	0.00
	218	GS M SEC	28,133.56	642.68	27,490.88	214,119	0	751.2	1	0	0	13.14	12.84	0.00
	223	GS LM ON	3,280.45	61.38	3,219.07	22,598	14,653	0.0	3	0	0	14.52	14.24	0.00
	225	GS LM TOD	3,673.78	63.76	3,610.02	24,769	14,392	0.0	3	0	0	14.83	14.57	0.00
	229	GS-TOD	22,108.15	509.55	21,598.60	152,169	86,992	0.0	10	0	0	14.53	14.19	0.00
	240	LGS SEC	8,182,916.03	225,928.75	7,956,987.28	71,505,945	0	188,303.0	93	0	0	11.44	11.13	0.00
	242	LGS M SEC	691,908.50	18,126.09	673,782.41	6,250,701	0	14,717.0	6	0	0	11.07	10.78	0.00
	244	LGS PRI	302,707.50	9,430.64	293,276.86	2,914,029	0	8,724.0	3	0	0	10.39	10.06	0.00
	246	LGS M PRI	69,017.38	2,083.17	66,934.21	676,075	0	1,914.0	1	0	0	10.21	9.90	0.00
	251	LGS-LM-TD	90,179.27	2,093.02	88,086.25	813,242	444,480	0.0	2	0	0	11.09	10.83	0.00
	358	IGS PRI	2,263,705.84	87,674.14	2,176,031.70	26,881,061	0	55,320.0	4	0	0	8.42	8.10	0.00
	540	MW	221,697.63	6,637.53	215,060.10	1,986,738	0	2,885.0	10	0	0	11.16	10.82	0.00
Total 216			22,666,647.10	582,361.54	22,084,285.56	188,246,421	636,671	538,710.5	3,074	725	1,806	12.04	11.73	17,839.25
221	093	OL 175 MV	1,203.24	19.41	1,183.83	6,894	0	0.0	0	8	8	17.45	17.17	0.00
	094	OL 100 HP	7,908.37	86.78	7,821.59	28,336	0	0.0	0	33	59	27.91	27.60	128.02
	095	OL 400 MV	1,073.42	24.42	1,049.00	7,483	0	0.0	0	3	4	14.34	14.02	40.48

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	097	OL 200 HP	5,956.01	103.04	5,852.97	32,290	0	0.0	0	9	32	18.45	18.13	144.71
	098	OL 400 HP	561.80	11.71	550.09	3,986	0	0.0	0	1	2	14.09	13.80	0.00
	107	OL 200HPF	4,110.28	59.74	4,050.54	19,619	0	0.0	0	13	20	20.95	20.65	0.00
	109	OL400 HPF	55,151.88	1,121.82	54,030.06	360,758	0	0.0	0	42	183	15.29	14.98	1,505.28
	110	OL 250 MH	1,635.79	23.71	1,612.08	7,861	0	0.0	0	1	7	20.81	20.51	0.00
	111	OL100 HPP	1,244.52	9.93	1,234.59	2,872	0	0.0	0	1	6	43.33	42.99	0.00
	113	OL 150 HP	8,169.76	107.26	8,062.50	34,060	0	0.0	0	28	49	23.99	23.67	754.31
	116	OL 400 MH	10,646.44	196.96	10,449.48	64,188	0	0.0	0	11	34	16.59	16.28	64.06
	131	OL 1000MH	3,527.66	79.79	3,447.87	27,017	0	0.0	0	3	6	13.06	12.76	128.02
	204	GS-MTRD	1,542.58	24.80	1,517.78	7,675	0	0.0	3	0	0	20.10	19.78	0.00
	211	GS SEC	578,426.55	10,340.25	568,086.30	3,341,001	0	4,280.7	599	0	0	17.31	17.00	0.00
	215	GS SEC	1,301,008.41	31,048.96	1,269,959.45	9,739,613	0	40,975.3	126	0	0	13.36	13.04	0.00
	217	GS PRI	27,428.09	647.41	26,780.68	186,202	0	1,038.6	5	0	0	14.73	14.38	0.00
	220	GSCC PRI	168,406.73	4,271.38	164,135.35	1,368,372	0	3,542.6	11	0	0	12.31	11.99	0.00
	236	GSCC SUB	21,390.54	591.48	20,799.06	172,901	0	252.3	1	0	0	12.37	12.03	0.00
	240	LGS SEC	3,942,468.32	99,672.21	3,842,796.11	29,572,524	0	132,394.0	49	0	0	13.33	12.99	0.00
	244	LGS PRI	1,568,971.15	42,612.41	1,526,358.74	13,189,689	0	54,292.0	11	0	0	11.90	11.57	0.00
	248	LGS SUB	248,422.80	8,581.88	239,840.92	2,718,225	0	9,244.0	2	0	0	9.14	8.82	0.00
	250	LGS TRAN	289,588.06	7,715.12	281,872.94	3,528,000	0	7,271.0	1	0	0	8.21	7.99	0.00
	321	CS-IRP	53,460.29	2,679.68-	56,139.97	910,340	0	3,822.0	0	0	0	5.87	6.17	0.00
	331	CS-IRP ST	7,857,820.21	427,708.60	7,430,111.61	143,328,000	0	253,656.0	1	0	0	5.48	5.18	0.00
	332	CS-IRP TR	375,435.31	7,887.20	367,548.11	4,116,000	0	13,776.0	0	0	0	9.12	8.93	0.00
	358	IGS PRI	7,233,408.02	315,127.82	6,918,280.20	93,851,171	0	173,459.0	12	0	0	7.71	7.37	0.00
	359	IGS SUB	7,261,146.67	247,760.01	7,013,386.66	91,739,260	0	268,034.0	6	0	0	7.91	7.64	0.00
	360	IGS	1,186,695.74	26,488.28	1,160,207.46	9,306,000	0	47,501.0	1	0	0	12.75	12.47	0.00
	371	IGS	72,283,639.86	3,749,294.79	68,534,345.07	1,296,513,998	0	1,953,839.0	4	0	0	5.58	5.29	0.00
	372	IGS	17,298,542.89	1,074,763.79	16,223,779.10	318,770,518	0	456,642.0	2	0	0	5.43	5.09	0.00
Total 221			121,798,991.39	6,053,701.28	115,745,290.11	2,022,954,853	0	3,424,019.5	835	152	411	6.02	5.72	2,764.88
222	097	OL 200 HP	723.82	12.20	711.62	3,727	0	0.0	0	2	4	19.42	19.09	47.60
	107	OL 200HPF	208.71	3.07	205.64	996	0	0.0	0	1	1	20.95	20.65	0.00
	109	OL400 HPF	2,114.00	40.44	2,073.56	13,918	0	0.0	0	4	7	15.19	14.90	47.56
	113	OL 150 HP	1,638.75	20.67	1,618.08	6,279	0	0.0	0	5	9	26.10	25.77	256.16
	211	GS SEC	43,434.67	835.73	42,598.94	298,429	0	426.3	27	0	0	14.55	14.27	0.00
	215	GS SEC	149,590.96	2,960.84	146,630.12	1,102,494	0	5,497.6	17	0	0	13.57	13.30	0.00
	220	GSCC PRI	25,284.51	493.71	24,790.80	203,100	0	636.0	2	0	0	12.45	12.21	0.00
	229	GS-TOD	4,562.44	37.43	4,525.01	42,000	30,000	0.0	1	0	0	10.86	10.77	0.00
	240	LGS SEC	1,240,273.88	33,517.54	1,206,756.34	9,905,218	0	38,016.0	11	0	0	12.52	12.18	0.00
	244	LGS PRI	354,261.22	14,242.27	340,018.95	3,869,093	0	6,395.0	1	0	0	9.16	8.79	0.00
	251	LGS-LM-TD	1,246.08	2.33	1,243.75	490	300	0.0	1	0	0	254.30	253.83	0.00
	358	IGS PRI	908,975.94	38,175.44	870,800.50	10,238,798	0	23,107.0	1	0	0	8.88	8.50	0.00
	359	IGS SUB	97,794.29	925.24	96,869.05	264,000	0	5,066.0	0	0	0	37.04	36.69	0.00
Total 222			2,830,109.27	91,266.91	2,738,842.36	25,948,542	30,300	79,143.9	61	12	21	10.91	10.65	351.32

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
230	093	OL 175 MV	149.97	2.94	147.03	855	0	0.0	0	1	1	17.54	17.20	0.00
	094	OL 100 HP	1,054.05	11.09	1,042.96	3,852	0	0.0	0	7	8	27.36	27.08	0.00
	095	OL 400 MV	760.37	17.85	742.52	5,561	0	0.0	0	2	3	13.67	13.35	0.00
	097	OL 200 HP	9,281.00	132.71	9,148.29	48,156	0	0.0	0	8	48	19.27	19.00	608.29
	107	OL 200HPF	1,318.05	16.79	1,301.26	6,054	0	0.0	0	4	6	21.77	21.49	47.70
	109	OL400 HPF	12,493.74	224.42	12,269.32	81,644	0	0.0	0	19	41	15.30	15.03	392.83
	113	OL 150 HP	4,730.56	61.32	4,669.24	20,322	0	0.0	0	17	29	23.28	22.98	344.59
	116	OL 400 MH	931.86	14.78	917.08	5,679	0	0.0	0	2	3	16.41	16.15	0.00
	211	GS SEC	80,349.45	1,339.42	79,010.03	488,349	0	967.2	75	0	0	16.45	16.18	0.00
	215	GS SEC	430,133.38	8,703.78	421,429.60	3,157,551	0	15,025.5	64	0	0	13.62	13.35	0.00
	217	GS PRI	43,274.21	1,154.13	42,120.08	344,864	0	1,069.5	3	0	0	12.55	12.21	0.00
	220	GSCC PRI	376,362.84	9,137.66	367,225.18	2,898,632	0	8,884.3	35	0	0	12.98	12.67	0.00
	236	GSCC SUB	83,450.85	1,789.15	81,661.70	608,802	0	1,855.0	4	0	0	13.71	13.41	0.00
	240	LGS SEC	432,527.21	8,161.40	424,365.81	2,589,503	0	19,664.0	7	0	0	16.70	16.39	0.00
	244	LGS PRI	4,412,868.26	112,528.43	4,300,339.83	36,409,029	113,750	169,524.0	27	0	0	12.12	11.81	0.00
	248	LGS SUB	901,245.55	29,165.25	872,080.30	9,688,560	0	33,750.0	10	0	0	9.30	9.00	0.00
	250	LGS TRAN	188,006.41	6,925.88	181,080.53	2,066,238	0	8,206.0	2	0	0	9.10	8.76	0.00
	257	LGSPRITOD	291,217.45	9,411.34	281,806.11	3,449,480	1,957,700	4,914.0	1	0	0	8.44	8.17	0.00
	330	CS-IRP PR	707,262.22	13,720.46	693,541.76	4,252,976	0	27,159.0	1	0	0	16.63	16.31	0.00
	331	CS-IRP ST	4,237,771.35	172,770.84	4,065,000.51	61,621,717	0	162,677.0	2	0	0	6.88	6.60	0.00
	358	IGS PRI	9,946,871.84	261,300.50	9,685,571.34	83,866,670	0	284,558.0	12	0	0	11.86	11.55	0.00
	359	IGS SUB	11,147,224.23	382,834.75	10,764,389.48	123,627,165	0	417,171.0	8	0	0	9.02	8.71	0.00
	360	IGS	266,051.36	10,558.10	255,493.26	3,048,234	0	8,470.0	0	0	0	8.73	8.38	0.00
	371	IGS	785,547.96	35,829.78	749,718.18	11,350,921	0	20,314.0	1	0	0	6.92	6.60	0.00
Total 230			34,360,884.17	1,065,812.77	33,295,071.40	349,640,814	2,071,450	1,184,208.5	253	60	139	9.83	9.52	1,393.41
400	093	OL 175 MV	297.46	5.69	291.77	1,694	0	0.0	0	1	2	17.56	17.22	0.00
	094	OL 100 HP	524.28	5.99	518.29	1,911	0	0.0	0	2	4	27.43	27.12	0.00
	097	OL 200 HP	178.98	2.79	176.19	1,007	0	0.0	0	1	1	17.77	17.50	0.00
	107	OL 200HPF	210.25	2.96	207.29	1,006	0	0.0	0	1	1	20.90	20.61	0.00
	109	OL400 HPF	6,968.46	129.65	6,838.81	45,718	0	0.0	0	7	23	15.24	14.96	192.75
	111	OL100 HPP	19,149.29	123.33	19,025.96	44,338	0	0.0	0	19	92	43.19	42.91	0.00
	113	OL 150 HP	746.97	8.77	738.20	2,803	0	0.0	0	2	4	26.65	26.34	128.30
	122	OL150 HPP	2,737.06	16.06	2,721.00	5,604	0	0.0	0	2	8	48.84	48.55	0.00
	131	OL 1000MH	561.24	13.34	547.90	4,512	0	0.0	0	1	1	12.44	12.14	0.00
	204	GS-MTRD	1,600.37	0.23	1,600.14	64	0	0.0	8	0	0	2,500.58	2,500.22	0.00
	211	GS SEC	150,546.99	1,793.39	148,753.60	575,721	0	410.3	260	0	0	26.15	25.84	0.00
	213	GS-UMR	213.59	0.19	213.40	59	0	0.0	1	0	0	362.02	361.69	0.00
	215	GS SEC	149,784.86	3,688.83	146,096.03	1,172,480	0	3,515.0	13	0	0	12.78	12.46	0.00
	528	SL	1,636,835.67	21,241.66	1,615,594.01	8,453,335	0	0.0	55	0	0	19.36	19.11	0.00
Total 400			1,970,355.47	27,032.88	1,943,322.59	10,310,252	0	3,925.3	337	36	136	19.11	18.85	321.05

REV CLASS	TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total		578,189,782.44	17,057,525.07	561,132,257.37	5,847,628,188	11,922,829	8,485,550.4	166,602	45,270	54,306	9.89	9.60	284,861.52

TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
011	RSW-LMWH	186,272.82	4,611.55	181,661.27	1,678,345	0	0.0	78	0	0	11.10	10.82	0.00
012	RSW-A	26,299.90	662.01	25,637.89	240,746	0	0.0	10	0	0	10.92	10.65	0.00
013	RSW-B	3,917.76	107.26	3,810.50	36,543	0	0.0	2	0	0	10.72	10.43	0.00
015	RS	112,656,945.82	2,612,032.09	110,044,913.73	936,402,523	60,183	8,585.7	64,571	0	0	12.03	11.75	0.00
017	RS EMP	1,094,460.43	24,441.96	1,070,018.47	9,416,046	0	0.0	466	0	0	11.62	11.36	0.00
022	RSW-RS	139,980,196.94	3,146,831.65	136,833,365.29	1,181,642,088	52,964	18,198.5	69,668	0	0	11.85	11.58	0.00
028	AORH-W ON	11,447.22	244.20	11,203.02	106,403	72,021	0.0	7	0	0	10.76	10.53	0.00
030	RSW-ONPK	163,914.08	3,897.72	160,016.36	1,452,157	884,220	0.0	67	0	0	11.29	11.02	0.00
032	RS LM-ON	210,366.85	4,876.48	205,490.37	1,942,721	1,276,669	0.0	84	0	0	10.83	10.58	0.00
034	AORH-ON	1,647.97	21.82	1,626.15	14,808	8,738	0.0	2	0	0	11.13	10.98	0.00
036	RS-TOD-ON	12,243.05	345.67	11,897.38	112,723	74,118	0.0	5	0	0	10.86	10.55	0.00
093	OL 175 MV	105,801.31	1,888.84	103,912.47	620,080	0	0.0	0	697	732	17.06	16.76	104.43
094	OL 100 HP	2,781,700.46	31,341.34	2,750,359.12	10,304,425	0	0.0	0	20,042	21,650	27.00	26.69	57,283.55
095	OL 400 MV	20,830.56	458.25	20,372.31	152,422	0	0.0	0	59	81	13.67	13.37	40.48
097	OL 200 HP	321,678.81	5,325.28	316,353.53	1,757,376	0	0.0	0	1,342	1,762	18.30	18.00	10,918.79
098	OL 400 HP	64,211.75	1,378.79	62,832.96	430,469	0	0.0	0	77	214	14.92	14.60	3,452.28
099	OL175 MVP	1,540.48	24.24	1,516.24	7,700	0	0.0	0	4	9	20.01	19.69	0.00
103	OL 250 HP	488.37	7.79	480.58	2,452	0	0.0	0	1	2	19.92	19.60	0.00
107	OL 200HPF	377,421.20	5,342.59	372,078.61	1,769,358	0	0.0	0	1,263	1,774	21.33	21.03	10,367.28
109	OL400 HPF	1,248,686.35	24,769.53	1,223,916.82	8,189,932	0	0.0	0	1,740	4,154	15.25	14.94	35,563.81
110	OL 250 MH	35,517.84	494.71	35,023.13	162,140	0	0.0	0	72	137	21.91	21.60	1,991.51
111	OL100 HPP	164,712.06	1,142.14	163,569.92	380,038	0	0.0	0	198	792	43.34	43.04	1,468.02
113	OL 150 HP	3,307,860.43	45,503.44	3,262,356.99	15,190,834	0	0.0	0	19,422	21,903	21.78	21.48	154,237.81
116	OL 400 MH	299,309.00	5,535.76	293,773.24	1,758,142	0	0.0	0	290	934	17.02	16.71	8,653.67
120	OL 250HPP	579.69	6.29	573.40	1,935	0	0.0	0	2	2	29.96	29.63	0.00
122	OL150 HPP	22,651.26	141.63	22,509.63	46,526	0	0.0	0	15	67	48.69	48.38	0.00
126	OL 400HPP	357.13	4.06	353.07	1,467	0	0.0	0	0	1	24.34	24.07	0.00
130	OL 250MON	911.25	11.32	899.93	3,423	0	0.0	0	3	3	26.62	26.29	0.00
131	OL 1000MH	49,798.40	1,197.54	48,600.86	393,236	0	0.0	0	43	87	12.66	12.36	779.89
136	OL 400MON	308.51	5.38	303.13	1,549	0	0.0	0	1	1	19.92	19.57	0.00
204	GS-MTRD	238,699.53	4,028.70	234,670.83	1,228,707	0	0.0	468	0	0	19.43	19.10	0.00
211	GS SEC	23,603,544.83	404,086.02	23,199,458.81	140,883,662	118,202	175,199.2	22,670	0	0	16.75	16.47	0.00
213	GS-UMR	457,327.25	6,679.45	450,647.80	2,344,032	0	0.0	600	0	0	19.51	19.23	0.00
214	GS - AF	182,207.38	4,256.20	177,951.18	1,347,532	0	27,719.0	87	0	0	13.52	13.21	0.00
215	GS SEC	59,506,659.19	1,360,838.32	58,145,820.87	448,093,898	0	1,854,791.7	6,394	0	0	13.28	12.98	0.00
217	GS PRI	416,886.88	8,405.80	408,481.08	2,755,859	0	17,704.0	23	0	0	15.13	14.82	0.00
218	GS M SEC	28,133.56	642.68	27,490.88	214,119	0	751.2	1	0	0	13.14	12.84	0.00
220	GSCC PRI	714,426.55	16,889.93	697,536.62	5,645,798	0	16,498.5	53	0	0	12.65	12.35	0.00
223	GS LM ON	115,055.30	2,095.32	112,959.98	958,623	602,021	0.0	43	0	0	12.00	11.78	0.00
225	GS LM TOD	37,248.02	766.92	36,481.10	254,065	153,807	0.0	31	0	0	14.66	14.36	0.00
227	EXP GSTOD	239,090.03	4,547.18	234,542.85	1,483,815	992,328	0.0	224	0	0	16.11	15.81	0.00

TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
229	GS-TOD	481,238.64	11,709.96	469,528.68	3,911,355	2,436,624	463.2	86	0	0	12.30	12.00	0.00
236	GSCC SUB	115,784.37	2,550.68	113,233.69	838,022	0	2,331.3	6	0	0	13.82	13.51	0.00
240	LGS SEC	45,155,873.44	1,239,502.54	43,916,370.90	388,936,137	0	1,096,890.1	560	0	0	11.61	11.29	0.00
242	LGS M SEC	860,880.88	22,766.87	838,114.01	7,800,503	0	18,110.0	7	0	0	11.04	10.74	0.00
244	LGS PRI	8,917,601.48	249,943.17	8,667,658.31	79,387,889	113,750	296,047.0	60	0	0	11.23	10.92	0.00
246	LGS M PRI	69,017.38	2,083.17	66,934.21	676,075	0	1,914.0	1	0	0	10.21	9.90	0.00
248	LGS SUB	1,697,058.39	60,947.59	1,636,110.80	19,397,183	0	58,975.0	16	0	0	8.75	8.43	0.00
250	LGS TRAN	477,594.47	14,641.00	462,953.47	5,594,238	0	15,477.0	2	0	0	8.54	8.28	0.00
251	LGS-LM-TD	189,686.86	4,231.83	185,455.03	1,635,537	867,020	0.0	7	0	0	11.60	11.34	0.00
256	LGSSECTOD	397,744.06	12,599.60	385,144.46	4,016,296	2,252,464	7,966.0	5	0	0	9.90	9.59	0.00
257	LGSPRITOD	291,217.45	9,411.34	281,806.11	3,449,480	1,957,700	4,914.0	1	0	0	8.44	8.17	0.00
260	PS SEC	13,369,345.64	331,357.15	13,037,988.49	108,038,008	0	402,989.0	158	0	0	12.37	12.07	0.00
264	PS PRI	236,470.06	6,431.75	230,038.31	2,259,540	0	7,549.0	1	0	0	10.47	10.18	0.00
321	CS-IRP	53,460.29	2,679.68-	56,139.97	910,340	0	3,822.0	0	0	0	5.87	6.17	0.00
330	CS-IRP PR	707,262.22	13,720.46	693,541.76	4,252,976	0	27,159.0	1	0	0	16.63	16.31	0.00
331	CS-IRP ST	12,095,591.56	600,479.44	11,495,112.12	204,949,717	0	416,333.0	3	0	0	5.90	5.61	0.00
332	CS-IRP TR	375,435.31	7,887.20	367,548.11	4,116,000	0	13,776.0	0	0	0	9.12	8.93	0.00
356	IGS SEC	1,566,240.62	49,973.09	1,516,267.53	16,532,300	0	33,680.0	4	0	0	9.47	9.17	0.00
358	IGS PRI	28,692,309.19	1,050,243.29	27,642,065.90	323,054,331	0	732,309.0	40	0	0	8.88	8.56	0.00
359	IGS SUB	20,069,602.80	709,022.84	19,360,579.96	239,013,800	0	735,747.0	18	0	0	8.40	8.10	0.00
360	IGS	1,452,747.10	37,046.38	1,415,700.72	12,354,234	0	55,971.0	1	0	0	11.76	11.46	0.00
371	IGS	73,069,187.82	3,785,124.57	69,284,063.25	1,307,864,919	0	1,974,153.0	5	0	0	5.59	5.30	0.00
372	IGS	17,298,542.89	1,074,763.79	16,223,779.10	318,770,518	0	456,642.0	2	0	0	5.43	5.09	0.00
528	SL	1,636,835.67	21,241.66	1,615,594.01	8,453,335	0	0.0	55	0	0	19.36	19.11	0.00
540	MW	221,697.63	6,637.53	215,060.10	1,986,738	0	2,885.0	10	0	0	11.16	10.82	0.00
Grand Total		578,189,782.44	17,057,525.07	561,132,257.37	5,847,628,188	11,922,829	8,485,550.4	166,602	45,270	54,306	9.89	9.60	284,861.52

State:

TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total	0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
010	011	RSW-LMWH	56,918.62	1,445.53	55,473.09	507,702	0	0.0	30	0	0	11.21	10.93	0.00
	015	RS	57,223,477.27	1,357,598.83	55,865,878.44	466,912,369	6,771	4,703.8	37,896	0	0	12.26	11.96	0.00
	022	RSW-RS	21,239,797.07	487,718.75	20,752,078.32	175,451,684	0	569.9	12,811	0	0	12.11	11.83	0.00
	036	RS-TOD-ON	2,191.73	49.27	2,142.46	16,994	10,438	0.0	2	0	0	12.90	12.61	0.00
	093	OL 175 MV	55,152.85	992.65	54,160.20	325,612	0	0.0	0	384	387	16.94	16.63	64.07
	094	OL 100 HP	1,094,998.61	12,437.16	1,082,561.45	4,087,958	0	0.0	0	8,093	8,591	26.79	26.48	18,618.92
	095	OL 400 MV	1,501.59	31.80	1,469.79	11,325	0	0.0	0	4	6	13.26	12.98	0.00
	097	OL 200 HP	64,397.02	1,100.12	63,296.90	365,477	0	0.0	0	340	366	17.62	17.32	1,120.49
	098	OL 400 HP	375.14	7.73	367.41	2,751	0	0.0	0	2	1	13.64	13.36	0.00
	107	OL 200HPF	52,044.70	763.63	51,281.07	253,676	0	0.0	0	215	254	20.52	20.22	888.66
	109	OL400 HPF	51,229.30	1,075.23	50,154.07	351,037	0	0.0	0	112	178	14.59	14.29	799.87
	110	OL 250 MH	3,034.98	46.91	2,988.07	15,271	0	0.0	0	12	13	19.87	19.57	0.00
	111	OL100 HPP	5,544.44	40.59	5,503.85	13,290	0	0.0	0	16	28	41.72	41.41	54.01
	113	OL 150 HP	921,417.93	12,889.83	908,528.10	4,288,913	0	0.0	0	5,654	6,190	21.48	21.18	36,997.53
	116	OL 400 MH	4,913.15	91.09	4,822.06	29,788	0	0.0	0	10	16	16.49	16.19	152.20
	122	OL150 HPP	359.85	2.75	357.10	795	0	0.0	0	1	1	45.26	44.92	0.00
	131	OL 1000MH	278.02	7.56	270.46	2,193	0	0.0	0	0	1	12.68	12.33	0.00
	136	OL 400MON	308.51	5.38	303.13	1,549	0	0.0	0	1	1	19.92	19.57	0.00
Total 010			80,777,940.78	1,876,304.81	78,901,635.97	652,638,384	17,209	5,273.7	50,739	14,844	16,033	12.38	12.09	58,695.75
020	011	RSW-LMWH	129,354.20	3,166.02	126,188.18	1,170,643	0	0.0	48	0	0	11.05	10.78	0.00
	012	RSW-A	26,299.90	662.01	25,637.89	240,746	0	0.0	10	0	0	10.92	10.65	0.00
	013	RSW-B	3,917.76	107.26	3,810.50	36,543	0	0.0	2	0	0	10.72	10.43	0.00
	015	RS	55,433,468.55	1,254,433.26	54,179,035.29	469,490,154	53,412	3,881.9	26,675	0	0	11.81	11.54	0.00
	017	RS EMP	1,094,460.43	24,441.96	1,070,018.47	9,416,046	0	0.0	466	0	0	11.62	11.36	0.00
	022	RSW-RS	118,740,399.87	2,659,112.90	116,081,286.97	1,006,190,404	52,964	17,628.6	56,857	0	0	11.80	11.54	0.00
	028	AORH-W ON	11,447.22	244.20	11,203.02	106,403	72,021	0.0	7	0	0	10.76	10.53	0.00
	030	RSW-ONPK	163,914.08	3,897.72	160,016.36	1,452,157	884,220	0.0	67	0	0	11.29	11.02	0.00
	032	RS LM-ON	210,366.85	4,876.48	205,490.37	1,942,721	1,276,669	0.0	84	0	0	10.83	10.58	0.00
	034	AORH-ON	1,647.97	21.82	1,626.15	14,808	8,738	0.0	2	0	0	11.13	10.98	0.00
	036	RS-TOD-ON	10,051.32	296.40	9,754.92	95,729	63,680	0.0	3	0	0	10.50	10.19	0.00
	093	OL 175 MV	27,247.62	489.71	26,757.91	160,776	0	0.0	0	184	189	16.95	16.64	40.36
	094	OL 100 HP	1,431,440.99	16,153.96	1,415,287.03	5,308,562	0	0.0	0	10,456	11,152	26.96	26.66	33,052.68
	095	OL 400 MV	999.48	23.91	975.57	7,508	0	0.0	0	4	4	13.31	12.99	0.00
	097	OL 200 HP	91,638.69	1,565.90	90,072.79	516,867	0	0.0	0	484	521	17.73	17.43	1,974.55
	098	OL 400 HP	3,708.66	106.45	3,602.21	27,192	0	0.0	0	10	12	13.64	13.25	78.82
	107	OL 200HPF	74,572.93	1,075.23	73,497.70	357,179	0	0.0	0	319	359	20.88	20.58	2,232.71
	109	OL400 HPF	75,667.32	1,556.47	74,110.85	511,876	0	0.0	0	198	260	14.78	14.48	2,047.35
	110	OL 250 MH	2,393.71	36.32	2,357.39	11,965	0	0.0	0	10	10	20.01	19.70	34.02
	111	OL100 HPP	20,292.83	142.44	20,150.39	48,031	0	0.0	0	83	101	42.25	41.95	449.01
	113	OL 150 HP	1,878,372.09	26,071.93	1,852,300.16	8,733,592	0	0.0	0	11,547	12,593	21.51	21.21	78,015.43

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	116	OL 400 MH	5,573.36	105.68	5,467.68	34,516	0	0.0	0	13	19	16.15	15.84	40.34
	120	OL 250HPP	199.57	2.05	197.52	713	0	0.0	0	1	1	27.99	27.70	0.00
	122	OL150 HPP	1,134.34	7.35	1,126.99	2,451	0	0.0	0	4	4	46.28	45.98	0.00
	130	OL 250MON	308.61	3.51	305.10	1,200	0	0.0	0	1	1	25.72	25.43	0.00
	131	OL 1000MH	2,138.11	52.15	2,085.96	17,678	0	0.0	0	1	4	12.09	11.80	0.00
	211	GS SEC	481.56	21.87	459.69	3,623	0	0.0	0	0	0	13.29	12.69	0.00
Total 020			179,441,498.02	3,998,674.96	175,442,823.06	1,505,900,083	2,411,704	21,510.5	84,220	23,315	25,227	11.92	11.65	117,965.27
211	093	OL 175 MV	13,678.39	236.01	13,442.38	78,157	0	0.0	0	76	92	17.50	17.20	0.00
	094	OL 100 HP	174,505.17	1,880.63	172,624.54	621,351	0	0.0	0	1,066	1,306	28.08	27.78	3,733.10
	095	OL 400 MV	7,696.98	168.99	7,527.99	56,278	0	0.0	0	25	30	13.68	13.38	0.00
	097	OL 200 HP	92,312.45	1,515.38	90,797.07	490,829	0	0.0	0	311	491	18.81	18.50	3,784.99
	098	OL 400 HP	27,753.09	605.17	27,147.92	193,773	0	0.0	0	35	97	14.32	14.01	473.92
	099	OL175 MVP	1,369.09	21.46	1,347.63	6,844	0	0.0	0	3	8	20.00	19.69	0.00
	103	OL 250 HP	488.37	7.79	480.58	2,452	0	0.0	0	1	2	19.92	19.60	0.00
	107	OL 200HPF	138,309.53	1,952.41	136,357.12	639,675	0	0.0	0	413	642	21.62	21.32	3,751.04
	109	OL400 HPF	557,127.31	11,059.71	546,067.60	3,651,323	0	0.0	0	767	1,856	15.26	14.96	14,272.94
	110	OL 250 MH	14,700.72	202.63	14,498.09	66,293	0	0.0	0	32	56	22.18	21.87	906.13
	111	OL100 HPP	39,545.35	276.38	39,268.97	89,652	0	0.0	0	34	187	44.11	43.80	708.06
	113	OL 150 HP	335,851.32	4,381.56	331,469.76	1,456,179	0	0.0	0	1,597	2,099	23.06	22.76	21,699.42
	116	OL 400 MH	168,475.50	3,147.11	165,328.39	987,502	0	0.0	0	148	520	17.06	16.74	5,122.39
	122	OL150 HPP	7,519.41	45.76	7,473.65	15,390	0	0.0	0	2	22	48.86	48.56	0.00
	126	OL 400HPP	357.13	4.06	353.07	1,467	0	0.0	0	0	1	24.34	24.07	0.00
	130	OL 250MON	602.64	7.81	594.83	2,223	0	0.0	0	2	2	27.11	26.76	0.00
	131	OL 1000MH	26,150.75	634.87	25,515.88	206,496	0	0.0	0	23	46	12.66	12.36	394.62
	204	GS-MTRD	223,928.90	3,907.49	220,021.41	1,193,856	0	0.0	413	0	0	18.76	18.43	0.00
	211	GS SEC	16,914,845.78	285,501.74	16,629,344.04	98,256,813	36,023	98,678.2	17,191	0	0	17.21	16.92	0.00
	213	GS-UMR	365,022.87	5,882.76	359,140.11	1,795,865	0	0.0	464	0	0	20.33	20.00	0.00
	214	GS - AF	10,268.31	259.20	10,009.11	60,667	0	1,553.9	10	0	0	16.93	16.50	0.00
	215	GS SEC	28,508,338.49	668,453.41	27,839,885.08	215,209,058	0	875,182.9	3,120	0	0	13.25	12.94	0.00
	217	GS PRI	82,065.41	1,903.96	80,161.45	641,394	0	2,151.6	6	0	0	12.79	12.50	0.00
	220	GSCC PRI	90,790.67	2,082.94	88,707.73	747,825	0	1,983.6	4	0	0	12.14	11.86	0.00
	223	GS LM ON	7,611.55	189.33	7,422.22	57,579	34,516	0.0	4	0	0	13.22	12.89	0.00
	225	GS LM TOD	1,423.02	13.89	1,409.13	7,008	3,951	0.0	2	0	0	20.31	20.11	0.00
	227	EXP GSTOD	109,877.31	2,035.87	107,841.44	657,974	409,673	0.0	108	0	0	16.70	16.39	0.00
	229	GS-TOD	168,941.76	4,345.41	164,596.35	1,390,884	896,085	463.2	34	0	0	12.15	11.83	0.00
	236	GSCC SUB	10,942.98	170.05	10,772.93	56,319	0	224.0	1	0	0	19.43	19.13	0.00
	240	LGS SEC	12,799,819.21	371,718.39	12,428,100.82	113,770,207	0	279,092.0	164	0	0	11.25	10.92	0.00
	244	LGS PRI	1,391,475.13	45,059.78	1,346,415.35	14,038,252	0	34,525.0	12	0	0	9.91	9.59	0.00
	248	LGS SUB	336,867.43	13,958.43	322,909.00	4,243,066	0	9,400.0	3	0	0	7.94	7.61	0.00
	256	LGSSECTOD	397,744.06	12,599.60	385,144.46	4,016,296	2,252,464	7,966.0	5	0	0	9.90	9.59	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	356	IGS SEC	1,566,240.62	49,973.09	1,516,267.53	16,532,300	0	33,680.0	4	0	0	9.47	9.17	0.00
	358	IGS PRI	6,975,116.74	294,061.03	6,681,055.71	92,151,375	0	161,990.0	8	0	0	7.57	7.25	0.00
	359	IGS SUB	1,367,128.07	71,120.33	1,296,007.74	21,467,039	0	38,958.0	3	0	0	6.37	6.04	0.00
Total 211			72,934,891.51	1,859,384.43	71,075,507.08	594,859,661	3,632,712	1,545,848.4	21,556	4,535	7,456	12.26	11.95	54,846.61
212	093	OL 175 MV	2,144.59	38.89	2,105.70	12,250	0	0.0	0	14	14	17.51	17.19	0.00
	094	OL 100 HP	41,438.00	438.90	40,999.10	145,554	0	0.0	0	243	306	28.47	28.17	1,285.39
	095	OL 400 MV	4,207.23	86.95	4,120.28	30,840	0	0.0	0	9	16	13.64	13.36	0.00
	097	OL 200 HP	27,667.94	435.64	27,232.30	146,651	0	0.0	0	110	147	18.87	18.57	1,255.92
	098	OL 400 HP	5,051.34	106.23	4,945.11	33,082	0	0.0	0	12	17	15.27	14.95	344.27
	099	OL175 MVP	171.39	2.78	168.61	856	0	0.0	0	1	1	20.02	19.70	0.00
	107	OL 200HPF	49,922.97	692.95	49,230.02	231,793	0	0.0	0	157	232	21.54	21.24	1,298.43
	109	OL400 HPF	217,347.03	4,336.47	213,010.56	1,418,865	0	0.0	0	299	721	15.32	15.01	6,377.65
	110	OL 250 MH	10,410.68	137.93	10,272.75	45,246	0	0.0	0	9	38	23.01	22.70	922.88
	111	OL100 HPP	3,894.74	26.73	3,868.01	9,000	0	0.0	0	5	19	43.27	42.98	0.00
	113	OL 150 HP	93,460.73	1,203.62	92,257.11	394,569	0	0.0	0	396	567	23.69	23.38	8,029.84
	116	OL 400 MH	56,989.35	1,031.81	55,957.54	332,994	0	0.0	0	65	180	17.11	16.80	1,747.16
	131	OL 1000MH	11,944.57	287.36	11,657.21	94,741	0	0.0	0	7	21	12.61	12.30	128.50
	211	GS SEC	3,207,183.24	58,005.00	3,149,178.24	21,511,825	6,025	44,235.8	2,249	0	0	14.91	14.64	0.00
	215	GS SEC	18,600,820.96	411,284.96	18,189,536.00	139,262,563	0	608,216.8	2,122	0	0	13.36	13.06	0.00
	217	GS PRI	130,006.20	3,088.49	126,917.71	1,061,987	0	3,056.5	5	0	0	12.24	11.95	0.00
	220	GSCC PRI	53,581.80	904.24	52,677.56	427,869	0	1,452.0	1	0	0	12.52	12.31	0.00
	223	GS LM ON	98,786.38	1,737.57	97,048.81	823,106	511,812	0.0	35	0	0	12.00	11.79	0.00
	225	GS LM TOD	32,151.22	689.27	31,461.95	222,288	135,464	0.0	26	0	0	14.46	14.15	0.00
	227	EXP GSTOD	129,212.72	2,511.31	126,701.41	825,841	582,655	0.0	116	0	0	15.65	15.34	0.00
	229	GS-TOD	285,626.29	6,817.57	278,808.72	2,326,302	1,423,547	0.0	41	0	0	12.28	11.99	0.00
	240	LGS SEC	16,066,199.73	436,748.92	15,629,450.81	140,580,327	0	374,343.0	200	0	0	11.43	11.12	0.00
	242	LGS M SEC	168,972.38	4,640.78	164,331.60	1,549,802	0	3,393.0	1	0	0	10.90	10.60	0.00
	244	LGS PRI	887,318.22	26,069.64	861,248.58	8,967,797	0	22,587.0	6	0	0	9.89	9.60	0.00
	248	LGS SUB	210,522.61	9,242.03	201,280.58	2,747,332	0	6,581.0	1	0	0	7.66	7.33	0.00
	251	LGS-LM-TD	98,261.51	2,136.48	96,125.03	821,805	422,240	0.0	4	0	0	11.96	11.70	0.00
	358	IGS PRI	975,547.26	41,568.07	933,979.19	12,009,552	0	23,400.0	2	0	0	8.12	7.78	0.00
Total 212			41,468,841.08	1,014,270.59	40,454,570.49	336,034,837	3,081,743	1,087,265.1	4,808	1,328	2,279	12.34	12.04	21,390.04
213	093	OL 175 MV	900.79	14.99	885.80	5,157	0	0.0	0	6	6	17.47	17.18	0.00
	094	OL 100 HP	5,238.17	58.25	5,179.92	19,043	0	0.0	0	25	40	27.51	27.20	9.54
	095	OL 400 MV	1,030.80	22.31	1,008.49	7,539	0	0.0	0	3	4	13.67	13.38	0.00
	097	OL 200 HP	5,689.27	90.07	5,599.20	30,306	0	0.0	0	20	30	18.77	18.48	233.17
	098	OL 400 HP	4,876.47	103.97	4,772.50	31,788	0	0.0	0	5	16	15.34	15.01	343.79
	107	OL 200HPF	20,150.29	284.16	19,866.13	93,108	0	0.0	0	47	93	21.64	21.34	569.46

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	109	OL400 HPF	133,714.40	2,579.93	131,134.47	861,780	0	0.0	0	99	435	15.52	15.22	5,449.58
	110	OL 250 MH	1,056.39	15.22	1,041.17	4,754	0	0.0	0	3	4	22.22	21.90	64.18
	111	OL100 HPP	6,031.96	40.87	5,991.09	13,959	0	0.0	0	4	29	43.21	42.92	0.00
	113	OL 150 HP	10,945.30	129.85	10,815.45	41,876	0	0.0	0	30	60	26.14	25.83	1,732.44
	116	OL 400 MH	25,625.89	463.95	25,161.94	149,811	0	0.0	0	20	80	17.11	16.80	828.31
	131	OL 1000MH	637.09	11.76	625.33	4,536	0	0.0	0	1	1	14.05	13.79	64.47
	211	GS SEC	326,788.64	5,698.78	321,089.86	2,144,494	0	3,855.6	252	0	0	15.24	14.97	0.00
	214	GS - AF	112,039.21	2,660.93	109,378.28	817,381	0	19,139.6	57	0	0	13.71	13.38	0.00
	215	GS SEC	2,597,044.21	56,169.79	2,540,874.42	19,531,468	0	80,040.7	212	0	0	13.30	13.01	0.00
	223	GS LM ON	5,376.92	107.04	5,269.88	55,340	41,040	0.0	1	0	0	9.72	9.52	0.00
	240	LGS SEC	2,491,669.06	63,755.33	2,427,913.73	21,012,413	0	65,078.1	36	0	0	11.86	11.55	0.00
	260	PS SEC	13,369,345.64	331,357.15	13,037,988.49	108,038,008	0	402,989.0	158	0	0	12.37	12.07	0.00
	264	PS PRI	236,470.06	6,431.75	230,038.31	2,259,540	0	7,549.0	1	0	0	10.47	10.18	0.00
	358	IGS PRI	388,683.55	12,336.29	376,347.26	4,055,704	0	10,475.0	1	0	0	9.58	9.28	0.00
	359	IGS SUB	196,309.54	6,382.51	189,927.03	1,916,336	0	6,518.0	1	0	0	10.24	9.91	0.00
Total 213			19,939,623.65	488,714.90	19,450,908.75	161,094,341	41,040	595,645.0	719	263	798	12.38	12.07	9,293.94
216	093	OL 175 MV	5,026.40	88.55	4,937.85	28,685	0	0.0	0	23	34	17.52	17.21	0.00
	094	OL 100 HP	24,592.82	268.58	24,324.24	87,858	0	0.0	0	116	184	27.99	27.69	455.90
	095	OL 400 MV	3,560.69	82.02	3,478.67	25,888	0	0.0	0	9	14	13.75	13.44	0.00
	097	OL 200 HP	23,833.63	367.43	23,466.20	122,066	0	0.0	0	56	122	19.53	19.22	1,749.07
	098	OL 400 HP	21,885.25	437.53	21,447.72	137,897	0	0.0	0	13	69	15.87	15.55	2,211.48
	107	OL 200HPF	36,573.49	491.65	36,081.84	166,252	0	0.0	0	94	167	22.00	21.70	1,580.28
	109	OL400 HPF	136,872.91	2,645.39	134,227.52	893,013	0	0.0	0	192	450	15.33	15.03	4,478.00
	110	OL 250 MH	2,285.57	31.99	2,253.58	10,750	0	0.0	0	6	9	21.26	20.96	64.30
	111	OL100 HPP	69,008.93	481.87	68,527.06	158,896	0	0.0	0	37	331	43.43	43.13	256.94
	113	OL 150 HP	52,527.02	628.63	51,898.39	212,241	0	0.0	0	146	304	24.75	24.45	6,279.79
	116	OL 400 MH	26,153.45	484.38	25,669.07	153,664	0	0.0	0	21	82	17.02	16.70	699.21
	120	OL 250HPP	380.12	4.24	375.88	1,222	0	0.0	0	1	1	31.11	30.76	0.00
	122	OL150 HPP	10,900.60	69.71	10,830.89	22,286	0	0.0	0	6	32	48.91	48.60	0.00
	131	OL 1000MH	4,560.96	110.71	4,450.25	36,063	0	0.0	0	6	8	12.65	12.34	64.28
	204	GS-MTRD	11,627.68	96.18	11,531.50	27,112	0	0.0	43	0	0	42.89	42.53	0.00
	211	GS SEC	2,301,487.95	40,549.84	2,260,938.11	14,263,407	76,154	22,345.1	2,017	0	0	16.14	15.85	0.00
	213	GS-UMR	92,090.79	796.50	91,294.29	548,108	0	0.0	135	0	0	16.80	16.66	0.00
	214	GS - AF	59,899.86	1,336.07	58,563.79	469,484	0	7,025.5	19	0	0	12.76	12.47	0.00
	215	GS SEC	7,769,937.92	178,527.75	7,591,410.17	58,918,671	0	226,337.9	720	0	0	13.19	12.88	0.00
	217	GS PRI	134,112.97	1,611.81	132,501.16	521,412	0	10,387.8	4	0	0	25.72	25.41	0.00
	218	GS M SEC	28,133.56	642.68	27,490.88	214,119	0	751.2	1	0	0	13.14	12.84	0.00
	223	GS LM ON	3,280.45	61.38	3,219.07	22,598	14,653	0.0	3	0	0	14.52	14.24	0.00
	225	GS LM TOD	3,673.78	63.76	3,610.02	24,769	14,392	0.0	3	0	0	14.83	14.57	0.00
	229	GS-TOD	22,108.15	509.55	21,598.60	152,169	86,992	0.0	10	0	0	14.53	14.19	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	240	LGS SEC	8,182,916.03	225,928.75	7,956,987.28	71,505,945	0	188,303.0	93	0	0	11.44	11.13	0.00
	242	LGS M SEC	691,908.50	18,126.09	673,782.41	6,250,701	0	14,717.0	6	0	0	11.07	10.78	0.00
	244	LGS PRI	302,707.50	9,430.64	293,276.86	2,914,029	0	8,724.0	3	0	0	10.39	10.06	0.00
	246	LGS M PRI	69,017.38	2,083.17	66,934.21	676,075	0	1,914.0	1	0	0	10.21	9.90	0.00
	251	LGS-LM-TD	90,179.27	2,093.02	88,086.25	813,242	444,480	0.0	2	0	0	11.09	10.83	0.00
	358	IGS PRI	2,263,705.84	87,674.14	2,176,031.70	26,881,061	0	55,320.0	4	0	0	8.42	8.10	0.00
	540	MW	221,697.63	6,637.53	215,060.10	1,986,738	0	2,885.0	10	0	0	11.16	10.82	0.00
Total 216			22,666,647.10	582,361.54	22,084,285.56	188,246,421	636,671	538,710.5	3,074	725	1,806	12.04	11.73	17,839.25
221	093	OL 175 MV	1,203.24	19.41	1,183.83	6,894	0	0.0	0	8	8	17.45	17.17	0.00
	094	OL 100 HP	7,908.37	86.78	7,821.59	28,336	0	0.0	0	33	59	27.91	27.60	128.02
	095	OL 400 MV	1,073.42	24.42	1,049.00	7,483	0	0.0	0	3	4	14.34	14.02	40.48
	097	OL 200 HP	5,956.01	103.04	5,852.97	32,290	0	0.0	0	9	32	18.45	18.13	144.71
	098	OL 400 HP	561.80	11.71	550.09	3,986	0	0.0	0	1	2	14.09	13.80	0.00
	107	OL 200HPF	4,110.28	59.74	4,050.54	19,619	0	0.0	0	13	20	20.95	20.65	0.00
	109	OL400 HPF	55,151.88	1,121.82	54,030.06	360,758	0	0.0	0	42	183	15.29	14.98	1,505.28
	110	OL 250 MH	1,635.79	23.71	1,612.08	7,861	0	0.0	0	1	7	20.81	20.51	0.00
	111	OL100 HPP	1,244.52	9.93	1,234.59	2,872	0	0.0	0	1	6	43.33	42.99	0.00
	113	OL 150 HP	8,169.76	107.26	8,062.50	34,060	0	0.0	0	28	49	23.99	23.67	754.31
	116	OL 400 MH	10,646.44	196.96	10,449.48	64,188	0	0.0	0	11	34	16.59	16.28	64.06
	131	OL 1000MH	3,527.66	79.79	3,447.87	27,017	0	0.0	0	3	6	13.06	12.76	128.02
	204	GS-MTRD	1,542.58	24.80	1,517.78	7,675	0	0.0	3	0	0	20.10	19.78	0.00
	211	GS SEC	578,426.55	10,340.25	568,086.30	3,341,001	0	4,280.7	599	0	0	17.31	17.00	0.00
	215	GS SEC	1,301,008.41	31,048.96	1,269,959.45	9,739,613	0	40,975.3	126	0	0	13.36	13.04	0.00
	217	GS PRI	27,428.09	647.41	26,780.68	186,202	0	1,038.6	5	0	0	14.73	14.38	0.00
	220	GSCC PRI	168,406.73	4,271.38	164,135.35	1,368,372	0	3,542.6	11	0	0	12.31	11.99	0.00
	236	GSCC SUB	21,390.54	591.48	20,799.06	172,901	0	252.3	1	0	0	12.37	12.03	0.00
	240	LGS SEC	3,942,468.32	99,672.21	3,842,796.11	29,572,524	0	132,394.0	49	0	0	13.33	12.99	0.00
	244	LGS PRI	1,568,971.15	42,612.41	1,526,358.74	13,189,689	0	54,292.0	11	0	0	11.90	11.57	0.00
	248	LGS SUB	248,422.80	8,581.88	239,840.92	2,718,225	0	9,244.0	2	0	0	9.14	8.82	0.00
	250	LGS TRAN	289,588.06	7,715.12	281,872.94	3,528,000	0	7,271.0	1	0	0	8.21	7.99	0.00
	321	CS-IRP	53,460.29	2,679.68-	56,139.97	910,340	0	3,822.0	0	0	0	5.87	6.17	0.00
	331	CS-IRP ST	7,857,820.21	427,708.60	7,430,111.61	143,328,000	0	253,656.0	1	0	0	5.48	5.18	0.00
	332	CS-IRP TR	375,435.31	7,887.20	367,548.11	4,116,000	0	13,776.0	0	0	0	9.12	8.93	0.00
	358	IGS PRI	7,233,408.02	315,127.82	6,918,280.20	93,851,171	0	173,459.0	12	0	0	7.71	7.37	0.00
	359	IGS SUB	7,261,146.67	247,760.01	7,013,386.66	91,739,260	0	268,034.0	6	0	0	7.91	7.64	0.00
	360	IGS	1,186,695.74	26,488.28	1,160,207.46	9,306,000	0	47,501.0	1	0	0	12.75	12.47	0.00
	371	IGS	72,283,639.86	3,749,294.79	68,534,345.07	1,296,513,998	0	1,953,839.0	4	0	0	5.58	5.29	0.00
	372	IGS	17,298,542.89	1,074,763.79	16,223,779.10	318,770,518	0	456,642.0	2	0	0	5.43	5.09	0.00
Total 221			121,798,991.39	6,053,701.28	115,745,290.11	2,022,954,853	0	3,424,019.5	835	152	411	6.02	5.72	2,764.88

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
222	097	OL 200 HP	723.82	12.20	711.62	3,727	0	0.0	0	2	4	19.42	19.09	47.60
	107	OL 200HPF	208.71	3.07	205.64	996	0	0.0	0	1	1	20.95	20.65	0.00
	109	OL400 HPF	2,114.00	40.44	2,073.56	13,918	0	0.0	0	4	7	15.19	14.90	47.56
	113	OL 150 HP	1,638.75	20.67	1,618.08	6,279	0	0.0	0	5	9	26.10	25.77	256.16
	211	GS SEC	43,434.67	835.73	42,598.94	298,429	0	426.3	27	0	0	14.55	14.27	0.00
	215	GS SEC	149,590.96	2,960.84	146,630.12	1,102,494	0	5,497.6	17	0	0	13.57	13.30	0.00
	220	GSCC PRI	25,284.51	493.71	24,790.80	203,100	0	636.0	2	0	0	12.45	12.21	0.00
	229	GS-TOD	4,562.44	37.43	4,525.01	42,000	30,000	0.0	1	0	0	10.86	10.77	0.00
	240	LGS SEC	1,240,273.88	33,517.54	1,206,756.34	9,905,218	0	38,016.0	11	0	0	12.52	12.18	0.00
	244	LGS PRI	354,261.22	14,242.27	340,018.95	3,869,093	0	6,395.0	1	0	0	9.16	8.79	0.00
	251	LGS-LM-TD	1,246.08	2.33	1,243.75	490	300	0.0	1	0	0	254.30	253.83	0.00
	358	IGS PRI	908,975.94	38,175.44	870,800.50	10,238,798	0	23,107.0	1	0	0	8.88	8.50	0.00
	359	IGS SUB	97,794.29	925.24	96,869.05	264,000	0	5,066.0	0	0	0	37.04	36.69	0.00
Total 222			2,830,109.27	91,266.91	2,738,842.36	25,948,542	30,300	79,143.9	61	12	21	10.91	10.55	351.32
230	093	OL 175 MV	149.97	2.94	147.03	855	0	0.0	0	1	1	17.54	17.20	0.00
	094	OL 100 HP	1,054.05	11.09	1,042.96	3,852	0	0.0	0	7	8	27.36	27.08	0.00
	095	OL 400 MV	760.37	17.85	742.52	5,561	0	0.0	0	2	3	13.67	13.35	0.00
	097	OL 200 HP	9,281.00	132.71	9,148.29	48,156	0	0.0	0	8	48	19.27	19.00	608.29
	107	OL 200HPF	1,318.05	16.79	1,301.26	6,054	0	0.0	0	4	6	21.77	21.49	47.70
	109	OL400 HPF	12,493.74	224.42	12,269.32	81,644	0	0.0	0	19	41	15.30	15.03	392.83
	113	OL 150 HP	4,730.56	61.32	4,669.24	20,322	0	0.0	0	17	29	23.28	22.98	344.59
	116	OL 400 MH	931.86	14.78	917.08	5,679	0	0.0	0	2	3	16.41	16.15	0.00
	211	GS SEC	80,349.45	1,339.42	79,010.03	488,349	0	967.2	75	0	0	16.45	16.18	0.00
	215	GS SEC	430,133.38	8,703.78	421,429.60	3,157,551	0	15,025.5	64	0	0	13.62	13.35	0.00
	217	GS PRI	43,274.21	1,154.13	42,120.08	344,864	0	1,069.5	3	0	0	12.55	12.21	0.00
	220	GSCC PRI	376,362.84	9,137.66	367,225.18	2,898,632	0	8,884.3	35	0	0	12.98	12.67	0.00
	236	GSCC SUB	83,450.85	1,789.15	81,661.70	608,802	0	1,855.0	4	0	0	13.71	13.41	0.00
	240	LGS SEC	432,527.21	8,161.40	424,365.81	2,589,503	0	19,664.0	7	0	0	16.70	16.39	0.00
	244	LGS PRI	4,412,868.26	112,528.43	4,300,339.83	36,409,029	113,750	169,524.0	27	0	0	12.12	11.81	0.00
	248	LGS SUB	901,245.55	29,165.25	872,080.30	9,688,560	0	33,750.0	10	0	0	9.30	9.00	0.00
	250	LGS TRAN	188,006.41	6,925.88	181,080.53	2,066,238	0	8,206.0	2	0	0	9.10	8.76	0.00
	257	LGSPRITOD	291,217.45	9,411.34	281,806.11	3,449,480	1,957,700	4,914.0	1	0	0	8.44	8.17	0.00
	330	CS-IRP PR	707,262.22	13,720.46	693,541.76	4,252,976	0	27,159.0	1	0	0	16.63	16.31	0.00
	331	CS-IRP ST	4,237,771.35	172,770.84	4,065,000.51	61,621,717	0	162,677.0	2	0	0	6.88	6.60	0.00
	358	IGS PRI	9,946,871.84	261,300.50	9,685,571.34	83,866,670	0	284,558.0	12	0	0	11.86	11.55	0.00
	359	IGS SUB	11,147,224.23	382,834.75	10,764,389.48	123,627,165	0	417,171.0	8	0	0	9.02	8.71	0.00
	360	IGS	266,051.36	10,558.10	255,493.26	3,048,234	0	8,470.0	0	0	0	8.73	8.38	0.00
	371	IGS	785,547.96	35,829.78	749,718.18	11,350,921	0	20,314.0	1	0	0	6.92	6.60	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Total 230			34,360,884.17	1,065,812.77	33,295,071.40	349,640,814	2,071,450	1,184,208.5	253	60	139	9.83	9.52	1,393.41
400	093	OL 175 MV	297.46	5.69	291.77	1,694	0	0.0	0	1	2	17.56	17.22	0.00
	094	OL 100 HP	524.28	5.99	518.29	1,911	0	0.0	0	2	4	27.43	27.12	0.00
	097	OL 200 HP	178.98	2.79	176.19	1,007	0	0.0	0	1	1	17.77	17.50	0.00
	107	OL 200HPF	210.25	2.96	207.29	1,006	0	0.0	0	1	1	20.90	20.61	0.00
	109	OL400 HPF	6,968.46	129.65	6,838.81	45,718	0	0.0	0	7	23	15.24	14.96	192.75
	111	OL100 HPP	19,149.29	123.33	19,025.96	44,338	0	0.0	0	19	92	43.19	42.91	0.00
	113	OL 150 HP	746.97	8.77	738.20	2,803	0	0.0	0	2	4	26.65	26.34	128.30
	122	OL150 HPP	2,737.06	16.06	2,721.00	5,604	0	0.0	0	2	8	48.84	48.55	0.00
	131	OL 1000MH	561.24	13.34	547.90	4,512	0	0.0	0	1	1	12.44	12.14	0.00
	204	GS-MTRD	1,600.37	0.23	1,600.14	64	0	0.0	8	0	0	2,500.58	2,500.22	0.00
	211	GS SEC	150,546.99	1,793.39	148,753.60	575,721	0	410.3	260	0	0	26.15	25.84	0.00
	213	GS-UMR	213.59	0.19	213.40	59	0	0.0	1	0	0	362.02	361.69	0.00
	215	GS SEC	149,784.86	3,688.83	146,096.03	1,172,480	0	3,515.0	13	0	0	12.78	12.46	0.00
	528	SL	1,636,835.67	21,241.66	1,615,594.01	8,453,335	0	0.0	55	0	0	19.36	19.11	0.00
Total 400			1,970,355.47	27,032.88	1,943,322.59	10,310,252	0	3,925.3	337	36	136	19.11	18.85	321.05
Grand Total			578,189,782.44	17,057,525.07	561,132,257.37	5,847,628,188	11,922,829	8,485,550.4	166,602	45,270	54,306	9.89	9.60	284,861.52

REV CLASS	TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

American Electric Power

TARIFF SUMMARY REVENUE- BY REVENUE CLASS

12 MONTHS BILLED AND ACCRUED - MCSR0162 - FINAL

Standard Service Offer

Prepared: 01/09/2019 03:10:59

December 2018

REV CLASS	TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total	0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

REV CLASS	TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
011	RSW-LMWH	185,561.15	3,757.30	181,803.85	1,677,801	0	0.0	78	0	0	11.06	10.84	0.00
012	RSW-A	26,329.71	549.07	25,780.64	241,901	0	0.0	10	0	0	10.88	10.66	0.00
013	RSW-B	3,907.41	90.03	3,817.38	36,587	0	0.0	2	0	0	10.68	10.43	0.00
015	RS	112,699,953.76	2,127,520.49	110,572,433.27	940,173,151	60,183	8,585.7	64,571	0	0	11.99	11.76	0.00
017	RS EMP	1,098,541.74	20,067.88	1,078,473.86	9,484,912	0	0.0	466	0	0	11.58	11.37	0.00
022	RSW-RS	140,101,879.92	2,492,703.17	137,609,176.75	1,187,203,473	52,964	18,198.5	69,668	0	0	11.80	11.59	0.00
028	AORH-W ON	11,386.89	185.50	11,201.39	106,309	72,021	0.0	7	0	0	10.71	10.54	0.00
030	RSW-ONPK	163,184.22	2,974.32	160,209.90	1,454,202	884,220	0.0	67	0	0	11.22	11.02	0.00
032	RS LM-ON	209,961.21	3,813.15	206,148.06	1,949,381	1,276,669	0.0	84	0	0	10.77	10.58	0.00
034	AORH-ON	1,639.56	19.54	1,620.02	14,747	8,738	0.0	2	0	0	11.12	10.99	0.00
036	RS-TOD-ON	12,049.67	266.06	11,783.61	111,602	74,118	0.0	5	0	0	10.80	10.56	0.00
093	OL 175 MV	106,230.54	1,520.28	104,710.26	626,906	0	0.0	0	697	732	16.95	16.70	104.43
094	OL 100 HP	2,793,727.63	25,326.99	2,768,400.64	10,392,940	0	0.0	0	20,042	21,650	26.88	26.64	57,283.55
095	OL 400 MV	20,832.97	372.43	20,460.54	153,607	0	0.0	0	59	81	13.56	13.32	40.48
097	OL 200 HP	322,296.14	4,301.33	317,994.81	1,773,955	0	0.0	0	1,342	1,762	18.17	17.93	10,918.79
098	OL 400 HP	63,247.79	1,035.36	62,212.43	426,859	0	0.0	0	77	214	14.82	14.57	3,452.28
099	OL175 MVP	1,544.66	18.93	1,525.73	7,776	0	0.0	0	4	9	19.86	19.62	0.00
103	OL 250 HP	489.78	6.00	483.78	2,472	0	0.0	0	1	2	19.81	19.57	0.00
107	OL 200HPF	378,021.64	4,334.70	373,686.94	1,783,711	0	0.0	0	1,263	1,774	21.19	20.95	10,367.28
109	OL400 HPF	1,248,339.45	20,074.27	1,228,265.18	8,255,122	0	0.0	0	1,740	4,154	15.12	14.88	35,563.81
110	OL 250 MH	35,720.73	398.16	35,322.57	163,589	0	0.0	0	72	137	21.84	21.59	1,991.51
111	OL100 HPP	165,115.78	929.16	164,186.62	382,779	0	0.0	0	198	792	43.14	42.89	1,468.02
113	OL 150 HP	3,315,211.12	36,891.78	3,278,319.34	15,287,503	0	0.0	0	19,422	21,903	21.69	21.44	154,237.81
116	OL 400 MH	298,548.81	4,297.86	294,250.95	1,761,431	0	0.0	0	290	934	16.95	16.71	8,653.67
120	OL 250HPP	560.34	4.42	555.92	1,866	0	0.0	0	2	2	30.03	29.79	0.00
122	OL150 HPP	22,740.65	113.25	22,627.40	46,948	0	0.0	0	15	67	48.44	48.20	0.00
126	OL 400HPP	315.05	2.50	312.55	1,284	0	0.0	0	0	1	24.54	24.34	0.00
130	OL 250MON	880.20	9.43	870.77	3,280	0	0.0	0	3	3	26.84	26.55	0.00
131	OL 1000MH	49,636.09	963.69	48,672.40	394,137	0	0.0	0	43	87	12.59	12.35	779.89
136	OL 400MON	305.37	5.22	300.15	1,530	0	0.0	0	1	1	19.96	19.62	0.00
204	GS-MTRD	240,296.53	3,458.83	236,837.70	1,237,866	0	0.0	468	0	0	19.41	19.13	0.00
211	GS SEC	23,549,582.29	334,968.08	23,214,614.21	141,454,600	118,202	175,199.2	22,670	0	0	16.65	16.41	0.00
213	GS-UMR	459,669.10	5,448.37	454,220.73	2,364,974	0	0.0	600	0	0	19.44	19.21	0.00
214	GS - AF	182,116.09	3,794.93	178,321.16	1,351,741	0	27,719.0	87	0	0	13.47	13.19	0.00
215	GS SEC	59,579,001.88	1,151,216.38	58,427,785.50	450,024,882	0	1,854,791.7	6,394	0	0	13.24	12.98	0.00
217	GS PRI	415,238.05	7,152.01	408,086.04	2,763,916	0	17,704.0	23	0	0	15.02	14.76	0.00
218	GS M SEC	28,034.39	495.57	27,538.82	214,880	0	751.2	1	0	0	13.05	12.82	0.00
220	GSCC PRI	713,998.67	14,594.26	699,404.41	5,665,245	0	16,498.5	53	0	0	12.60	12.35	0.00
223	GS LM ON	114,666.51	1,554.12	113,112.39	960,429	602,021	0.0	43	0	0	11.94	11.78	0.00
225	GS LM TOD	37,158.74	662.22	36,496.52	254,762	153,807	0.0	31	0	0	14.59	14.33	0.00
227	EXP GSTOD	222,092.28	3,199.61	218,892.67	1,368,578	992,328	0.0	224	0	0	16.23	15.98	0.00
229	GS-TOD	480,232.83	9,625.55	470,607.28	3,929,470	2,436,624	463.2	86	0	0	12.22	11.98	0.00

TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
236	GSCC SUB	116,449.46	2,255.39	114,194.07	841,750	0	2,331.3	6	0	0	13.83	13.57	0.00
240	LGS SEC	45,245,153.13	1,050,781.83	44,194,371.30	391,191,305	0	1,096,890.1	560	0	0	11.57	11.30	0.00
242	LGS M SEC	862,062.21	19,459.80	842,602.41	7,831,400	0	18,110.0	7	0	0	11.01	10.76	0.00
244	LGS PRI	8,901,892.43	212,430.58	8,689,461.85	79,727,190	113,750	296,047.0	60	0	0	11.17	10.90	0.00
246	LGS M PRI	68,865.33	1,887.24	66,978.09	676,080	0	1,914.0	1	0	0	10.19	9.91	0.00
248	LGS SUB	1,697,760.54	52,460.06	1,645,300.48	19,535,881	0	58,975.0	16	0	0	8.69	8.42	0.00
250	LGS TRAN	477,225.26	14,371.51	462,853.75	5,579,000	0	15,477.0	2	0	0	8.55	8.30	0.00
251	LGS-LM-TD	184,595.50	3,493.79	181,101.71	1,598,272	867,020	0.0	7	0	0	11.55	11.33	0.00
256	LGSSECTOD	389,740.78	10,476.71	379,264.07	3,961,200	2,252,464	7,966.0	5	0	0	9.84	9.57	0.00
257	LGSPRITOD	282,429.21	8,375.65	274,053.56	3,353,300	1,957,700	4,914.0	1	0	0	8.42	8.17	0.00
260	PS SEC	13,381,988.96	279,939.16	13,102,049.80	108,809,577	0	402,989.0	158	0	0	12.30	12.04	0.00
264	PS PRI	235,671.16	5,045.90	230,625.26	2,274,000	0	7,549.0	1	0	0	10.36	10.14	0.00
321	CS-IRP	61,324.87	3,090.78-	64,415.65	1,050,000	0	3,822.0	0	0	0	5.84	6.13	0.00
330	CS-IRP PR	707,182.46	10,493.22	696,689.24	4,277,000	0	27,159.0	1	0	0	16.53	16.29	0.00
331	CS-IRP ST	12,093,413.56	592,805.48	11,500,608.08	205,060,000	0	416,333.0	3	0	0	5.90	5.61	0.00
332	CS-IRP TR	375,435.31	7,887.20	367,548.11	4,116,000	0	13,776.0	0	0	0	9.12	8.93	0.00
356	IGS SEC	1,562,966.10	43,663.50	1,519,302.60	16,574,400	0	33,680.0	4	0	0	9.43	9.17	0.00
358	IGS PRI	28,564,171.95	905,958.99	27,658,212.96	324,305,980	0	732,309.0	40	0	0	8.81	8.53	0.00
359	IGS SUB	20,147,577.00	653,906.57	19,493,670.43	240,993,100	0	735,747.0	18	0	0	8.36	8.09	0.00
360	IGS	1,378,817.71	30,135.98	1,348,681.73	11,546,000	0	55,971.0	1	0	0	11.94	11.68	0.00
371	IGS	73,095,511.67	3,762,600.03	69,332,911.64	1,308,664,000	0	1,974,153.0	5	0	0	5.59	5.30	0.00
372	IGS	17,189,863.39	918,525.21	16,271,338.18	317,929,026	0	456,642.0	2	0	0	5.41	5.12	0.00
528	SL	1,638,188.91	21,194.61	1,616,994.30	8,462,892	0	0.0	55	0	0	19.36	19.11	0.00
540	MW	222,404.42	5,336.33	217,068.09	2,003,777	0	2,885.0	10	0	0	11.10	10.83	0.00
Grand Total		578,240,938.66	14,899,116.16	563,341,822.50	5,865,874,234	11,922,829	8,485,550.4	166,602	45,270	54,306	9.86	9.60	284,861.52

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
010	011	RSW-LMWH	56,615.62	1,233.18	55,382.44	506,357	0	0.0	30	0	0	11.18	10.94	0.00
	015	RS	57,280,679.15	1,137,669.99	56,143,009.16	468,994,236	6,771	4,703.8	37,896	0	0	12.21	11.97	0.00
	022	RSW-RS	21,275,435.13	398,553.95	20,876,881.18	176,393,877	0	569.9	12,811	0	0	12.06	11.84	0.00
	036	RS-TOD-ON	2,201.80	42.89	2,158.91	17,145	10,438	0.0	2	0	0	12.84	12.59	0.00
	093	OL 175 MV	55,406.21	796.70	54,609.51	329,374	0	0.0	0	384	387	16.82	16.58	64.07
	094	OL 100 HP	1,100,223.74	10,064.38	1,090,159.36	4,125,104	0	0.0	0	8,093	8,591	26.67	26.43	18,618.92
	095	OL 400 MV	1,501.51	27.36	1,474.15	11,376	0	0.0	0	4	6	13.20	12.96	0.00
	097	OL 200 HP	64,507.56	889.49	63,618.07	368,671	0	0.0	0	340	366	17.50	17.26	1,120.49
	098	OL 400 HP	379.23	6.40	372.83	2,809	0	0.0	0	2	1	13.50	13.27	0.00
	107	OL 200HPF	52,115.96	616.87	51,499.09	255,556	0	0.0	0	215	254	20.39	20.15	888.66
	109	OL400 HPF	51,184.37	853.38	50,330.99	353,368	0	0.0	0	112	178	14.48	14.24	799.87
	110	OL 250 MH	3,038.16	38.14	3,000.02	15,329	0	0.0	0	12	13	19.82	19.57	0.00
	111	OL100 HPP	5,568.45	32.87	5,535.58	13,415	0	0.0	0	16	28	41.51	41.26	54.01
	113	OL 150 HP	923,779.32	10,434.06	913,345.26	4,317,848	0	0.0	0	5,654	6,190	21.39	21.15	36,997.53
	116	OL 400 MH	4,910.33	73.24	4,837.09	29,869	0	0.0	0	10	16	16.44	16.19	152.20
	122	OL150 HPP	381.36	1.99	379.37	849	0	0.0	0	1	1	44.92	44.68	0.00
	131	OL 1000MH	278.02	7.56	270.46	2,193	0	0.0	0	0	1	12.68	12.33	0.00
	136	OL 400MON	305.37	5.22	300.15	1,530	0	0.0	0	1	1	19.96	19.62	0.00
Total 010			80,878,511.29	1,561,347.67	79,317,163.62	655,738,906	17,209	5,273.7	50,739	14,844	16,033	12.33	12.10	58,695.75
020	011	RSW-LMWH	128,945.53	2,524.12	126,421.41	1,171,444	0	0.0	48	0	0	11.01	10.79	0.00
	012	RSW-A	26,329.71	549.07	25,780.64	241,901	0	0.0	10	0	0	10.88	10.66	0.00
	013	RSW-B	3,907.41	90.03	3,817.38	36,587	0	0.0	2	0	0	10.68	10.43	0.00
	015	RS	55,419,274.61	989,850.50	54,429,424.11	471,178,915	53,412	3,881.9	26,675	0	0	11.76	11.55	0.00
	017	RS EMP	1,098,541.74	20,067.88	1,078,473.86	9,484,912	0	0.0	466	0	0	11.58	11.37	0.00
	022	RSW-RS	118,826,444.79	2,094,149.22	116,732,295.57	1,010,809,596	52,964	17,628.6	56,857	0	0	11.76	11.55	0.00
	028	AORH-W ON	11,386.89	185.50	11,201.39	106,309	72,021	0.0	7	0	0	10.71	10.54	0.00
	030	RSW-ONPK	163,184.22	2,974.32	160,209.90	1,454,202	884,220	0.0	67	0	0	11.22	11.02	0.00
	032	RS LM-ON	209,961.21	3,813.15	206,148.06	1,949,381	1,276,669	0.0	84	0	0	10.77	10.58	0.00
	034	AORH-ON	1,639.56	19.54	1,620.02	14,747	8,738	0.0	2	0	0	11.12	10.99	0.00
	036	RS-TOD-ON	9,847.87	223.17	9,624.70	94,457	63,680	0.0	3	0	0	10.43	10.19	0.00
	093	OL 175 MV	27,355.84	395.16	26,960.68	162,472	0	0.0	0	184	189	16.84	16.59	40.36
	094	OL 100 HP	1,437,243.06	13,041.11	1,424,201.95	5,352,186	0	0.0	0	10,456	11,152	26.85	26.61	33,052.68
	095	OL 400 MV	1,000.81	18.46	982.35	7,584	0	0.0	0	4	4	13.20	12.95	0.00
	097	OL 200 HP	91,907.94	1,266.80	90,641.14	522,221	0	0.0	0	484	521	17.60	17.36	1,974.55
	098	OL 400 HP	3,118.90	53.24	3,065.66	22,436	0	0.0	0	10	12	13.90	13.66	78.82
	107	OL 200HPF	74,761.47	881.33	73,880.14	360,255	0	0.0	0	319	359	20.75	20.51	2,232.71
	109	OL400 HPF	75,473.80	1,257.41	74,216.39	514,082	0	0.0	0	198	260	14.68	14.44	2,047.35
	110	OL 250 MH	2,380.46	28.49	2,351.97	11,942	0	0.0	0	10	10	19.93	19.69	34.02
	111	OL100 HPP	20,321.94	116.60	20,205.34	48,306	0	0.0	0	83	101	42.07	41.83	449.01
	113	OL 150 HP	1,882,220.47	21,169.64	1,861,050.83	8,786,013	0	0.0	0	11,547	12,593	21.42	21.18	78,015.43

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	116	OL 400 MH	5,604.28	86.14	5,518.14	34,876	0	0.0	0	13	19	16.07	15.82	40.34
	120	OL 250HPP	179.59	1.34	178.25	630	0	0.0	0	1	1	28.51	28.29	0.00
	122	OL150 HPP	1,131.60	5.90	1,125.70	2,451	0	0.0	0	4	4	46.17	45.93	0.00
	130	OL 250MON	309.76	2.87	306.89	1,204	0	0.0	0	1	1	25.73	25.49	0.00
	131	OL 1000MH	2,135.36	42.41	2,092.95	17,734	0	0.0	0	1	4	12.04	11.80	0.00
	211	GS SEC	397.01	4.52	392.49	3,090	0	0.0	0	0	0	12.85	12.70	0.00
Total 020			179,525,005.83	3,152,817.92	176,372,187.91	1,512,389,933	2,411,704	21,510.5	84,220	23,315	25,227	11.87	11.66	117,965.27
211	093	OL 175 MV	13,720.63	191.64	13,528.99	78,964	0	0.0	0	76	92	17.38	17.13	0.00
	094	OL 100 HP	175,133.44	1,517.93	173,615.51	626,419	0	0.0	0	1,066	1,306	27.96	27.72	3,733.10
	095	OL 400 MV	7,698.09	137.85	7,560.24	56,719	0	0.0	0	25	30	13.57	13.33	0.00
	097	OL 200 HP	92,341.46	1,208.43	91,133.03	494,905	0	0.0	0	311	491	18.66	18.41	3,784.99
	098	OL 400 HP	27,538.11	472.93	27,065.18	193,925	0	0.0	0	35	97	14.20	13.96	473.92
	099	OL175 MVP	1,373.05	16.81	1,356.24	6,912	0	0.0	0	3	8	19.86	19.62	0.00
	103	OL 250 HP	489.78	6.00	483.78	2,472	0	0.0	0	1	2	19.81	19.57	0.00
	107	OL 200HPF	138,525.47	1,568.16	136,957.31	645,219	0	0.0	0	413	642	21.47	21.23	3,751.04
	109	OL400 HPF	557,226.57	8,977.22	548,249.35	3,682,859	0	0.0	0	767	1,856	15.13	14.89	14,272.94
	110	OL 250 MH	14,842.12	163.17	14,678.95	67,058	0	0.0	0	32	56	22.13	21.89	906.13
	111	OL100 HPP	39,649.32	218.19	39,431.13	90,361	0	0.0	0	34	187	43.88	43.64	708.06
	113	OL 150 HP	336,606.25	3,541.99	333,064.26	1,466,463	0	0.0	0	1,597	2,099	22.95	22.71	21,699.42
	116	OL 400 MH	166,795.44	2,395.03	164,400.41	980,587	0	0.0	0	148	520	17.01	16.77	5,122.39
	122	OL150 HPP	7,533.97	37.17	7,496.80	15,488	0	0.0	0	2	22	48.64	48.40	0.00
	126	OL 400HPP	315.05	2.50	312.55	1,284	0	0.0	0	0	1	24.54	24.34	0.00
	130	OL 250MON	570.44	6.56	563.88	2,076	0	0.0	0	2	2	27.48	27.16	0.00
	131	OL 1000MH	26,010.90	505.66	25,505.24	206,516	0	0.0	0	23	46	12.60	12.35	394.62
	204	GS-MTRD	225,454.48	3,349.75	222,104.73	1,202,460	0	0.0	413	0	0	18.75	18.47	0.00
	211	GS SEC	16,885,200.33	237,754.84	16,647,445.49	98,678,557	36,023	98,678.2	17,191	0	0	17.11	16.87	0.00
	213	GS-UMR	366,539.73	5,099.35	361,440.38	1,804,454	0	0.0	464	0	0	20.31	20.03	0.00
	214	GS - AF	10,397.49	238.57	10,158.92	61,970	0	1,553.9	10	0	0	16.78	16.39	0.00
	215	GS SEC	28,557,674.56	571,850.78	27,985,823.78	216,197,348	0	875,182.9	3,120	0	0	13.21	12.94	0.00
	217	GS PRI	82,263.21	1,505.73	80,757.48	647,160	0	2,151.6	6	0	0	12.71	12.48	0.00
	220	GSCC PRI	90,333.92	1,642.60	88,691.32	749,000	0	1,983.6	4	0	0	12.06	11.84	0.00
	223	GS LM ON	7,721.19	169.77	7,551.42	59,060	34,516	0.0	4	0	0	13.07	12.79	0.00
	225	GS LM TOD	1,420.54	13.27	1,407.27	6,996	3,951	0.0	2	0	0	20.31	20.12	0.00
	227	EXP GSTOD	96,484.79	1,224.17	95,260.62	571,426	409,673	0.0	108	0	0	16.88	16.67	0.00
	229	GS-TOD	168,684.12	3,594.94	165,089.18	1,399,646	896,085	463.2	34	0	0	12.05	11.80	0.00
	236	GSCC SUB	10,383.90	92.47	10,291.43	50,400	0	224.0	1	0	0	20.60	20.42	0.00
	240	LGS SEC	12,833,692.64	318,013.32	12,515,679.32	114,464,194	0	279,092.0	164	0	0	11.21	10.93	0.00
	244	LGS PRI	1,395,294.84	37,643.98	1,357,650.86	14,156,640	0	34,525.0	12	0	0	9.86	9.59	0.00
	248	LGS SUB	336,915.05	11,981.88	324,933.17	4,269,300	0	9,400.0	3	0	0	7.89	7.61	0.00
	256	LGSSECTOD	389,740.78	10,476.71	379,264.07	3,961,200	2,252,464	7,966.0	5	0	0	9.84	9.57	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	356	IGS SEC	1,562,966.10	43,663.50	1,519,302.60	16,574,400	0	33,680.0	4	0	0	9.43	9.17	0.00
	358	IGS PRI	6,985,865.12	267,730.58	6,718,134.54	92,630,400	0	161,990.0	8	0	0	7.54	7.25	0.00
	359	IGS SUB	1,363,605.69	59,580.51	1,304,025.18	21,572,900	0	38,958.0	3	0	0	6.32	6.04	0.00
Total 211			72,977,008.57	1,596,593.96	71,380,414.61	597,675,738	3,632,712	1,545,848.4	21,556	4,535	7,456	12.21	11.94	54,846.61
212	093	OL 175 MV	2,152.28	29.74	2,122.54	12,408	0	0.0	0	14	14	17.35	17.11	0.00
	094	OL 100 HP	41,659.03	358.32	41,300.71	147,022	0	0.0	0	243	306	28.34	28.09	1,285.39
	095	OL 400 MV	4,204.42	73.95	4,130.47	30,993	0	0.0	0	9	16	13.57	13.33	0.00
	097	OL 200 HP	27,729.19	355.33	27,373.86	148,062	0	0.0	0	110	147	18.73	18.49	1,255.92
	098	OL 400 HP	5,061.82	79.32	4,982.50	33,594	0	0.0	0	12	17	15.07	14.83	344.27
	099	OL175 MVP	171.61	2.12	169.49	864	0	0.0	0	1	1	19.86	19.62	0.00
	107	OL 200HPF	49,952.49	563.23	49,389.26	233,407	0	0.0	0	157	232	21.40	21.16	1,298.43
	109	OL400 HPF	217,174.85	3,467.98	213,706.87	1,430,383	0	0.0	0	299	721	15.18	14.94	6,377.65
	110	OL 250 MH	10,451.94	111.15	10,340.79	45,634	0	0.0	0	9	38	22.90	22.66	922.88
	111	OL100 HPP	3,896.26	22.09	3,874.17	9,038	0	0.0	0	5	19	43.11	42.87	0.00
	113	OL 150 HP	93,673.78	968.69	92,705.09	397,395	0	0.0	0	396	567	23.57	23.33	8,029.84
	116	OL 400 MH	57,612.02	826.13	56,785.89	338,894	0	0.0	0	65	180	17.00	16.76	1,747.16
	131	OL 1000MH	11,925.15	230.55	11,694.60	95,162	0	0.0	0	7	21	12.53	12.29	128.50
	211	GS SEC	3,193,573.37	46,968.47	3,146,604.90	21,580,290	6,025	44,235.8	2,249	0	0	14.80	14.58	0.00
	215	GS SEC	18,630,065.58	343,491.70	18,286,573.88	139,907,336	0	608,216.8	2,122	0	0	13.32	13.07	0.00
	217	GS PRI	129,612.13	2,623.77	126,988.36	1,062,420	0	3,056.5	5	0	0	12.20	11.95	0.00
	220	GSCC PRI	56,525.77	826.73	55,699.04	454,200	0	1,452.0	1	0	0	12.45	12.26	0.00
	223	GS LM ON	98,553.36	1,261.38	97,291.98	825,521	511,812	0.0	35	0	0	11.94	11.79	0.00
	225	GS LM TOD	32,085.03	596.05	31,488.98	223,086	135,464	0.0	26	0	0	14.38	14.12	0.00
	227	EXP GSTOD	125,607.49	1,975.44	123,632.05	797,152	582,655	0.0	116	0	0	15.76	15.51	0.00
	229	GS-TOD	284,692.24	5,542.49	279,149.75	2,332,647	1,423,547	0.0	41	0	0	12.20	11.97	0.00
	240	LGS SEC	16,133,774.45	368,396.56	15,765,377.89	141,704,336	0	374,343.0	200	0	0	11.39	11.13	0.00
	242	LGS M SEC	168,561.85	3,971.32	164,590.53	1,549,600	0	3,393.0	1	0	0	10.88	10.62	0.00
	244	LGS PRI	878,399.89	21,627.71	856,772.18	8,911,200	0	22,587.0	6	0	0	9.86	9.61	0.00
	248	LGS SUB	213,602.89	7,481.26	206,121.63	2,800,875	0	6,581.0	1	0	0	7.63	7.36	0.00
	251	LGS-LM-TD	98,018.70	1,975.35	96,043.35	820,940	422,240	0.0	4	0	0	11.94	11.70	0.00
	358	IGS PRI	983,774.90	34,739.01	949,035.89	12,283,680	0	23,400.0	2	0	0	8.01	7.73	0.00
Total 212			41,552,512.49	848,565.84	40,703,946.65	338,176,139	3,081,743	1,087,265.1	4,808	1,328	2,279	12.29	12.04	21,390.04
213	093	OL 175 MV	900.88	12.60	888.28	5,184	0	0.0	0	6	6	17.38	17.14	0.00
	094	OL 100 HP	5,250.56	46.56	5,204.00	19,171	0	0.0	0	25	40	27.39	27.15	9.54
	095	OL 400 MV	1,029.79	18.34	1,011.45	7,584	0	0.0	0	3	4	13.58	13.34	0.00
	097	OL 200 HP	5,697.44	73.60	5,623.84	30,573	0	0.0	0	20	30	18.64	18.39	233.17
	098	OL 400 HP	4,854.83	78.60	4,776.23	32,000	0	0.0	0	5	16	15.17	14.93	343.79
	107	OL 200HPF	20,150.75	228.83	19,921.92	93,708	0	0.0	0	47	93	21.50	21.26	566.46
	109	OL400 HPF	133,664.75	2,109.48	131,555.27	868,180	0	0.0	0	99	455	15.40	15.15	8,449.58

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	110	OL 250 MH	1,063.74	11.70	1,052.04	4,816	0	0.0	0	3	4	22.09	21.84	64.18
	111	OL100 HPP	6,041.09	34.20	6,006.89	14,036	0	0.0	0	4	29	43.04	42.80	0.00
	113	OL 150 HP	10,967.44	102.85	10,864.59	42,164	0	0.0	0	30	60	26.01	25.77	1,732.44
	116	OL 400 MH	25,701.53	369.39	25,332.14	151,087	0	0.0	0	20	80	17.01	16.77	828.31
	131	OL 1000MH	637.14	11.35	625.79	4,540	0	0.0	0	1	1	14.03	13.78	64.47
	211	GS SEC	326,198.43	4,665.53	321,532.90	2,157,205	0	3,855.6	252	0	0	15.12	14.91	0.00
	214	GS - AF	111,511.71	2,348.43	109,163.28	816,231	0	19,139.6	57	0	0	13.66	13.37	0.00
	215	GS SEC	2,600,493.96	46,214.14	2,554,279.82	19,626,152	0	80,040.7	212	0	0	13.25	13.01	0.00
	223	GS LM ON	5,149.85	74.29	5,075.56	53,280	41,040	0.0	1	0	0	9.67	9.53	0.00
	240	LGS SEC	2,496,020.37	55,190.02	2,440,830.35	21,117,288	0	65,078.1	36	0	0	11.82	11.56	0.00
	260	PS SEC	13,381,988.96	279,939.16	13,102,049.80	108,809,577	0	402,989.0	158	0	0	12.30	12.04	0.00
	264	PS PRI	235,671.16	5,045.90	230,625.26	2,274,000	0	7,549.0	1	0	0	10.36	10.14	0.00
	358	IGS PRI	389,056.25	10,567.38	378,488.87	4,082,400	0	10,475.0	1	0	0	9.53	9.27	0.00
	359	IGS SUB	197,168.06	5,567.99	191,600.07	1,929,900	0	6,518.0	1	0	0	10.22	9.93	0.00
Total 213			19,959,218.69	412,710.34	19,546,508.35	162,139,076	41,040	595,645.0	719	263	798	12.31	12.06	9,293.94
216	093	OL 175 MV	5,042.71	71.01	4,971.70	29,000	0	0.0	0	23	34	17.39	17.14	0.00
	094	OL 100 HP	24,701.23	215.70	24,485.53	88,679	0	0.0	0	116	184	27.85	27.61	455.90
	095	OL 400 MV	3,563.22	64.27	3,498.95	26,159	0	0.0	0	9	14	13.62	13.38	0.00
	097	OL 200 HP	23,891.18	298.33	23,592.85	123,296	0	0.0	0	56	122	19.38	19.14	1,749.07
	098	OL 400 HP	21,735.56	335.30	21,400.26	138,096	0	0.0	0	13	69	15.74	15.50	2,211.48
	107	OL 200HPF	36,647.16	406.87	36,240.29	167,612	0	0.0	0	94	167	21.86	21.62	1,580.28
	109	OL400 HPF	136,733.45	2,178.16	134,555.29	898,658	0	0.0	0	192	450	15.22	14.97	4,478.00
	110	OL 250 MH	2,294.25	26.11	2,268.14	10,836	0	0.0	0	6	9	21.17	20.93	64.30
	111	OL100 HPP	69,215.50	390.06	68,825.44	160,191	0	0.0	0	37	331	43.21	42.96	256.94
	113	OL 150 HP	52,611.45	519.18	52,092.27	213,475	0	0.0	0	146	304	24.65	24.40	6,279.79
	116	OL 400 MH	26,287.17	377.89	25,909.28	155,472	0	0.0	0	21	82	16.91	16.66	699.21
	120	OL 250HPP	380.75	3.08	377.67	1,236	0	0.0	0	1	1	30.81	30.56	0.00
	122	OL150 HPP	10,952.47	54.59	10,897.88	22,528	0	0.0	0	6	32	48.62	48.37	0.00
	131	OL 1000MH	4,562.13	88.06	4,474.07	36,320	0	0.0	0	6	8	12.56	12.32	64.28
	204	GS-MTRD	11,696.13	87.48	11,608.65	27,603	0	0.0	43	0	0	42.37	42.06	0.00
	211	GS SEC	2,291,789.42	33,483.78	2,258,305.64	14,297,609	76,154	22,345.1	2,017	0	0	16.03	15.79	0.00
	213	GS-UMR	92,914.88	348.85	92,566.03	560,460	0	0.0	135	0	0	16.58	16.52	0.00
	214	GS - AF	60,206.89	1,207.93	58,998.96	473,540	0	7,025.5	19	0	0	12.71	12.46	0.00
	215	GS SEC	7,768,566.37	151,415.78	7,617,150.59	59,112,577	0	226,337.9	720	0	0	13.14	12.89	0.00
	217	GS PRI	132,664.39	1,486.61	131,177.78	522,650	0	10,387.8	4	0	0	25.38	25.10	0.00
	218	GS M SEC	28,034.39	495.57	27,538.82	214,880	0	751.2	1	0	0	13.05	12.82	0.00
	223	GS LM ON	3,242.11	48.68	3,193.43	22,568	14,653	0.0	3	0	0	14.37	14.15	0.00
	225	GS LM TOD	3,653.17	52.90	3,600.27	24,680	14,392	0.0	3	0	0	14.80	14.59	0.00
	229	GS-TOD	22,294.03	450.69	21,843.34	155,177	86,992	0.0	10	0	0	14.37	14.08	0.00
	240	LGS SEC	8,176,415.65	192,094.79	7,984,320.86	71,685,137	0	188,303.0	93	0	0	11.41	11.14	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	242	LGS M SEC	693,500.36	15,488.48	678,011.88	6,281,800	0	14,717.0	6	0	0	11.04	10.79	0.00
	244	LGS PRI	301,501.49	7,952.84	293,548.65	2,913,600	0	8,724.0	3	0	0	10.35	10.08	0.00
	246	LGS M PRI	68,865.33	1,887.24	66,978.09	676,080	0	1,914.0	1	0	0	10.19	9.91	0.00
	251	LGS-LM-TD	85,325.38	1,517.01	83,808.37	776,832	444,480	0.0	2	0	0	10.98	10.79	0.00
	358	IGS PRI	2,267,793.90	74,520.28	2,193,273.62	27,121,800	0	55,320.0	4	0	0	8.36	8.09	0.00
	540	MW	222,404.42	5,336.33	217,068.09	2,003,777	0	2,885.0	10	0	0	11.10	10.83	0.00
Total 216			22,649,486.54	492,903.85	22,156,582.69	188,942,328	636,671	538,710.5	3,074	725	1,806	11.99	11.73	17,839.25
221	093	OL 175 MV	1,202.08	17.03	1,185.05	6,912	0	0.0	0	8	8	17.39	17.14	0.00
	094	OL 100 HP	7,931.91	68.98	7,862.93	28,552	0	0.0	0	33	59	27.78	27.54	128.02
	095	OL 400 MV	1,075.80	18.49	1,057.31	7,584	0	0.0	0	3	4	14.19	13.94	40.48
	097	OL 200 HP	5,957.24	80.23	5,877.01	32,591	0	0.0	0	9	32	18.28	18.03	144.71
	098	OL 400 HP	559.34	9.57	549.77	3,999	0	0.0	0	1	2	13.99	13.75	0.00
	107	OL 200HPF	4,130.14	49.61	4,080.53	19,858	0	0.0	0	13	20	20.80	20.55	0.00
	109	OL400 HPF	55,318.25	884.46	54,433.79	365,714	0	0.0	0	42	183	15.13	14.88	1,505.28
	110	OL 250 MH	1,650.06	19.40	1,630.66	7,974	0	0.0	0	1	7	20.69	20.45	0.00
	111	OL100 HPP	1,248.30	7.19	1,241.11	2,904	0	0.0	0	1	6	42.99	42.74	0.00
	113	OL 150 HP	8,216.46	83.77	8,132.69	34,502	0	0.0	0	28	49	23.81	23.57	754.31
	116	OL 400 MH	10,705.82	156.02	10,549.80	64,958	0	0.0	0	11	34	16.48	16.24	64.06
	131	OL 1000MH	3,526.04	67.22	3,458.82	27,132	0	0.0	0	3	6	13.00	12.75	128.02
	204	GS-MTRD	1,557.64	21.40	1,536.24	7,735	0	0.0	3	0	0	20.14	19.86	0.00
	211	GS SEC	578,605.44	8,867.27	569,738.17	3,367,886	0	4,280.7	599	0	0	17.18	16.92	0.00
	215	GS SEC	1,290,937.01	25,609.05	1,265,327.96	9,717,123	0	40,975.3	126	0	0	13.29	13.02	0.00
	217	GS PRI	27,814.46	496.01	27,318.45	189,786	0	1,038.6	5	0	0	14.66	14.39	0.00
	220	GSCC PRI	165,076.58	3,449.15	161,627.43	1,348,040	0	3,542.6	11	0	0	12.25	11.99	0.00
	236	GSCC SUB	22,065.50	492.53	21,572.97	178,500	0	252.3	1	0	0	12.36	12.09	0.00
	240	LGS SEC	3,940,353.73	83,607.10	3,856,746.63	29,717,070	0	132,394.0	49	0	0	13.26	12.98	0.00
	244	LGS PRI	1,548,705.98	35,161.67	1,513,544.31	13,065,900	0	54,292.0	11	0	0	11.85	11.58	0.00
	248	LGS SUB	257,070.06	8,109.33	248,960.73	2,841,300	0	9,244.0	2	0	0	9.05	8.76	0.00
	250	LGS TRAN	289,588.06	7,715.12	281,872.94	3,528,000	0	7,271.0	1	0	0	8.21	7.99	0.00
	321	CS-IRP	61,324.87	3,090.78-	64,415.65	1,050,000	0	3,822.0	0	0	0	5.84	6.13	0.00
	331	CS-IRP ST	7,857,820.21	427,708.60	7,430,111.61	143,328,000	0	253,656.0	1	0	0	5.48	5.18	0.00
	332	CS-IRP TR	375,435.31	7,887.20	367,548.11	4,116,000	0	13,776.0	0	0	0	9.12	8.93	0.00
	358	IGS PRI	7,178,360.17	257,900.46	6,920,459.71	94,152,100	0	173,459.0	12	0	0	7.62	7.35	0.00
	359	IGS SUB	7,264,916.04	240,835.16	7,024,080.88	92,018,600	0	268,034.0	6	0	0	7.90	7.63	0.00
	360	IGS	1,186,695.74	26,488.28	1,160,207.46	9,306,000	0	47,501.0	1	0	0	12.75	12.47	0.00
	371	IGS	72,277,634.03	3,735,652.56	68,541,981.47	1,296,589,000	0	1,953,839.0	4	0	0	5.57	5.29	0.00
	372	IGS	17,189,863.39	918,525.21	16,271,338.18	317,929,026	0	456,642.0	2	0	0	5.41	5.12	0.00
Total 221			121,615,345.66	5,786,897.29	115,828,448.37	2,023,052,746	0	3,424,019.5	835	152	411	6.01	5.73	2,764.88
222	097	OL 200 HP	771.36	9.65	761.71	4,048	0	0.0	0	2	4	19.06	18.82	47.60

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	107	OL 200HPF	210.17	2.43	207.74	1,012	0	0.0	0	1	1	20.77	20.53	0.00
	109	OL400 HPF	2,110.94	33.98	2,076.96	13,986	0	0.0	0	4	7	15.09	14.85	47.56
	113	OL 150 HP	1,642.92	15.44	1,627.48	6,336	0	0.0	0	5	9	25.93	25.69	256.16
	211	GS SEC	43,570.48	669.70	42,900.78	302,729	0	426.3	27	0	0	14.39	14.17	0.00
	215	GS SEC	149,749.46	2,327.04	147,422.42	1,107,320	0	5,497.6	17	0	0	13.52	13.31	0.00
	220	GSCC PRI	24,979.19	456.61	24,522.58	201,000	0	636.0	2	0	0	12.43	12.20	0.00
	229	GS-TOD	4,562.44	37.43	4,525.01	42,000	30,000	0.0	1	0	0	10.86	10.77	0.00
	240	LGS SEC	1,235,908.46	27,084.18	1,208,824.28	9,913,224	0	38,016.0	11	0	0	12.47	12.19	0.00
	244	LGS PRI	351,350.77	10,525.57	340,825.20	3,863,400	0	6,395.0	1	0	0	9.09	8.82	0.00
	251	LGS-LM-TD	1,251.42	1.43	1,249.99	500	300	0.0	1	0	0	250.28	250.00	0.00
	358	IGS PRI	906,026.62	29,440.76	876,585.86	10,352,400	0	23,107.0	1	0	0	8.75	8.47	0.00
	359	IGS SUB	97,794.29	925.24	96,869.05	264,000	0	5,066.0	0	0	0	37.04	36.69	0.00
Total 222			2,819,928.52	71,529.46	2,748,399.06	26,071,955	30,300	79,143.9	61	12	21	10.82	10.54	351.32
230	093	OL 175 MV	149.99	2.13	147.86	864	0	0.0	0	1	1	17.36	17.11	0.00
	094	OL 100 HP	1,056.72	9.36	1,047.36	3,871	0	0.0	0	7	8	27.30	27.06	0.00
	095	OL 400 MV	759.33	13.71	745.62	5,608	0	0.0	0	2	3	13.54	13.30	0.00
	097	OL 200 HP	9,313.87	117.06	9,196.81	48,576	0	0.0	0	8	48	19.17	18.93	608.29
	107	OL 200HPF	1,317.76	14.95	1,302.81	6,072	0	0.0	0	4	6	21.70	21.46	47.70
	109	OL400 HPF	12,494.96	201.30	12,293.66	81,993	0	0.0	0	19	41	15.24	14.99	392.83
	113	OL 150 HP	4,746.14	49.34	4,696.80	20,491	0	0.0	0	17	29	23.16	22.92	344.59
	116	OL 400 MH	932.22	14.02	918.20	5,688	0	0.0	0	2	3	16.39	16.14	0.00
	211	GS SEC	79,638.64	1,076.54	78,562.10	487,513	0	967.2	75	0	0	16.34	16.11	0.00
	215	GS SEC	430,056.03	7,369.60	422,686.43	3,163,636	0	15,025.5	64	0	0	13.59	13.36	0.00
	217	GS PRI	42,883.86	1,039.89	41,843.97	341,900	0	1,069.5	3	0	0	12.54	12.24	0.00
	220	GSCC PRI	377,083.21	8,219.17	368,864.04	2,913,005	0	8,884.3	35	0	0	12.94	12.66	0.00
	236	GSCC SUB	84,000.06	1,670.39	82,329.67	612,850	0	1,855.0	4	0	0	13.71	13.43	0.00
	240	LGS SEC	428,987.83	6,395.86	422,591.97	2,590,056	0	19,664.0	7	0	0	16.56	16.32	0.00
	244	LGS PRI	4,426,639.46	99,518.81	4,327,120.65	36,816,450	113,750	169,524.0	27	0	0	12.02	11.75	0.00
	248	LGS SUB	890,172.54	24,887.59	865,284.95	9,624,406	0	33,750.0	10	0	0	9.25	8.99	0.00
	250	LGS TRAN	187,637.20	6,656.39	180,980.81	2,051,000	0	8,206.0	2	0	0	9.15	8.82	0.00
	257	LGSPRITOD	282,429.21	8,375.65	274,053.56	3,353,300	1,957,700	4,914.0	1	0	0	8.42	8.17	0.00
	330	CS-IRP PR	707,182.46	10,493.22	696,689.24	4,277,000	0	27,159.0	1	0	0	16.53	16.29	0.00
	331	CS-IRP ST	4,235,593.35	165,096.88	4,070,496.47	61,732,000	0	162,677.0	2	0	0	6.86	6.59	0.00
	358	IGS PRI	9,853,294.99	231,060.52	9,622,234.47	83,683,200	0	284,558.0	12	0	0	11.77	11.50	0.00
	359	IGS SUB	11,224,092.92	346,997.67	10,877,095.25	125,207,700	0	417,171.0	8	0	0	8.96	8.69	0.00
	360	IGS	192,121.97	3,647.70	188,474.27	2,240,000	0	8,470.0	0	0	0	8.58	8.41	0.00
	371	IGS	817,877.64	26,947.47	790,930.17	12,075,000	0	20,314.0	1	0	0	6.77	6.55	0.00
Total 230			34,290,462.36	949,875.22	33,340,587.14	351,342,179	2,071,450	1,184,208.5	253	60	139	9.76	9.49	1,393.41
400	093	OL 175 MV	299.92	4.27	295.65	1,728	0	0.0	0	1	2	17.36	17.14	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	094	OL 100 HP	527.94	4.65	523.29	1,936	0	0.0	0	2	4	27.27	27.03	0.00
	097	OL 200 HP	178.90	2.41	176.49	1,012	0	0.0	0	1	1	17.68	17.44	0.00
	107	OL 200HPF	210.27	2.42	207.85	1,012	0	0.0	0	1	1	20.78	20.54	0.00
	109	OL400 HPF	6,957.51	110.90	6,846.61	45,899	0	0.0	0	7	23	15.16	14.92	192.75
	111	OL100 HPP	19,174.92	107.96	19,066.96	44,528	0	0.0	0	19	92	43.06	42.82	0.00
	113	OL 150 HP	746.89	6.82	740.07	2,816	0	0.0	0	2	4	26.52	26.28	128.30
	122	OL150 HPP	2,741.25	13.60	2,727.65	5,632	0	0.0	0	2	8	48.67	48.43	0.00
	131	OL 1000MH	561.35	10.88	550.47	4,540	0	0.0	0	1	1	12.36	12.12	0.00
	204	GS-MTRD	1,588.28	0.20	1,588.08	68	0	0.0	8	0	0	2,335.71	2,335.41	0.00
	211	GS SEC	150,609.17	1,477.43	149,131.74	579,721	0	410.3	260	0	0	25.98	25.72	0.00
	213	GS-UMR	214.49	0.17	214.32	60	0	0.0	1	0	0	357.48	357.20	0.00
	215	GS SEC	151,458.91	2,938.29	148,520.62	1,193,390	0	3,515.0	13	0	0	12.69	12.45	0.00
	528	SL	1,638,188.91	21,194.61	1,616,994.30	8,462,892	0	0.0	55	0	0	19.36	19.11	0.00
Total 400			1,973,458.71	25,874.61	1,947,584.10	10,345,234	0	3,925.3	337	36	136	19.08	18.83	321.05
Grand Total			578,240,938.66	14,899,116.16	563,341,822.50	5,865,874,234	11,922,829	8,485,550.4	166,602	45,270	54,306	9.86	9.60	284,861.52

TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
011	RSW-LMWH	185,561.15	3,757.30	181,803.85	1,677,801	0	0.0	78	0	0	11.06	10.84	0.00
012	RSW-A	26,329.71	549.07	25,780.64	241,901	0	0.0	10	0	0	10.88	10.66	0.00
013	RSW-B	3,907.41	90.03	3,817.38	36,587	0	0.0	2	0	0	10.68	10.43	0.00
015	RS	112,699,953.76	2,127,520.49	110,572,433.27	940,173,151	60,183	8,585.7	64,571	0	0	11.99	11.76	0.00
017	RS EMP	1,098,541.74	20,067.88	1,078,473.86	9,484,912	0	0.0	466	0	0	11.58	11.37	0.00
022	RSW-RS	140,101,879.92	2,492,703.17	137,609,176.75	1,187,203,473	52,964	18,198.5	69,668	0	0	11.80	11.59	0.00
028	AORH-W ON	11,386.89	185.50	11,201.39	106,309	72,021	0.0	7	0	0	10.71	10.54	0.00
030	RSW-ONPK	163,184.22	2,974.32	160,209.90	1,454,202	884,220	0.0	67	0	0	11.22	11.02	0.00
032	RS LM-ON	209,961.21	3,813.15	206,148.06	1,949,381	1,276,669	0.0	84	0	0	10.77	10.58	0.00
034	AORH-ON	1,639.56	19.54	1,620.02	14,747	8,738	0.0	2	0	0	11.12	10.99	0.00
036	RS-TOD-ON	12,049.67	266.06	11,783.61	111,602	74,118	0.0	5	0	0	10.80	10.56	0.00
093	OL 175 MV	106,230.54	1,520.28	104,710.26	626,906	0	0.0	0	697	732	16.95	16.70	104.43
094	OL 100 HP	2,793,727.63	25,326.99	2,768,400.64	10,392,940	0	0.0	0	20,042	21,650	26.88	26.64	57,283.55
095	OL 400 MV	20,832.97	372.43	20,460.54	153,607	0	0.0	0	59	81	13.56	13.32	40.48
097	OL 200 HP	322,296.14	4,301.33	317,994.81	1,773,955	0	0.0	0	1,342	1,762	18.17	17.93	10,918.79
098	OL 400 HP	63,247.79	1,035.36	62,212.43	426,859	0	0.0	0	77	214	14.82	14.57	3,452.28
099	OL175 MVP	1,544.66	18.93	1,525.73	7,776	0	0.0	0	4	9	19.86	19.62	0.00
103	OL 250 HP	489.78	6.00	483.78	2,472	0	0.0	0	1	2	19.81	19.57	0.00
107	OL 200HPF	378,021.64	4,334.70	373,686.94	1,783,711	0	0.0	0	1,263	1,774	21.19	20.95	10,367.28
109	OL400 HPF	1,248,339.45	20,074.27	1,228,265.18	8,255,122	0	0.0	0	1,740	4,154	15.12	14.88	35,563.81
110	OL 250 MH	35,720.73	398.16	35,322.57	163,589	0	0.0	0	72	137	21.84	21.59	1,991.51
111	OL100 HPP	165,115.78	929.16	164,186.62	382,779	0	0.0	0	198	792	43.14	42.89	1,468.02
113	OL 150 HP	3,315,211.12	36,891.78	3,278,319.34	15,287,503	0	0.0	0	19,422	21,903	21.69	21.44	154,237.81
116	OL 400 MH	298,548.81	4,297.86	294,250.95	1,761,431	0	0.0	0	290	934	16.95	16.71	8,653.67
120	OL 250HPP	560.34	4.42	555.92	1,866	0	0.0	0	2	2	30.03	29.79	0.00
122	OL150 HPP	22,740.65	113.25	22,627.40	46,948	0	0.0	0	15	67	48.44	48.20	0.00
126	OL 400HPP	315.05	2.50	312.55	1,284	0	0.0	0	0	1	24.54	24.34	0.00
130	OL 250MON	880.20	9.43	870.77	3,280	0	0.0	0	3	3	26.84	26.55	0.00
131	OL 1000MH	49,636.09	963.69	48,672.40	394,137	0	0.0	0	43	87	12.59	12.35	779.89
136	OL 400MON	305.37	5.22	300.15	1,530	0	0.0	0	1	1	19.96	19.62	0.00
204	GS-MTRD	240,296.53	3,458.83	236,837.70	1,237,866	0	0.0	468	0	0	19.41	19.13	0.00
211	GS SEC	23,549,582.29	334,968.08	23,214,614.21	141,454,600	118,202	175,199.2	22,670	0	0	16.65	16.41	0.00
213	GS-UMR	459,669.10	5,448.37	454,220.73	2,364,974	0	0.0	600	0	0	19.44	19.21	0.00
214	GS - AF	182,116.09	3,794.93	178,321.16	1,351,741	0	27,719.0	87	0	0	13.47	13.19	0.00
215	GS SEC	59,579,001.88	1,151,216.38	58,427,785.50	450,024,882	0	1,854,791.7	6,394	0	0	13.24	12.98	0.00
217	GS PRI	415,238.05	7,152.01	408,086.04	2,763,916	0	17,704.0	23	0	0	15.02	14.76	0.00

TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
218	GS M SEC	28,034.39	495.57	27,538.82	214,880	0	751.2	1	0	0	13.05	12.82	0.00
220	GSCC PRI	713,998.67	14,594.26	699,404.41	5,665,245	0	16,498.5	53	0	0	12.60	12.35	0.00
223	GS LM ON	114,666.51	1,554.12	113,112.39	960,429	602,021	0.0	43	0	0	11.94	11.78	0.00
225	GS LM TOD	37,158.74	662.22	36,496.52	254,762	153,807	0.0	31	0	0	14.59	14.33	0.00
227	EXP GSTOD	222,092.28	3,199.61	218,892.67	1,368,578	992,328	0.0	224	0	0	16.23	15.99	0.00
229	GS-TOD	480,232.83	9,625.55	470,607.28	3,929,470	2,436,624	463.2	86	0	0	12.22	11.98	0.00
236	GSCC SUB	116,449.46	2,255.39	114,194.07	841,750	0	2,331.3	6	0	0	13.83	13.57	0.00
240	LGS SEC	45,245,153.13	1,050,781.83	44,194,371.30	391,191,305	0	1,096,890.1	560	0	0	11.57	11.30	0.00
242	LGS M SEC	862,062.21	19,459.80	842,602.41	7,831,400	0	18,110.0	7	0	0	11.01	10.76	0.00
244	LGS PRI	8,901,892.43	212,430.58	8,689,461.85	79,727,190	113,750	296,047.0	60	0	0	11.17	10.90	0.00
246	LGS M PRI	68,865.33	1,887.24	66,978.09	676,080	0	1,914.0	1	0	0	10.19	9.91	0.00
248	LGS SUB	1,697,760.54	52,460.06	1,645,300.48	19,535,881	0	58,975.0	16	0	0	8.69	8.42	0.00
250	LGS TRAN	477,225.26	14,371.51	462,853.75	5,579,000	0	15,477.0	2	0	0	8.55	8.30	0.00
251	LGS-LM-TD	184,595.50	3,493.79	181,101.71	1,598,272	867,020	0.0	7	0	0	11.55	11.33	0.00
256	LGSSECTOD	389,740.78	10,476.71	379,264.07	3,961,200	2,252,464	7,966.0	5	0	0	9.84	9.57	0.00
257	LGSPRITOD	282,429.21	8,375.65	274,053.56	3,353,300	1,957,700	4,914.0	1	0	0	8.42	8.17	0.00
260	PS SEC	13,381,988.96	279,939.16	13,102,049.80	108,809,577	0	402,989.0	158	0	0	12.30	12.04	0.00
264	PS PRI	235,671.16	5,045.90	230,625.26	2,274,000	0	7,549.0	1	0	0	10.36	10.14	0.00
321	CS-IRP	61,324.87	3,090.78-	64,415.65	1,050,000	0	3,822.0	0	0	0	5.84	6.13	0.00
330	CS-IRP PR	707,182.46	10,493.22	696,689.24	4,277,000	0	27,159.0	1	0	0	16.53	16.29	0.00
331	CS-IRP ST	12,093,413.56	592,805.48	11,500,608.08	205,060,000	0	416,333.0	3	0	0	5.90	5.61	0.00
332	CS-IRP TR	375,435.31	7,887.20	367,548.11	4,116,000	0	13,776.0	0	0	0	9.12	8.93	0.00
356	IGS SEC	1,562,966.10	43,663.50	1,519,302.60	16,574,400	0	33,680.0	4	0	0	9.43	9.17	0.00
358	IGS PRI	28,564,171.95	905,958.99	27,658,212.96	324,305,980	0	732,309.0	40	0	0	8.81	8.53	0.00
359	IGS SUB	20,147,577.00	653,906.57	19,493,670.43	240,993,100	0	735,747.0	18	0	0	8.36	8.09	0.00
360	IGS	1,378,817.71	30,135.98	1,348,681.73	11,546,000	0	55,971.0	1	0	0	11.94	11.68	0.00
371	IGS	73,095,511.67	3,762,600.03	69,332,911.64	1,308,664,000	0	1,974,153.0	5	0	0	5.59	5.30	0.00
372	IGS	17,189,863.39	918,525.21	16,271,338.18	317,929,026	0	456,642.0	2	0	0	5.41	5.12	0.00
528	SL	1,638,188.91	21,194.61	1,616,994.30	8,462,892	0	0.0	55	0	0	19.36	19.11	0.00
540	MW	222,404.42	5,336.33	217,068.09	2,003,777	0	2,885.0	10	0	0	11.10	10.83	0.00
Grand Total		578,240,938.66	14,899,116.16	563,341,822.50	5,865,874,234	11,922,829	8,485,550.4	166,602	45,270	54,306	9.86	9.60	284,861.52

State:

December 2018

TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total	0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
010	011	RSW-LMWH	56,615.62	1,233.18	55,382.44	506,357	0	0.0	30	0	0	11.18	10.94	0.00
	015	RS	57,280,679.15	1,137,669.99	56,143,009.16	468,994,236	6,771	4,703.8	37,896	0	0	12.21	11.97	0.00
	022	RSW-RS	21,275,435.13	398,553.95	20,876,881.18	176,393,877	0	569.9	12,811	0	0	12.06	11.84	0.00
	036	RS-TOD-ON	2,201.80	42.89	2,158.91	17,145	10,438	0.0	2	0	0	12.84	12.59	0.00
	093	OL 175 MV	55,406.21	796.70	54,609.51	329,374	0	0.0	0	384	387	16.82	16.58	64.07
	094	OL 100 HP	1,100,223.74	10,064.38	1,090,159.36	4,125,104	0	0.0	0	8,093	8,591	26.67	26.43	18,618.92
	095	OL 400 MV	1,501.51	27.36	1,474.15	11,376	0	0.0	0	4	6	13.20	12.96	0.00
	097	OL 200 HP	64,507.56	889.49	63,618.07	368,671	0	0.0	0	340	366	17.50	17.26	1,120.49
	098	OL 400 HP	379.23	6.40	372.83	2,809	0	0.0	0	2	1	13.50	13.27	0.00
	107	OL 200HPF	52,115.96	616.87	51,499.09	255,556	0	0.0	0	215	254	20.39	20.15	888.66
	109	OL400 HPF	51,184.37	853.38	50,330.99	353,368	0	0.0	0	112	178	14.48	14.24	799.87
	110	OL 250 MH	3,038.16	38.14	3,000.02	15,329	0	0.0	0	12	13	19.82	19.57	0.00
	111	OL100 HPP	5,568.45	32.87	5,535.58	13,415	0	0.0	0	16	28	41.51	41.26	54.01
	113	OL 150 HP	923,779.32	10,434.06	913,345.26	4,317,848	0	0.0	0	5,654	6,190	21.39	21.15	36,997.53
	116	OL 400 MH	4,910.33	73.24	4,837.09	29,869	0	0.0	0	10	16	16.44	16.19	152.20
	122	OL150 HPP	381.36	1.99	379.37	849	0	0.0	0	1	1	44.92	44.68	0.00
	131	OL 1000MH	278.02	7.56	270.46	2,193	0	0.0	0	0	1	12.68	12.33	0.00
	136	OL 400MON	305.37	5.22	300.15	1,530	0	0.0	0	1	1	19.96	19.62	0.00
Total 010			80,878,511.29	1,561,347.67	79,317,163.62	655,738,906	17,209	5,273.7	50,739	14,844	16,033	12.33	12.10	58,695.75
020	011	RSW-LMWH	128,945.53	2,524.12	126,421.41	1,171,444	0	0.0	48	0	0	11.01	10.79	0.00
	012	RSW-A	26,329.71	549.07	25,780.64	241,901	0	0.0	10	0	0	10.88	10.66	0.00
	013	RSW-B	3,907.41	90.03	3,817.38	36,587	0	0.0	2	0	0	10.68	10.43	0.00
	015	RS	55,419,274.61	989,850.50	54,429,424.11	471,178,915	53,412	3,881.9	26,675	0	0	11.76	11.55	0.00
	017	RS EMP	1,098,541.74	20,067.88	1,078,473.86	9,484,912	0	0.0	466	0	0	11.58	11.37	0.00
	022	RSW-RS	118,826,444.79	2,094,149.22	116,732,295.57	1,010,809,596	52,964	17,628.6	56,857	0	0	11.76	11.55	0.00
	028	AORH-W ON	11,386.89	185.50	11,201.39	106,309	72,021	0.0	7	0	0	10.71	10.54	0.00
	030	RSW-ONPK	163,184.22	2,974.32	160,209.90	1,454,202	884,220	0.0	67	0	0	11.22	11.02	0.00
	032	RS LM-ON	209,961.21	3,813.15	206,148.06	1,949,381	1,276,669	0.0	84	0	0	10.77	10.58	0.00
	034	AORH-ON	1,639.56	19.54	1,620.02	14,747	8,738	0.0	2	0	0	11.12	10.99	0.00
	036	RS-TOD-ON	9,847.87	223.17	9,624.70	94,457	63,680	0.0	3	0	0	10.43	10.19	0.00
	093	OL 175 MV	27,355.84	395.16	26,960.68	162,472	0	0.0	0	184	189	16.84	16.59	40.36
	094	OL 100 HP	1,437,243.06	13,041.11	1,424,201.95	5,352,186	0	0.0	0	10,456	11,152	26.85	26.61	33,052.68
	095	OL 400 MV	1,000.81	18.46	982.35	7,584	0	0.0	0	4	4	13.20	12.95	0.00
	097	OL 200 HP	91,907.94	1,266.80	90,641.14	522,221	0	0.0	0	484	521	17.60	17.36	1,974.55
	098	OL 400 HP	3,118.90	53.24	3,065.66	22,436	0	0.0	0	10	12	13.90	13.66	78.82
	107	OL 200HPF	74,761.47	881.33	73,880.14	360,255	0	0.0	0	319	359	20.75	20.51	2,232.71
	109	OL400 HPF	75,473.80	1,257.41	74,216.39	514,082	0	0.0	0	198	260	14.68	14.44	2,047.35
	110	OL 250 MH	2,380.46	28.49	2,351.97	11,942	0	0.0	0	10	10	19.93	19.69	34.02
	111	OL100 HPP	20,321.94	116.60	20,205.34	48,306	0	0.0	0	83	101	42.07	41.83	449.01
	113	OL 150 HP	1,882,220.47	21,169.64	1,861,050.83	8,786,013	0	0.0	0	11,547	12,593	21.42	21.18	78,015.43

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	116	OL 400 MH	5,604.28	86.14	5,518.14	34,876	0	0.0	0	13	19	16.07	15.82	40.34
	120	OL 250HPP	179.59	1.34	178.25	630	0	0.0	0	1	1	28.51	28.29	0.00
	122	OL150 HPP	1,131.60	5.90	1,125.70	2,451	0	0.0	0	4	4	46.17	45.93	0.00
	130	OL 250MON	309.76	2.87	306.89	1,204	0	0.0	0	1	1	25.73	25.49	0.00
	131	OL 1000MH	2,135.36	42.41	2,092.95	17,734	0	0.0	0	1	4	12.04	11.80	0.00
	211	GS SEC	397.01	4.52	392.49	3,090	0	0.0	0	0	0	12.85	12.70	0.00
Total 020			179,525,005.83	3,152,817.92	176,372,187.91	1,512,389,933	2,411,704	21,510.5	84,220	23,315	25,227	11.87	11.66	117,965.27
211	093	OL 175 MV	13,720.63	191.64	13,528.99	78,964	0	0.0	0	76	92	17.38	17.13	0.00
	094	OL 100 HP	175,133.44	1,517.93	173,615.51	626,419	0	0.0	0	1,066	1,306	27.96	27.72	3,733.10
	095	OL 400 MV	7,698.09	137.85	7,560.24	56,719	0	0.0	0	25	30	13.57	13.33	0.00
	097	OL 200 HP	92,341.46	1,208.43	91,133.03	494,905	0	0.0	0	311	491	18.66	18.41	3,784.99
	098	OL 400 HP	27,538.11	472.93	27,065.18	193,925	0	0.0	0	35	97	14.20	13.96	473.92
	099	OL175 MVP	1,373.05	16.81	1,356.24	6,912	0	0.0	0	3	8	19.86	19.62	0.00
	103	OL 250 HP	489.78	6.00	483.78	2,472	0	0.0	0	1	2	19.81	19.57	0.00
	107	OL 200HPF	138,525.47	1,568.16	136,957.31	645,219	0	0.0	0	413	642	21.47	21.23	3,751.04
	109	OL400 HPF	557,226.57	8,977.22	548,249.35	3,682,859	0	0.0	0	767	1,856	15.13	14.89	14,272.94
	110	OL 250 MH	14,842.12	163.17	14,678.95	67,058	0	0.0	0	32	56	22.13	21.89	906.13
	111	OL100 HPP	39,649.32	218.19	39,431.13	90,361	0	0.0	0	34	187	43.88	43.64	708.06
	113	OL 150 HP	336,606.25	3,541.99	333,064.26	1,466,463	0	0.0	0	1,597	2,099	22.95	22.71	21,699.42
	116	OL 400 MH	166,795.44	2,395.03	164,400.41	980,587	0	0.0	0	148	520	17.01	16.77	5,122.39
	122	OL150 HPP	7,533.97	37.17	7,496.80	15,488	0	0.0	0	2	22	48.64	48.40	0.00
	126	OL 400HPP	315.05	2.50	312.55	1,284	0	0.0	0	0	1	24.54	24.34	0.00
	130	OL 250MON	570.44	6.56	563.88	2,076	0	0.0	0	2	2	27.48	27.16	0.00
	131	OL 1000MH	26,010.90	505.66	25,505.24	206,516	0	0.0	0	23	46	12.60	12.35	394.62
	204	GS-MTRD	225,454.48	3,349.75	222,104.73	1,202,460	0	0.0	413	0	0	18.75	18.47	0.00
	211	GS SEC	16,885,200.33	237,754.84	16,647,445.49	98,678,557	36,023	98,678.2	17,191	0	0	17.11	16.87	0.00
	213	GS-UMR	366,539.73	5,099.35	361,440.38	1,804,454	0	0.0	464	0	0	20.31	20.03	0.00
	214	GS - AF	10,397.49	238.57	10,158.92	61,970	0	1,553.9	10	0	0	16.78	16.39	0.00
	215	GS SEC	28,557,674.56	571,850.78	27,985,823.78	216,197,348	0	875,182.9	3,120	0	0	13.21	12.94	0.00
	217	GS PRI	82,263.21	1,505.73	80,757.48	647,160	0	2,151.6	6	0	0	12.71	12.48	0.00
	220	GSCC PRI	90,333.92	1,642.60	88,691.32	749,000	0	1,983.6	4	0	0	12.06	11.84	0.00
	223	GS LM ON	7,721.19	169.77	7,551.42	59,060	34,516	0.0	4	0	0	13.07	12.79	0.00
	225	GS LM TOD	1,420.54	13.27	1,407.27	6,996	3,951	0.0	2	0	0	20.31	20.12	0.00
	227	EXP GSTOD	96,484.79	1,224.17	95,260.62	571,426	409,673	0.0	108	0	0	16.88	16.67	0.00
	229	GS-TOD	168,684.12	3,594.94	165,089.18	1,399,646	896,085	463.2	34	0	0	12.05	11.80	0.00
	236	GSCC SUB	10,383.90	92.47	10,291.43	50,400	0	224.0	1	0	0	20.60	20.42	0.00
	240	LGS SEC	12,833,692.64	318,013.32	12,515,679.32	114,464,194	0	279,092.0	164	0	0	11.21	10.93	0.00
	244	LGS PRI	1,395,294.84	37,643.98	1,357,650.86	14,156,640	0	34,525.0	12	0	0	9.86	9.59	0.00
	248	LGS SUB	336,915.05	11,981.88	324,933.17	4,269,300	0	9,400.0	3	0	0	7.89	7.61	0.00
	256	LGSSECTOD	389,740.78	10,476.71	379,264.07	3,961,200	2,252,464	7,966.0	5	0	0	9.84	9.57	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	356	IGS SEC	1,562,966.10	43,663.50	1,519,302.60	16,574,400	0	33,680.0	4	0	0	9.43	9.17	0.00
	358	IGS PRI	6,985,865.12	267,730.58	6,718,134.54	92,630,400	0	161,990.0	8	0	0	7.54	7.25	0.00
	359	IGS SUB	1,363,605.69	59,580.51	1,304,025.18	21,572,900	0	38,958.0	3	0	0	6.32	6.04	0.00
Total 211			72,977,008.57	1,596,593.96	71,380,414.61	597,675,738	3,632,712	1,545,848.4	21,556	4,535	7,456	12.21	11.94	54,846.61
212	093	OL 175 MV	2,152.28	29.74	2,122.54	12,408	0	0.0	0	14	14	17.35	17.11	0.00
	094	OL 100 HP	41,659.03	358.32	41,300.71	147,022	0	0.0	0	243	306	28.34	28.09	1,285.39
	095	OL 400 MV	4,204.42	73.95	4,130.47	30,993	0	0.0	0	9	16	13.57	13.33	0.00
	097	OL 200 HP	27,729.19	355.33	27,373.86	148,062	0	0.0	0	110	147	18.73	18.49	1,255.92
	098	OL 400 HP	5,061.82	79.32	4,982.50	33,594	0	0.0	0	12	17	15.07	14.83	344.27
	099	OL175 MVP	171.61	2.12	169.49	864	0	0.0	0	1	1	19.86	19.62	0.00
	107	OL 200HPF	49,952.49	563.23	49,389.26	233,407	0	0.0	0	157	232	21.40	21.16	1,298.43
	109	OL400 HPF	217,174.85	3,467.98	213,706.87	1,430,383	0	0.0	0	299	721	15.18	14.94	6,377.65
	110	OL 250 MH	10,451.94	111.15	10,340.79	45,634	0	0.0	0	9	38	22.90	22.66	922.88
	111	OL100 HPP	3,896.26	22.09	3,874.17	9,038	0	0.0	0	5	19	43.11	42.87	0.00
	113	OL 150 HP	93,673.78	968.69	92,705.09	397,395	0	0.0	0	396	567	23.57	23.33	8,029.84
	116	OL 400 MH	57,612.02	826.13	56,785.89	338,894	0	0.0	0	65	180	17.00	16.76	1,747.16
	131	OL 1000MH	11,925.15	230.55	11,694.60	95,162	0	0.0	0	7	21	12.53	12.29	128.50
	211	GS SEC	3,193,573.37	46,968.47	3,146,604.90	21,580,290	6,025	44,235.8	2,249	0	0	14.80	14.58	0.00
	215	GS SEC	18,630,065.58	343,491.70	18,286,573.88	139,907,336	0	608,216.8	2,122	0	0	13.32	13.07	0.00
	217	GS PRI	129,612.13	2,623.77	126,988.36	1,062,420	0	3,056.5	5	0	0	12.20	11.95	0.00
	220	GSCC PRI	56,525.77	826.73	55,699.04	454,200	0	1,452.0	1	0	0	12.45	12.26	0.00
	223	GS LM ON	98,553.36	1,261.38	97,291.98	825,521	511,812	0.0	35	0	0	11.94	11.79	0.00
	225	GS LM TOD	32,085.03	596.05	31,488.98	223,086	135,464	0.0	26	0	0	14.38	14.12	0.00
	227	EXP GSTOD	125,607.49	1,975.44	123,632.05	797,152	582,655	0.0	116	0	0	15.76	15.51	0.00
	229	GS-TOD	284,692.24	5,542.49	279,149.75	2,332,647	1,423,547	0.0	41	0	0	12.20	11.97	0.00
	240	LGS SEC	16,133,774.45	368,396.56	15,765,377.89	141,704,336	0	374,343.0	200	0	0	11.39	11.13	0.00
	242	LGS M SEC	168,561.85	3,971.32	164,590.53	1,549,600	0	3,393.0	1	0	0	10.88	10.62	0.00
	244	LGS PRI	878,399.89	21,627.71	856,772.18	8,911,200	0	22,587.0	6	0	0	9.86	9.61	0.00
	248	LGS SUB	213,602.89	7,481.26	206,121.63	2,800,875	0	6,581.0	1	0	0	7.63	7.36	0.00
	251	LGS-LM-TD	98,018.70	1,975.35	96,043.35	820,940	422,240	0.0	4	0	0	11.94	11.70	0.00
	358	IGS PRI	983,774.90	34,739.01	949,035.89	12,283,680	0	23,400.0	2	0	0	8.01	7.73	0.00
Total 212			41,552,512.49	848,565.84	40,703,946.65	338,176,139	3,081,743	1,087,265.1	4,808	1,328	2,279	12.29	12.04	21,390.04
213	093	OL 175 MV	900.88	12.60	888.28	5,184	0	0.0	0	6	6	17.38	17.14	0.00
	094	OL 100 HP	5,250.56	46.56	5,204.00	19,171	0	0.0	0	25	40	27.39	27.15	9.54
	095	OL 400 MV	1,029.79	18.34	1,011.45	7,584	0	0.0	0	3	4	13.58	13.34	0.00
	097	OL 200 HP	5,697.44	73.60	5,623.84	30,573	0	0.0	0	20	30	18.64	18.39	233.17
	098	OL 400 HP	4,854.83	78.60	4,776.23	32,000	0	0.0	0	5	16	15.17	14.93	0.00
	107	OL 200HPF	20,150.75	228.83	19,921.92	93,708	0	0.0	0	47	91	23.50	23.26	568.46

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	109	OL400 HPF	133,664.75	2,109.48	131,555.27	868,180	0	0.0	0	99	435	15.40	15.15	5,449.58
	110	OL 250 MH	1,063.74	11.70	1,052.04	4,816	0	0.0	0	3	4	22.09	21.84	64.18
	111	OL100 HPP	6,041.09	34.20	6,006.89	14,036	0	0.0	0	4	29	43.04	42.80	0.00
	113	OL 150 HP	10,967.44	102.85	10,864.59	42,164	0	0.0	0	30	60	26.01	25.77	1,732.44
	116	OL 400 MH	25,701.53	369.39	25,332.14	151,087	0	0.0	0	20	80	17.01	16.77	828.31
	131	OL 1000MH	637.14	11.35	625.79	4,540	0	0.0	0	1	1	14.03	13.78	64.47
	211	GS SEC	326,198.43	4,665.53	321,532.90	2,157,205	0	3,855.6	252	0	0	15.12	14.91	0.00
	214	GS - AF	111,511.71	2,348.43	109,163.28	816,231	0	19,139.6	57	0	0	13.66	13.37	0.00
	215	GS SEC	2,600,493.96	46,214.14	2,554,279.82	19,626,152	0	80,040.7	212	0	0	13.25	13.01	0.00
	223	GS LM ON	5,149.85	74.29	5,075.56	53,280	41,040	0.0	1	0	0	9.67	9.53	0.00
	240	LGS SEC	2,496,020.37	55,190.02	2,440,830.35	21,117,288	0	65,078.1	36	0	0	11.82	11.56	0.00
	260	PS SEC	13,381,988.96	279,939.16	13,102,049.80	108,809,577	0	402,989.0	158	0	0	12.30	12.04	0.00
	264	PS PRI	235,671.16	5,045.90	230,625.26	2,274,000	0	7,549.0	1	0	0	10.36	10.14	0.00
	358	IGS PRI	389,056.25	10,567.38	378,488.87	4,082,400	0	10,475.0	1	0	0	9.53	9.27	0.00
	359	IGS SUB	197,168.06	5,567.99	191,600.07	1,929,900	0	6,518.0	1	0	0	10.22	9.93	0.00
Total 213			19,959,218.69	412,710.34	19,546,508.35	162,139,076	41,040	595,645.0	719	263	798	12.31	12.06	9,293.94
216	093	OL 175 MV	5,042.71	71.01	4,971.70	29,000	0	0.0	0	23	34	17.39	17.14	0.00
	094	OL 100 HP	24,701.23	215.70	24,485.53	88,679	0	0.0	0	116	184	27.85	27.61	455.90
	095	OL 400 MV	3,563.22	64.27	3,498.95	26,159	0	0.0	0	9	14	13.62	13.38	0.00
	097	OL 200 HP	23,891.18	298.33	23,592.85	123,296	0	0.0	0	56	122	19.38	19.14	1,749.07
	098	OL 400 HP	21,735.56	335.30	21,400.26	138,096	0	0.0	0	13	69	15.74	15.50	2,211.48
	107	OL 200HPF	36,647.16	406.87	36,240.29	167,612	0	0.0	0	94	167	21.86	21.62	1,580.28
	109	OL400 HPF	136,733.45	2,178.16	134,555.29	898,658	0	0.0	0	192	450	15.22	14.97	4,478.00
	110	OL 250 MH	2,294.25	26.11	2,268.14	10,836	0	0.0	0	6	9	21.17	20.93	64.30
	111	OL100 HPP	69,215.50	390.06	68,825.44	160,191	0	0.0	0	37	331	43.21	42.96	256.94
	113	OL 150 HP	52,611.45	519.18	52,092.27	213,475	0	0.0	0	146	304	24.65	24.40	6,279.79
	116	OL 400 MH	26,287.17	377.89	25,909.28	155,472	0	0.0	0	21	82	16.91	16.66	699.21
	120	OL 250HPP	380.75	3.08	377.67	1,236	0	0.0	0	1	1	30.81	30.56	0.00
	122	OL150 HPP	10,952.47	54.59	10,897.88	22,528	0	0.0	0	6	32	48.62	48.37	0.00
	131	OL 1000MH	4,562.13	88.06	4,474.07	36,320	0	0.0	0	6	8	12.56	12.32	64.28
	204	GS-MTRD	11,696.13	87.48	11,608.65	27,603	0	0.0	43	0	0	42.37	42.06	0.00
	211	GS SEC	2,291,789.42	33,483.78	2,258,305.64	14,297,609	76,154	22,345.1	2,017	0	0	16.03	15.79	0.00
	213	GS-UMR	92,914.88	348.85	92,566.03	560,460	0	0.0	135	0	0	16.58	16.52	0.00
	214	GS - AF	60,206.89	1,207.93	58,998.96	473,540	0	7,025.5	19	0	0	12.71	12.46	0.00
	215	GS SEC	7,768,566.37	151,415.78	7,617,150.59	59,112,577	0	226,337.9	720	0	0	13.14	12.89	0.00
	217	GS PRI	132,664.39	1,486.61	131,177.78	522,650	0	10,387.8	4	0	0	25.38	25.10	0.00
	218	GS M SEC	28,034.39	495.57	27,538.82	214,880	0	751.2	1	0	0	13.05	12.82	0.00
	223	GS LM ON	3,242.11	48.68	3,193.43	22,568	14,653	0.0	3	0	0	14.37	14.15	0.00
	225	GS LM TOD	3,653.17	52.90	3,600.27	24,680	14,392	0.0	3	0	0	14.80	14.59	0.00
	229	GS-TOD	22,294.03	450.69	21,843.34	155,177	86,992	0.0	10	0	0	14.37	14.08	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
	240	LGS SEC	8,176,415.65	192,094.79	7,984,320.86	71,685,137	0	188,303.0	93	0	0	11.41	11.14	0.00
	242	LGS M SEC	693,500.36	15,488.48	678,011.88	6,281,800	0	14,717.0	6	0	0	11.04	10.79	0.00
	244	LGS PRI	301,501.49	7,952.84	293,548.65	2,913,600	0	8,724.0	3	0	0	10.35	10.08	0.00
	246	LGS M PRI	68,865.33	1,887.24	66,978.09	676,080	0	1,914.0	1	0	0	10.19	9.91	0.00
	251	LGS-LM-TD	85,325.38	1,517.01	83,808.37	776,832	444,480	0.0	2	0	0	10.98	10.79	0.00
	358	IGS PRI	2,267,793.90	74,520.28	2,193,273.62	27,121,800	0	55,320.0	4	0	0	8.36	8.09	0.00
	540	MW	222,404.42	5,336.33	217,068.09	2,003,777	0	2,885.0	10	0	0	11.10	10.83	0.00
Total 216			22,649,486.54	492,903.85	22,156,582.69	188,942,328	636,671	538,710.5	3,074	725	1,806	11.99	11.73	17,839.25
221	093	OL 175 MV	1,202.08	17.03	1,185.05	6,912	0	0.0	0	8	8	17.39	17.14	0.00
	094	OL 100 HP	7,931.91	68.98	7,862.93	28,552	0	0.0	0	33	59	27.78	27.54	128.02
	095	OL 400 MV	1,075.80	18.49	1,057.31	7,584	0	0.0	0	3	4	14.19	13.94	40.48
	097	OL 200 HP	5,957.24	80.23	5,877.01	32,591	0	0.0	0	9	32	18.28	18.03	144.71
	098	OL 400 HP	559.34	9.57	549.77	3,999	0	0.0	0	1	2	13.99	13.75	0.00
	107	OL 200HPF	4,130.14	49.61	4,080.53	19,858	0	0.0	0	13	20	20.80	20.55	0.00
	109	OL400 HPF	55,318.25	884.46	54,433.79	365,714	0	0.0	0	42	183	15.13	14.88	1,505.28
	110	OL 250 MH	1,650.06	19.40	1,630.66	7,974	0	0.0	0	1	7	20.69	20.45	0.00
	111	OL100 HPP	1,248.30	7.19	1,241.11	2,904	0	0.0	0	1	6	42.99	42.74	0.00
	113	OL 150 HP	8,216.46	83.77	8,132.69	34,502	0	0.0	0	28	49	23.81	23.57	754.31
	116	OL 400 MH	10,705.82	156.02	10,549.80	64,958	0	0.0	0	11	34	16.48	16.24	64.06
	131	OL 1000MH	3,526.04	67.22	3,458.82	27,132	0	0.0	0	3	6	13.00	12.75	128.02
	204	GS-MTRD	1,557.64	21.40	1,536.24	7,735	0	0.0	3	0	0	20.14	19.86	0.00
	211	GS SEC	578,605.44	8,867.27	569,738.17	3,367,886	0	4,280.7	599	0	0	17.18	16.92	0.00
	215	GS SEC	1,290,937.01	25,609.05	1,265,327.96	9,717,123	0	40,975.3	126	0	0	13.29	13.02	0.00
	217	GS PRI	27,814.46	496.01	27,318.45	189,786	0	1,038.6	5	0	0	14.66	14.39	0.00
	220	GSCC PRI	165,076.58	3,449.15	161,627.43	1,348,040	0	3,542.6	11	0	0	12.25	11.99	0.00
	236	GSCC SUB	22,065.50	492.53	21,572.97	178,500	0	252.3	1	0	0	12.36	12.09	0.00
	240	LGS SEC	3,940,353.73	83,607.10	3,856,746.63	29,717,070	0	132,394.0	49	0	0	13.26	12.98	0.00
	244	LGS PRI	1,548,705.98	35,161.67	1,513,544.31	13,065,900	0	54,292.0	11	0	0	11.85	11.58	0.00
	248	LGS SUB	257,070.06	8,109.33	248,960.73	2,841,300	0	9,244.0	2	0	0	9.05	8.76	0.00
	250	LGS TRAN	289,588.06	7,715.12	281,872.94	3,528,000	0	7,271.0	1	0	0	8.21	7.99	0.00
	321	CS-IRP	61,324.87	3,090.78-	64,415.65	1,050,000	0	3,822.0	0	0	0	5.84	6.13	0.00
	331	CS-IRP ST	7,857,820.21	427,708.60	7,430,111.61	143,328,000	0	253,656.0	1	0	0	5.48	5.18	0.00
	332	CS-IRP TR	375,435.31	7,887.20	367,548.11	4,116,000	0	13,776.0	0	0	0	9.12	8.93	0.00
	358	IGS PRI	7,178,360.17	257,900.46	6,920,459.71	94,152,100	0	173,459.0	12	0	0	7.62	7.35	0.00
	359	IGS SUB	7,264,916.04	240,835.16	7,024,080.88	92,018,600	0	268,034.0	6	0	0	7.90	7.63	0.00
	360	IGS	1,186,695.74	26,488.28	1,160,207.46	9,306,000	0	47,501.0	1	0	0	12.75	12.47	0.00
	371	IGS	72,277,634.03	3,735,652.56	68,541,981.47	1,296,589,000	0	1,953,839.0	4	0	0	5.57	5.29	0.00
	372	IGS	17,189,863.39	918,525.21	16,271,338.18	317,929,026	0	456,642.0	2	0	0	5.41	5.12	0.00
Total 221			121,615,345.66	5,786,897.29	115,828,448.37	2,023,052,746	0	3,424,019.5	835	152	411	6.01	5.73	2,764.88

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
222	097	OL 200 HP	771.36	9.65	761.71	4,048	0	0.0	0	2	4	19.06	18.82	47.60
	107	OL 200HPF	210.17	2.43	207.74	1,012	0	0.0	0	1	1	20.77	20.53	0.00
	109	OL400 HPF	2,110.94	33.98	2,076.96	13,986	0	0.0	0	4	7	15.09	14.85	47.56
	113	OL 150 HP	1,642.92	15.44	1,627.48	6,336	0	0.0	0	5	9	25.93	25.69	256.16
	211	GS SEC	43,570.48	669.70	42,900.78	302,729	0	426.3	27	0	0	14.39	14.17	0.00
	215	GS SEC	149,749.46	2,327.04	147,422.42	1,107,320	0	5,497.6	17	0	0	13.52	13.31	0.00
	220	GSCC PRI	24,979.19	456.61	24,522.58	201,000	0	636.0	2	0	0	12.43	12.20	0.00
	229	GS-TOD	4,562.44	37.43	4,525.01	42,000	30,000	0.0	1	0	0	10.86	10.77	0.00
	240	LGS SEC	1,235,908.46	27,084.18	1,208,824.28	9,913,224	0	38,016.0	11	0	0	12.47	12.19	0.00
	244	LGS PRI	351,350.77	10,525.57	340,825.20	3,863,400	0	6,395.0	1	0	0	9.09	8.82	0.00
	251	LGS-LM-TD	1,251.42	1.43	1,249.99	500	300	0.0	1	0	0	250.28	250.00	0.00
	358	IGS PRI	906,026.62	29,440.76	876,585.86	10,352,400	0	23,107.0	1	0	0	8.75	8.47	0.00
	359	IGS SUB	97,794.29	925.24	96,869.05	264,000	0	5,066.0	0	0	0	37.04	36.69	0.00
Total 222			2,819,928.52	71,529.46	2,748,399.06	26,071,955	30,300	79,143.9	61	12	21	10.82	10.54	351.32
230	093	OL 175 MV	149.99	2.13	147.86	864	0	0.0	0	1	1	17.36	17.11	0.00
	094	OL 100 HP	1,056.72	9.36	1,047.36	3,871	0	0.0	0	7	8	27.30	27.06	0.00
	095	OL 400 MV	759.33	13.71	745.62	5,608	0	0.0	0	2	3	13.54	13.30	0.00
	097	OL 200 HP	9,313.87	117.06	9,196.81	48,576	0	0.0	0	8	48	19.17	18.93	608.29
	107	OL 200HPF	1,317.76	14.95	1,302.81	6,072	0	0.0	0	4	6	21.70	21.46	47.70
	109	OL400 HPF	12,494.96	201.30	12,293.66	81,993	0	0.0	0	19	41	15.24	14.99	392.83
	113	OL 150 HP	4,746.14	49.34	4,696.80	20,491	0	0.0	0	17	29	23.16	22.92	344.59
	116	OL 400 MH	932.22	14.02	918.20	5,688	0	0.0	0	2	3	16.39	16.14	0.00
	211	GS SEC	79,638.64	1,076.54	78,562.10	487,513	0	967.2	75	0	0	16.34	16.11	0.00
	215	GS SEC	430,056.03	7,369.60	422,686.43	3,163,636	0	15,025.5	64	0	0	13.59	13.36	0.00
	217	GS PRI	42,883.86	1,039.89	41,843.97	341,900	0	1,069.5	3	0	0	12.54	12.24	0.00
	220	GSCC PRI	377,083.21	8,219.17	368,864.04	2,913,005	0	8,884.3	35	0	0	12.94	12.66	0.00
	236	GSCC SUB	84,000.06	1,670.39	82,329.67	612,850	0	1,855.0	4	0	0	13.71	13.43	0.00
	240	LGS SEC	428,987.83	6,395.86	422,591.97	2,590,056	0	19,664.0	7	0	0	16.56	16.32	0.00
	244	LGS PRI	4,426,639.46	99,518.81	4,327,120.65	36,816,450	113,750	169,524.0	27	0	0	12.02	11.75	0.00
	248	LGS SUB	890,172.54	24,887.59	865,284.95	9,624,406	0	33,750.0	10	0	0	9.25	8.99	0.00
	250	LGS TRAN	187,637.20	6,656.39	180,980.81	2,051,000	0	8,206.0	2	0	0	9.15	8.82	0.00
	257	LGSPRITOD	282,429.21	8,375.65	274,053.56	3,353,300	1,957,700	4,914.0	1	0	0	8.42	8.17	0.00
	330	CS-IRP PR	707,182.46	10,493.22	696,689.24	4,277,000	0	27,159.0	1	0	0	16.53	16.29	0.00
	331	CS-IRP ST	4,235,593.35	165,096.88	4,070,496.47	61,732,000	0	162,677.0	2	0	0	6.86	6.59	0.00
	358	IGS PRI	9,853,294.99	231,060.52	9,622,234.47	83,683,200	0	284,558.0	12	0	0	11.77	11.50	0.00
	359	IGS SUB	11,224,092.92	346,997.67	10,877,095.25	125,207,700	0	417,171.0	8	0	0	8.96	8.69	0.00
	360	IGS	192,121.97	3,647.70	188,474.27	2,240,000	0	8,470.0	0	0	0	8.58	8.41	0.00
	371	IGS	817,877.64	26,947.47	790,930.17	12,075,000	0	20,314.0	1	0	0	6.55	6.40	0.00

REV CLASS	TARIFF		REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Total 230			34,290,462.36	949,875.22	33,340,587.14	351,342,179	2,071,450	1,184,208.5	253	60	139	9.76	9.49	1,393.41
400	093	OL 175 MV	299.92	4.27	295.65	1,728	0	0.0	0	1	2	17.36	17.11	0.00
	094	OL 100 HP	527.94	4.65	523.29	1,936	0	0.0	0	2	4	27.27	27.03	0.00
	097	OL 200 HP	178.90	2.41	176.49	1,012	0	0.0	0	1	1	17.68	17.44	0.00
	107	OL 200HPF	210.27	2.42	207.85	1,012	0	0.0	0	1	1	20.78	20.54	0.00
	109	OL400 HPF	6,957.51	110.90	6,846.61	45,899	0	0.0	0	7	23	15.16	14.92	192.75
	111	OL100 HPP	19,174.92	107.96	19,066.96	44,528	0	0.0	0	19	92	43.06	42.82	0.00
	113	OL 150 HP	746.89	6.82	740.07	2,816	0	0.0	0	2	4	26.52	26.28	128.30
	122	OL150 HPP	2,741.25	13.60	2,727.65	5,632	0	0.0	0	2	8	48.67	48.43	0.00
	131	OL 1000MH	561.35	10.88	550.47	4,540	0	0.0	0	1	1	12.36	12.12	0.00
	204	GS-MTRD	1,588.28	0.20	1,588.08	68	0	0.0	8	0	0	2,335.71	2,335.41	0.00
	211	GS SEC	150,609.17	1,477.43	149,131.74	579,721	0	410.3	260	0	0	25.98	25.72	0.00
	213	GS-UMR	214.49	0.17	214.32	60	0	0.0	1	0	0	357.48	357.20	0.00
	215	GS SEC	151,458.91	2,938.29	148,520.62	1,193,390	0	3,515.0	13	0	0	12.69	12.45	0.00
	528	SL	1,638,188.91	21,194.61	1,616,994.30	8,462,892	0	0.0	55	0	0	19.36	19.11	0.00
Total 400			1,973,458.71	25,874.61	1,947,584.10	10,345,234	0	3,925.3	337	36	136	19.08	18.83	321.05
Grand Total			578,240,938.66	14,899,116.16	563,341,822.50	5,865,874,234	11,922,829	8,485,550.4	166,602	45,270	54,306	9.86	9.60	284,861.52

State:

December 2018

REV CLASS	TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

American Electric Power

TARIFF SUMMARY REVENUE- BY REVENUE CLASS

12 MONTHS BILLED + ESTIMATED - MCSR0162 - FINAL

Standard Service Offer

Prepared: 01/09/2019 03:10:59

State:

December 2018

REV CLASS	TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total	0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

REV CLASS	TARIFF	REVENUE	FUEL CLAUSE	REVENUE EXCL FUEL CLAUSE	METERED KWH	OFF PEAK KWH	BILLING DEMAND	# OF CUST INCL	# OF CUST EXCL	# OF LAMPS	REALIZATION INCL FUEL	REALIZATION EXCL FUEL	FACILITY CHARGE
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

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December 2019

											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
011	RSW-LMWH	176,111.60	1,018.06	175,093.54	1,594,093	0	0.0	79	0	0	11.05	10.98	0.00
012	RSW-A	24,466.27	139.53	24,326.74	225,237	0	0.0	10	0	0	10.86	10.80	0.00
013	RSW-B	2,840.55	17.61	2,822.94	26,649	0	0.0	1	0	0	10.66	10.59	0.00
015	RS	108,641,862.69	560,843.25	108,081,019.44	904,328,373	65,150	8,594.1	64,555	0	0	12.01	11.95	0.00
017	RS EMP	908,491.38	5,966.11	902,525.27	7,796,057	0	0.0	413	0	0	11.65	11.58	0.00
022	RSW-RS	131,024,708.16	778,282.47	130,246,425.69	1,108,285,091	37,803	18,604.2	68,766	0	0	11.82	11.75	0.00
028	AORH-W ON	9,800.80	64.35	9,736.45	91,644	62,220	0.0	6	0	0	10.69	10.62	0.00
030	RSW-ONPK	156,089.73	925.67	155,164.06	1,389,927	833,639	0.0	66	0	0	11.23	11.16	0.00
032	RS LM-ON	187,812.31	1,242.93	186,569.38	1,699,768	1,079,326	0.0	82	0	0	11.05	10.98	0.00
034	AORH-ON	1,352.40	8.44	1,343.96	11,520	6,207	0.0	2	0	0	11.74	11.67	0.00
036	RS-TOD-ON	11,744.00	63.98	11,680.02	105,469	65,185	0.0	5	0	0	11.14	11.07	0.00
093	OL 175 MV	100,568.72	299.84	100,268.88	593,367	0	0.0	0	656	690	16.95	16.90	105.60
094	OL 100 HP	2,782,320.62	5,023.20	2,777,297.42	10,337,267	0	0.0	0	19,684	21,297	26.92	26.87	57,076.47
095	OL 400 MV	20,546.95	77.43	20,469.52	151,902	0	0.0	0	57	80	13.53	13.48	25.44
097	OL 200 HP	317,618.55	876.19	316,742.36	1,745,172	0	0.0	0	1,305	1,719	18.20	18.15	10,695.19
098	OL 400 HP	66,120.37	153.04	65,967.33	447,197	0	0.0	0	83	224	14.79	14.75	3,470.40
099	OL175 MVP	1,558.22	3.80	1,554.42	7,854	0	0.0	0	4	9	19.84	19.79	0.00
103	OL 250 HP	489.16	1.04	488.12	2,482	0	0.0	0	1	2	19.71	19.67	0.00
107	OL 200HPF	378,831.04	880.45	377,950.59	1,782,802	0	0.0	0	1,238	1,755	21.25	21.20	10,881.48
109	OL400 HPF	1,237,794.13	4,110.80	1,233,683.33	8,189,853	0	0.0	0	1,714	4,083	15.11	15.06	36,150.68
110	OL 250 MH	36,203.66	83.67	36,119.99	166,950	0	0.0	0	74	138	21.69	21.64	2,001.62
111	OL100 HPP	167,407.25	200.52	167,206.73	386,073	0	0.0	0	206	793	43.36	43.31	1,514.40
113	OL 150 HP	3,376,956.48	8,216.40	3,368,740.08	15,577,261	0	0.0	0	19,523	22,075	21.68	21.63	155,689.92
116	OL 400 MH	300,693.40	734.45	299,958.95	1,787,664	0	0.0	0	295	942	16.82	16.78	8,611.26
120	OL 250HPP	767.05	1.01	766.04	2,540	0	0.0	0	2	2	30.20	30.16	0.00
122	OL150 HPP	23,838.35	23.38	23,814.97	49,005	0	0.0	0	18	69	48.64	48.60	0.00
126	OL 400HPP	1,566.43	1.98	1,564.45	5,640	0	0.0	0	2	3	27.77	27.74	0.00
130	OL 250MON	1,165.24	1.71	1,163.53	4,453	0	0.0	0	4	4	26.17	26.13	0.00

December 2019

											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
131	OL 1000MH	53,822.65	212.12	53,610.53	432,494	0	0.0	0	44	94	12.44	12.40	835.20
136	OL 400MON	410.32	1.56	408.76	2,132	0	0.0	0	1	1	19.25	19.17	0.00
204	GS-MTRD	222,517.72	474.95	222,042.77	1,200,175	0	0.0	460	0	0	18.54	18.50	0.00
211	GS SEC	22,895,881.34	80,168.64	22,815,712.70	138,810,964	113,051	196,622.7	22,345	0	0	16.49	16.44	0.00
213	GS-UMR	440,475.22	1,780.82	438,694.40	2,293,718	0	0.0	583	0	0	19.20	19.13	0.00
214	GS - AF	173,318.05	552.40	172,765.65	1,301,689	0	27,602.6	85	0	0	13.31	13.27	0.00
215	GS SEC	57,272,590.39	210,647.01	57,061,943.38	432,933,636	0	1,787,688.3	6,348	0	0	13.23	13.18	0.00
217	GS PRI	391,627.84	1,602.38	390,025.46	2,758,962	0	14,406.8	27	0	0	14.19	14.14	0.00
218	GS M SEC	29,375.58	123.42	29,252.16	222,385	0	732.8	1	0	0	13.21	13.15	0.00
220	GSCC PRI	620,061.70	3,011.25	617,050.45	5,124,246	0	12,823.8	48	0	0	12.10	12.04	0.00
223	GS LM ON	105,830.29	777.27	105,053.02	885,295	541,473	0.0	42	0	0	11.95	11.87	0.00
225	GS LM TOD	39,205.88	155.33	39,050.55	272,526	160,368	0.0	31	0	0	14.39	14.33	0.00
227	EXP GSTOD	834,443.49	1,710.35	832,733.14	6,942,484	5,722,015	0.0	463	0	0	12.02	11.99	0.00
229	GS-TOD	497,405.47	2,206.69	495,198.78	4,014,494	2,384,078	532.8	98	0	0	12.39	12.34	0.00
236	GSCC SUB	108,433.06	508.69	107,924.37	818,985	0	2,497.1	5	0	0	13.24	13.18	0.00
240	LGS SEC	42,889,881.30	161,610.66	42,728,270.64	376,516,709	0	1,056,771.0	541	0	0	11.39	11.35	0.00
242	LGS M SEC	820,604.67	3,989.18	816,615.49	7,555,387	0	17,688.0	7	0	0	10.86	10.81	0.00
244	LGS PRI	8,512,273.97	41,525.35	8,470,748.62	75,807,094	0	296,886.0	64	0	0	11.23	11.17	0.00
246	LGS M PRI	66,973.04	228.16	66,744.88	668,438	0	1,882.0	1	0	0	10.02	9.99	0.00
248	LGS SUB	1,369,753.22	7,348.86	1,362,404.36	16,473,714	0	45,331.0	14	0	0	8.31	8.27	0.00
250	LGS TRAN	231,254.45	-1,140.34	232,394.79	4,459,289	0	5,631.0	1	0	0	5.19	5.21	0.00
251	LGS-LM-TD	202,317.45	946.93	201,370.52	1,784,201	961,600	0.0	7	0	0	11.34	11.29	0.00
256	LGSSECTOD	518,573.16	2,241.18	516,331.98	5,215,258	2,874,864	10,364.0	7	0	0	9.94	9.90	0.00
257	LGSPRITOD	450,119.03	2,474.34	447,644.69	5,326,086	2,987,250	8,467.0	2	0	0	8.45	8.40	0.00
260	PS SEC	13,006,063.39	52,840.44	12,953,222.95	106,220,116	0	396,857.0	156	0	0	12.24	12.19	0.00
264	PS PRI	224,314.33	1,163.37	223,150.96	2,147,036	0	7,465.0	1	0	0	10.45	10.39	0.00
330	CS-IRP PR	704,026.56	495.88	703,530.68	3,897,069	0	29,857.0	1	0	0	18.07	18.05	0.00
331	CS-IRP ST	10,376,123.55	108,216.57	10,267,906.98	180,310,176	0	354,434.0	3	0	0	5.75	5.69	0.00

American Electric Power
KENTUCKY POWER COMPANY

TARIFF SUMMARY REVENUE - ALL REVENUE CLASSES

12 MONTHS BILLED AND ACCRUED - MCSR0162 - FINAL

Prepared: 01/08/2020 01:01:49 AM

Go To TOC

December 2019

											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
333	CS-IRP	406,251.80	2,522.02	403,729.78	7,197,323	0	16,632.0	0	0	0	5.64	5.61	0.00
356	IGS SEC	1,912,870.88	9,923.08	1,902,947.80	19,171,670	0	40,930.0	5	0	0	9.98	9.93	0.00
358	IGS PRI	31,282,371.82	142,352.37	31,140,019.45	342,793,662	0	842,230.0	44	0	0	9.13	9.08	0.00
359	IGS SUB	13,461,528.65	95,756.96	13,365,771.69	150,528,128	0	515,224.0	15	0	0	8.94	8.88	0.00
360	IGS	2,321,160.33	14,007.71	2,307,152.62	21,690,199	0	103,859.0	2	0	0	10.70	10.64	0.00
370	IGS	420,505.61	-8,347.16	428,852.77	7,394,400	-1,720,800	14,014.2	0	0	0	5.69	5.80	0.00
371	IGS	69,838,108.04	700,128.14	69,137,979.90	1,300,513,822	0	1,958,038.0	5	0	0	5.37	5.32	0.00
372	IGS	17,619,737.35	169,331.03	17,450,406.32	320,988,302	-2,814,000	515,094.0	3	0	0	5.49	5.44	0.00
528	SL	1,628,767.37	6,015.92	1,622,751.45	8,435,679	0	0.0	54	0	0	19.31	19.24	0.00
540	MW	204,123.56	869.75	203,253.81	1,871,065	0	2,867.8	9	0	0	10.91	10.86	0.00
Grand Total - Summary		**552,112,828.04**	**3,187,694.59**	**548,925,133.45**	**5,631,770,318**	**13,359,429**	**8,310,627.2**	**165,462**	**44,911**	**53,979**	**9.80**	**9.75**	**287,057.66**

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
010	011	RSW-LMWH	51,560.38	254.11	51,306.27	460,093	0	0.0	30	0	0	11.21	11.15	0.00
	015	RS	55,153,556.87	241,788.65	54,911,768.22	450,028,006	11,534	4,952.5	37,524	0	0	12.26	12.20	0.00
	022	RSW-RS	20,014,145.26	103,493.26	19,910,652.00	165,382,124	0	696.4	12,579	0	0	12.10	12.04	0.00
	036	RS-TOD-ON	1,614.10	17.62	1,596.48	10,850	6,052	0.0	2	0	0	14.88	14.71	0.00
	093	OL 175 MV	52,070.75	157.51	51,913.24	309,376	0	0.0	0	355	358	16.83	16.78	64.80
	094	OL 100 HP	1,084,426.85	1,993.41	1,082,433.44	4,060,678	0	0.0	0	7,883	8,374	26.71	26.66	17,942.17
	095	OL 400 MV	1,510.59	6.33	1,504.26	11,446	0	0.0	0	4	6	13.20	13.14	0.00
	097	OL 200 HP	63,875.02	181.03	63,693.99	363,675	0	0.0	0	332	358	17.56	17.51	1,120.67
	098	OL 400 HP	572.66	1.13	571.53	4,277	0	0.0	0	2	2	13.39	13.36	0.00
	107	OL 200HPF	52,702.40	125.42	52,576.98	257,231	0	0.0	0	212	255	20.49	20.44	863.38
	109	OL400 HPF	50,059.74	163.57	49,896.17	345,946	0	0.0	0	110	173	14.47	14.42	751.02
	110	OL 250 MH	2,905.73	7.35	2,898.38	14,613	0	0.0	0	12	12	19.88	19.83	0.00
	111	OL100 HPP	5,606.79	6.88	5,599.91	13,332	0	0.0	0	16	28	42.06	42.00	64.80
	113	OL 150 HP	932,668.60	2,285.42	930,383.18	4,359,586	0	0.0	0	5,625	6,178	21.39	21.34	37,120.73
	116	OL 400 MH	6,009.22	18.13	5,991.09	36,621	0	0.0	0	13	19	16.41	16.36	210.48
	122	OL150 HPP	612.80	0.88	611.92	1,319	0	0.0	0	2	2	46.46	46.39	0.00
	136	OL 400MON	369.21	1.24	367.97	1,898	0	0.0	0	1	1	19.45	19.39	0.00
	211	GS SEC	1,565.79	-0.93	1,566.72	13,080	0	0.0	0	0	0	11.97	11.98	0.00
Total 010			**77,475,832.76**	**350,501.01**	**77,125,331.75**	**625,674,151**	**17,586**	**5,648.9**	**50,135**	**14,566**	**15,766**	**12.38**	**12.33**	**58,138.05**
020	011	RSW-LMWH	124,551.22	763.95	123,787.27	1,134,000	0	0.0	50	0	0	10.98	10.92	0.00
	012	RSW-A	24,466.27	139.53	24,326.74	225,237	0	0.0	10	0	0	10.86	10.80	0.00
	013	RSW-B	2,840.55	17.61	2,822.94	26,649	0	0.0	1	0	0	10.66	10.59	0.00
	015	RS	53,488,305.82	319,054.60	53,169,251.22	454,300,367	53,616	3,641.6	27,031	0	0	11.77	11.70	0.00
	017	RS EMP	908,491.38	5,966.11	902,525.27	7,796,057	0	0.0	413	0	0	11.65	11.58	0.00
	022	RSW-RS	111,010,562.90	674,789.21	110,335,773.69	942,902,967	37,803	17,907.8	56,187	0	0	11.77	11.70	0.00
	028	AORH-W ON	9,800.80	64.35	9,736.45	91,644	62,220	0.0	6	0	0	10.69	10.62	0.00
	030	RSW-ONPK	156,089.73	925.67	155,164.06	1,389,927	833,639	0.0	66	0	0	11.23	11.16	0.00
	032	RS LM-ON	187,812.31	1,242.93	186,569.38	1,699,768	1,079,326	0.0	82	0	0	11.05	10.98	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
020	034	AORH-ON	1,352.40	8.44	1,343.96	11,520	6,207	0.0	2	0	0	11.74	11.67	0.00
	036	RS-TOD-ON	10,129.90	46.36	10,083.54	94,619	59,133	0.0	3	0	0	10.71	10.66	0.00
	093	OL 175 MV	25,282.96	74.65	25,208.31	149,953	0	0.0	0	173	177	16.86	16.81	40.80
	094	OL 100 HP	1,440,263.50	2,582.01	1,437,681.49	5,355,238	0	0.0	0	10,332	11,032	26.89	26.85	33,283.07
	095	OL 400 MV	1,017.68	3.44	1,014.24	7,732	0	0.0	0	4	4	13.16	13.12	0.00
	097	OL 200 HP	88,613.95	245.89	88,368.06	503,305	0	0.0	0	465	496	17.61	17.56	1,837.55
	098	OL 400 HP	3,254.44	-31.41	3,285.85	22,787	0	0.0	0	13	14	14.28	14.42	105.60
	107	OL 200HPF	72,266.83	178.69	72,088.14	347,104	0	0.0	0	304	342	20.82	20.77	2,225.99
	109	OL400 HPF	73,861.84	259.67	73,602.17	500,162	0	0.0	0	193	251	14.77	14.72	2,222.93
	110	OL 250 MH	2,451.57	7.20	2,444.37	12,548	0	0.0	0	11	10	19.54	19.48	9.62
	111	OL100 HPP	21,805.14	25.45	21,779.69	51,448	0	0.0	0	89	107	42.38	42.33	477.60
	113	OL 150 HP	1,930,030.39	4,787.44	1,925,242.95	9,008,546	0	0.0	0	11,682	12,773	21.42	21.37	78,743.56
	116	OL 400 MH	5,511.94	16.39	5,495.55	34,497	0	0.0	0	12	18	15.98	15.93	40.80
	120	OL 250HPP	372.38	0.49	371.89	1,255	0	0.0	0	1	1	29.67	29.63	0.00
	122	OL150 HPP	1,106.94	0.04	1,106.90	2,397	0	0.0	0	5	3	46.18	46.18	0.00
	126	OL 400HPP	437.56	-0.09	437.65	1,596	0	0.0	0	1	1	27.42	27.42	0.00
	130	OL 250MON	523.06	0.70	522.36	2,034	0	0.0	0	2	2	25.72	25.68	0.00
	131	OL 1000MH	2,200.85	9.27	2,191.58	18,360	0	0.0	0	1	4	11.99	11.94	0.00
	211	GS SEC	1,094.33	5.79	1,088.54	5,907	0	0.0	1	0	0	18.53	18.43	0.00
Total 020			**169,594,498.64**	**1,011,184.38**	**168,583,314.26**	**1,425,697,624**	**2,131,944**	**21,549.4**	**83,852**	**23,289**	**25,235**	**11.90**	**11.82**	**118,987.52**
211	093	OL 175 MV	13,639.44	40.50	13,598.94	78,769	0	0.0	0	75	90	17.32	17.26	0.00
	094	OL 100 HP	175,607.78	304.19	175,303.59	627,701	0	0.0	0	1,051	1,291	27.98	27.93	3,970.02
	095	OL 400 MV	8,137.78	29.32	8,108.46	60,259	0	0.0	0	26	31	13.50	13.46	0.00
	097	OL 200 HP	92,362.95	250.46	92,112.49	496,410	0	0.0	0	303	484	18.61	18.56	3,711.30
	098	OL 400 HP	18,402.40	90.25	18,312.15	129,870	0	0.0	0	36	67	14.17	14.10	434.40
	099	OL175 MVP	1,383.51	3.18	1,380.33	6,984	0	0.0	0	3	8	19.81	19.76	0.00
	103	OL 250 HP	489.16	1.04	488.12	2,482	0	0.0	0	1	2	19.71	19.67	0.00
	107	OL 200HPF	137,763.48	312.76	137,450.72	641,094	0	0.0	0	406	629	21.49	21.44	2,991.32

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
211	109	OL400 HPF	543,353.35	1,815.18	541,538.17	3,597,722	0	0.0	0	746	1,795	15.10	15.05	14,176.41
	110	OL 250 MH	15,693.38	35.85	15,657.53	71,611	0	0.0	0	34	59	21.91	21.86	931.20
	111	OL100 HPP	39,171.65	44.51	39,127.14	88,812	0	0.0	0	34	184	44.11	44.06	567.00
	113	OL 150 HP	336,416.37	755.67	335,660.70	1,468,151	0	0.0	0	1,582	2,079	22.91	22.86	21,853.39
	116	OL 400 MH	164,761.48	337.19	164,424.29	977,320	0	0.0	0	150	521	16.86	16.82	4,731.80
	122	OL150 HPP	8,303.55	9.12	8,294.43	16,993	0	0.0	0	3	24	48.86	48.81	0.00
	126	OL 400HPP	1,128.87	2.07	1,126.80	4,044	0	0.0	0	1	2	27.91	27.86	0.00
	130	OL 250MON	642.18	1.01	641.17	2,419	0	0.0	0	2	2	26.55	26.51	0.00
	131	OL 1000MH	27,147.08	110.91	27,036.17	217,910	0	0.0	0	24	48	12.46	12.41	446.40
	136	OL 400MON	41.11	0.32	40.79	234	0	0.0	0	0	0	17.57	17.43	0.00
	204	GS-MTRD	208,996.60	474.39	208,522.21	1,173,248	0	0.0	406	0	0	17.81	17.77	0.00
	211	GS SEC	16,199,666.76	52,969.61	16,146,697.15	95,356,181	36,913	111,006.6	16,839	0	0	16.99	16.93	0.00
	213	GS-UMR	350,318.24	700.53	349,617.71	1,804,579	0	0.0	448	0	0	19.41	19.37	0.00
	214	GS - AF	3,563.34	-8.90	3,572.24	14,813	0	842.6	6	0	0	24.06	24.12	0.00
	215	GS SEC	27,290,718.41	91,703.02	27,199,015.39	207,721,109	0	835,607.1	3,072	0	0	13.14	13.09	0.00
	217	GS PRI	106,041.58	398.58	105,643.00	818,890	0	2,952.6	7	0	0	12.95	12.90	0.00
	220	GSCC PRI	62,090.79	540.89	61,549.90	534,853	0	1,262.2	3	0	0	11.61	11.51	0.00
	223	GS LM ON	7,917.96	26.26	7,891.70	59,390	31,763	0.0	4	0	0	13.33	13.29	0.00
	225	GS LM TOD	1,357.23	5.82	1,351.41	6,548	3,776	0.0	2	0	0	20.73	20.64	0.00
	227	EXP GSTOD	549,428.60	958.62	548,469.98	4,454,103	3,626,984	0.0	332	0	0	12.34	12.31	0.00
	229	GS-TOD	166,764.70	635.77	166,128.93	1,354,330	826,604	532.8	38	0	0	12.31	12.27	0.00
	236	GSCC SUB	21,694.27	60.74	21,633.53	141,180	0	766.2	1	0	0	15.37	15.32	0.00
	240	LGS SEC	12,217,191.41	42,776.91	12,174,414.50	110,927,068	0	270,344.0	160	0	0	11.01	10.98	0.00
	244	LGS PRI	1,344,452.42	5,777.10	1,338,675.32	13,870,340	0	34,395.0	12	0	0	9.69	9.65	0.00
	248	LGS SUB	329,641.39	1,371.19	328,270.20	4,353,767	0	8,909.0	3	0	0	7.57	7.54	0.00
	256	LGSSECTOD	518,573.16	2,241.18	516,331.98	5,215,258	2,874,864	10,364.0	7	0	0	9.94	9.90	0.00
	356	IGS SEC	1,583,718.34	9,206.30	1,574,512.04	16,795,659	0	33,362.0	4	0	0	9.43	9.37	0.00
	358	IGS PRI	6,898,576.03	38,939.53	6,859,636.50	92,094,104	0	164,691.0	9	0	0	7.49	7.45	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
211	359	IGS SUB	1,292,352.97	7,857.84	1,284,495.13	21,044,833	0	38,265.0	3	0	0	6.14	6.10	0.00
Total 211			**70,737,509.72**	**260,778.91**	**70,476,730.81**	**586,229,038**	**7,400,904**	**1,513,300.1**	**21,354**	**4,477**	**7,315**	**12.07**	**12.02**	**54,813.24**
212	093	OL 175 MV	2,122.02	5.38	2,116.64	12,264	0	0.0	0	14	14	17.30	17.26	0.00
	094	OL 100 HP	41,003.05	72.02	40,931.03	145,600	0	0.0	0	237	299	28.16	28.11	1,188.00
	095	OL 400 MV	3,946.87	17.69	3,929.18	28,944	0	0.0	0	9	16	13.64	13.58	0.00
	097	OL 200 HP	27,497.62	74.76	27,422.86	147,010	0	0.0	0	109	145	18.70	18.65	1,208.13
	098	OL 400 HP	7,673.86	13.15	7,660.71	52,066	0	0.0	0	13	25	14.74	14.71	348.00
	099	OL175 MVP	174.71	0.62	174.09	870	0	0.0	0	1	1	20.08	20.01	0.00
	107	OL 200HPF	53,190.19	118.68	53,071.51	246,657	0	0.0	0	159	243	21.56	21.52	1,624.17
	109	OL400 HPF	218,946.06	680.52	218,265.54	1,442,095	0	0.0	0	298	716	15.18	15.14	6,802.72
	110	OL 250 MH	10,280.26	21.82	10,258.44	45,041	0	0.0	0	8	37	22.82	22.78	931.20
	111	OL100 HPP	4,703.47	4.81	4,698.66	10,456	0	0.0	0	6	21	44.98	44.94	145.80
	113	OL 150 HP	97,368.52	216.86	97,151.66	414,191	0	0.0	0	405	584	23.51	23.46	8,326.59
	116	OL 400 MH	56,477.45	165.85	56,311.60	333,799	0	0.0	0	65	176	16.92	16.87	1,821.34
	131	OL 1000MH	15,200.87	54.52	15,146.35	122,892	0	0.0	0	8	26	12.37	12.32	129.60
	211	GS SEC	3,179,071.96	13,037.32	3,166,034.64	21,565,970	0	48,027.5	2,270	0	0	14.74	14.68	0.00
	215	GS SEC	17,486,617.37	68,799.30	17,417,818.07	130,805,742	0	578,599.6	2,095	0	0	13.37	13.32	0.00
	217	GS PRI	115,735.97	526.07	115,209.90	962,351	0	2,719.5	5	0	0	12.03	11.97	0.00
	223	GS LM ON	88,746.82	656.00	88,090.82	741,717	448,912	0.0	34	0	0	11.97	11.88	0.00
	225	GS LM TOD	34,128.47	124.56	34,003.91	240,713	142,114	0.0	26	0	0	14.18	14.13	0.00
	227	EXP GSTOD	285,014.89	751.73	284,263.16	2,488,381	2,095,031	0.0	131	0	0	11.45	11.42	0.00
	229	GS-TOD	294,705.66	1,464.09	293,241.57	2,411,403	1,442,162	0.0	49	0	0	12.22	12.16	0.00
	240	LGS SEC	14,900,297.75	63,523.92	14,836,773.83	133,229,893	0	349,511.0	186	0	0	11.18	11.14	0.00
	242	LGS M SEC	155,849.57	724.73	155,124.84	1,438,327	0	3,365.0	1	0	0	10.84	10.79	0.00
	244	LGS PRI	917,117.29	5,798.88	911,318.41	9,332,092	0	24,893.0	7	0	0	9.83	9.77	0.00
	248	LGS SUB	203,248.44	786.08	202,462.36	2,716,909	0	6,468.0	1	0	0	7.48	7.45	0.00
	251	LGS-LM-TD	90,305.75	774.85	89,530.90	758,932	384,340	0.0	4	0	0	11.90	11.80	0.00
	358	IGS PRI	781,958.40	2,812.88	779,145.52	9,443,986	0	18,439.0	2	0	0	8.28	8.25	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
Total 212			**39,071,383.29**	**161,227.09**	**38,910,156.20**	**319,138,301**	**4,512,559**	**1,032,022.6**	**4,812**	**1,331**	**2,304**	**12.24**	**12.19**	**22,525.55**
213	093	OL 175 MV	905.39	2.86	902.53	5,226	0	0.0	0	6	6	17.32	17.27	0.00
	094	OL 100 HP	5,551.78	10.29	5,541.49	20,460	0	0.0	0	25	42	27.13	27.08	0.00
	095	OL 400 MV	1,028.90	3.73	1,025.17	7,614	0	0.0	0	3	4	13.51	13.46	0.00
	097	OL 200 HP	5,710.50	15.17	5,695.33	30,619	0	0.0	0	20	30	18.65	18.60	235.20
	098	OL 400 HP	4,950.28	14.06	4,936.22	32,723	0	0.0	0	5	16	15.13	15.08	348.00
	107	OL 200HPF	19,582.58	45.23	19,537.35	91,471	0	0.0	0	44	89	21.41	21.36	518.40
	109	OL400 HPF	132,764.01	453.18	132,310.83	864,475	0	0.0	0	96	429	15.36	15.31	5,412.93
	110	OL 250 MH	1,070.88	2.14	1,068.74	4,878	0	0.0	0	3	4	21.95	21.91	64.80
	111	OL100 HPP	6,091.83	7.46	6,084.37	14,103	0	0.0	0	4	29	43.20	43.14	0.00
	113	OL 150 HP	11,146.99	21.82	11,125.17	43,297	0	0.0	0	30	60	25.75	25.70	1,703.78
	116	OL 400 MH	25,536.79	88.84	25,447.95	152,951	0	0.0	0	19	78	16.70	16.64	736.20
	131	OL 1000MH	590.41	1.36	589.05	4,184	0	0.0	0	1	1	14.11	14.08	64.80
	211	GS SEC	326,595.92	1,487.87	325,108.05	2,152,090	0	4,310.5	248	0	0	15.18	15.11	0.00
	214	GS - AF	122,735.94	323.55	122,412.39	921,934	0	19,982.8	60	0	0	13.31	13.28	0.00
	215	GS SEC	2,477,858.70	10,606.94	2,467,251.76	18,580,178	0	75,023.1	207	0	0	13.34	13.28	0.00
	223	GS LM ON	6,159.00	83.06	6,075.94	64,212	47,840	0.0	1	0	0	9.59	9.46	0.00
	240	LGS SEC	2,411,743.64	8,712.63	2,403,031.01	20,545,542	0	64,635.0	36	0	0	11.74	11.70	0.00
	260	PS SEC	13,006,063.39	52,840.44	12,953,222.95	106,220,116	0	396,857.0	156	0	0	12.24	12.19	0.00
	264	PS PRI	224,314.33	1,163.37	223,150.96	2,147,036	0	7,465.0	1	0	0	10.45	10.39	0.00
	358	IGS PRI	383,348.88	1,235.69	382,113.19	4,029,531	0	10,449.0	1	0	0	9.51	9.48	0.00
	359	IGS SUB	193,499.05	393.02	193,106.03	1,880,388	0	6,543.0	1	0	0	10.29	10.27	0.00
Total 213			**19,367,249.19**	**77,512.71**	**19,289,736.48**	**157,813,028**	**47,840**	**585,265.4**	**711**	**256**	**789**	**12.27**	**12.22**	**9,084.11**
216	093	OL 175 MV	5,001.44	14.03	4,987.41	28,847	0	0.0	0	23	34	17.34	17.29	0.00
	094	OL 100 HP	26,169.05	44.17	26,124.88	93,957	0	0.0	0	118	191	27.85	27.81	563.61
	095	OL 400 MV	3,615.96	11.87	3,604.09	26,772	0	0.0	0	8	14	13.51	13.46	0.00
	097	OL 200 HP	24,304.33	60.76	24,243.57	124,924	0	0.0	0	56	122	19.46	19.41	1,799.40
	098	OL 400 HP	30,704.77	63.79	30,640.98	201,430	0	0.0	0	14	98	15.34	15.31	2,234.40

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
216	107	OL 200HPF	37,368.27	84.96	37,283.31	170,881	0	0.0	0	94	168	21.87	21.82	1,610.22
	109	OL400 HPF	141,493.71	482.85	141,010.86	931,856	0	0.0	0	196	464	15.18	15.13	4,528.04
	110	OL 250 MH	2,310.98	5.63	2,305.35	10,952	0	0.0	0	6	9	21.10	21.05	64.80
	111	OL100 HPP	69,372.47	83.48	69,288.99	160,034	0	0.0	0	37	326	43.35	43.30	259.20
	113	OL 150 HP	53,542.34	113.68	53,428.66	217,923	0	0.0	0	149	307	24.57	24.52	6,338.40
	116	OL 400 MH	29,278.84	71.08	29,207.76	172,409	0	0.0	0	22	89	16.98	16.94	1,011.24
	120	OL 250HPP	394.67	0.52	394.15	1,285	0	0.0	0	1	1	30.71	30.67	0.00
	122	OL150 HPP	11,138.26	10.69	11,127.57	22,833	0	0.0	0	6	32	48.78	48.73	0.00
	131	OL 1000MH	4,580.13	18.38	4,561.75	36,877	0	0.0	0	6	8	12.42	12.37	64.80
	204	GS-MTRD	10,429.00	-3.78	10,432.78	18,869	0	0.0	43	0	0	55.27	55.29	0.00
	211	GS SEC	2,288,539.68	10,203.68	2,278,336.00	14,452,912	76,138	26,446.2	2,026	0	0	15.83	15.76	0.00
	213	GS-UMR	89,939.49	1,080.26	88,859.23	489,078	0	0.0	135	0	0	18.39	18.17	0.00
	214	GS - AF	47,018.77	237.75	46,781.02	364,942	0	6,777.2	19	0	0	12.88	12.82	0.00
	215	GS SEC	7,735,072.97	31,425.49	7,703,647.48	58,810,773	0	226,545.6	731	0	0	13.15	13.10	0.00
	217	GS PRI	95,755.07	223.62	95,531.45	485,614	0	6,013.8	4	0	0	19.72	19.67	0.00
	218	GS M SEC	29,375.58	123.42	29,252.16	222,385	0	732.8	1	0	0	13.21	13.15	0.00
	223	GS LM ON	3,006.51	11.95	2,994.56	19,976	12,958	0.0	3	0	0	15.05	14.99	0.00
	225	GS LM TOD	3,720.18	24.95	3,695.23	25,265	14,478	0.0	3	0	0	14.72	14.63	0.00
	229	GS-TOD	35,442.93	98.49	35,344.44	242,761	109,312	0.0	10	0	0	14.60	14.56	0.00
	240	LGS SEC	8,195,458.02	31,787.59	8,163,670.43	73,269,675	0	190,057.0	94	0	0	11.19	11.14	0.00
	242	LGS M SEC	664,755.10	3,264.45	661,490.65	6,117,060	0	14,323.0	6	0	0	10.87	10.81	0.00
	244	LGS PRI	316,448.20	871.20	315,577.00	2,908,622	0	10,804.0	3	0	0	10.88	10.85	0.00
	246	LGS M PRI	66,973.04	228.16	66,744.88	668,438	0	1,882.0	1	0	0	10.02	9.99	0.00
	251	LGS-LM-TD	110,725.97	173.11	110,552.86	1,024,739	576,960	0.0	2	0	0	10.81	10.79	0.00
	358	IGS PRI	2,104,030.51	9,876.95	2,094,153.56	25,582,173	0	51,229.0	4	0	0	8.22	8.19	0.00
	540	MW	204,123.56	869.75	203,253.81	1,871,065	0	2,867.8	9	0	0	10.91	10.86	0.00
Total 216			**22,440,089.80**	**91,562.93**	**22,348,526.87**	**188,775,327**	**789,846**	**537,678.4**	**3,094**	**735**	**1,864**	**11.89**	**11.84**	**18,474.11**
221	093	OL 175 MV	1,202.69	4.05	1,198.64	6,936	0	0.0	0	8	8	17.34	17.28	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
221	094	OL 100 HP	7,784.68	14.04	7,770.64	28,069	0	0.0	0	30	57	27.73	27.68	129.60
	095	OL 400 MV	956.83	3.10	953.73	6,763	0	0.0	0	3	4	14.15	14.10	25.44
	097	OL 200 HP	5,861.71	14.74	5,846.97	32,196	0	0.0	0	8	32	18.21	18.16	128.26
	098	OL 400 HP	561.96	2.07	559.89	4,044	0	0.0	0	1	2	13.90	13.84	0.00
	107	OL 200HPF	4,246.86	10.75	4,236.11	20,444	0	0.0	0	12	20	20.77	20.72	0.00
	109	OL400 HPF	56,215.76	171.27	56,044.49	369,126	0	0.0	0	45	183	15.23	15.18	1,626.60
	110	OL 250 MH	1,490.86	3.68	1,487.18	7,307	0	0.0	0	1	6	20.40	20.35	0.00
	111	OL100 HPP	1,295.38	1.28	1,294.10	3,019	0	0.0	0	1	6	42.91	42.87	0.00
	113	OL 150 HP	8,499.43	20.40	8,479.03	35,341	0	0.0	0	25	49	24.05	23.99	871.40
	116	OL 400 MH	12,184.44	33.19	12,151.25	74,367	0	0.0	0	13	39	16.38	16.34	59.40
	131	OL 1000MH	3,539.87	15.29	3,524.58	27,666	0	0.0	0	3	6	12.80	12.74	129.60
	204	GS-MTRD	1,477.79	4.30	1,473.49	7,989	0	0.0	3	0	0	18.50	18.44	0.00
	211	GS SEC	619,661.69	1,639.22	618,022.47	3,814,098	0	4,502.1	604	0	0	16.25	16.20	0.00
	215	GS SEC	1,486,759.46	4,447.24	1,482,312.22	11,043,238	0	47,079.8	141	0	0	13.46	13.42	0.00
	217	GS PRI	59,371.97	108.70	59,263.27	384,978	0	2,427.2	8	0	0	15.42	15.39	0.00
	220	GSCC PRI	150,318.65	754.35	149,564.30	1,277,220	0	2,790.9	10	0	0	11.77	11.71	0.00
	236	GSCC SUB	3,741.13	-66.19	3,807.32	26,075	0	52.5	0	0	0	14.35	14.60	0.00
	240	LGS SEC	3,719,591.98	10,425.51	3,709,166.47	27,966,668	0	128,287.0	48	0	0	13.30	13.26	0.00
	244	LGS PRI	1,582,781.16	8,019.03	1,574,762.13	13,088,830	0	57,614.0	13	0	0	12.09	12.03	0.00
	248	LGS SUB	165,701.69	396.26	165,305.43	2,095,301	0	5,544.0	1	0	0	7.91	7.89	0.00
	250	LGS TRAN	199,149.29	-1,591.72	200,741.01	4,087,639	0	4,780.0	0	0	0	4.87	4.91	0.00
	331	CS-IRP ST	7,068,967.01	76,341.22	6,992,625.79	132,528,000	0	221,597.0	1	0	0	5.33	5.28	0.00
	358	IGS PRI	7,464,300.61	34,246.71	7,430,053.90	95,147,364	0	180,085.0	12	0	0	7.84	7.81	0.00
	359	IGS SUB	4,968,920.87	24,831.12	4,944,089.75	44,239,631	0	195,519.0	5	0	0	11.23	11.18	0.00
	360	IGS	973,592.73	6,060.12	967,532.61	9,144,000	0	46,459.0	1	0	0	10.65	10.58	0.00
	370	IGS	420,505.61	-8,347.16	428,852.77	7,394,400	-1,720,800	14,014.2	0	0	0	5.69	5.80	0.00
	371	IGS	69,260,395.92	695,702.40	68,564,693.52	1,290,721,333	0	1,941,504.0	4	0	0	5.37	5.31	0.00
	372	IGS	17,619,737.35	169,331.03	17,450,406.32	320,988,302	-2,814,000	515,094.0	3	0	0	5.49	5.44	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
Total 221			**115,868,815.38**	**1,022,596.00**	**114,846,219.38**	**1,964,570,344**	**-4,534,800**	**3,367,349.7**	**855**	**150**	**412**	**5.90**	**5.85**	**2,970.30**
222	097	OL 200 HP	716.45	1.93	714.52	3,719	0	0.0	0	2	4	19.26	19.21	42.68
	107	OL 200HPF	212.65	0.49	212.16	1,024	0	0.0	0	1	1	20.77	20.72	0.00
	109	OL400 HPF	2,373.84	7.65	2,366.19	15,812	0	0.0	0	5	8	15.01	14.96	48.00
	113	OL 150 HP	1,778.81	2.53	1,776.28	6,958	0	0.0	0	6	10	25.56	25.53	259.20
	211	GS SEC	49,651.12	175.44	49,475.68	349,934	0	736.5	29	0	0	14.19	14.14	0.00
	215	GS SEC	209,327.43	885.22	208,442.21	1,527,672	0	7,049.8	21	0	0	13.70	13.64	0.00
	220	GSCC PRI	25,202.11	149.36	25,052.75	201,043	0	642.0	2	0	0	12.54	12.46	0.00
	229	GS-TOD	492.18	8.34	483.84	6,000	6,000	0.0	0	0	0	8.20	8.06	0.00
	240	LGS SEC	991,485.58	2,976.13	988,509.45	7,971,108	0	32,437.0	9	0	0	12.44	12.40	0.00
	244	LGS PRI	354,196.73	1,738.18	352,458.55	3,983,475	0	6,744.0	1	0	0	8.89	8.85	0.00
	251	LGS-LM-TD	1,285.73	-1.03	1,286.76	530	300	0.0	1	0	0	242.59	242.78	0.00
	356	IGS SEC	329,152.54	716.78	328,435.76	2,376,011	0	7,568.0	1	0	0	13.85	13.82	0.00
	358	IGS PRI	944,634.73	3,498.38	941,136.35	12,047,589	0	22,917.0	1	0	0	7.84	7.81	0.00
Total 222			**2,910,509.90**	**10,159.40**	**2,900,350.50**	**28,490,875**	**6,300**	**78,094.3**	**65**	**14**	**22**	**10.22**	**10.18**	**349.88**
230	093	OL 175 MV	40.35	0.12	40.23	240	0	0.0	0	0	0	16.81	16.76	0.00
	094	OL 100 HP	979.28	2.12	977.16	3,598	0	0.0	0	6	7	27.22	27.16	0.00
	095	OL 400 MV	332.34	1.95	330.39	2,372	0	0.0	0	1	2	14.01	13.93	0.00
	097	OL 200 HP	8,494.97	30.88	8,464.09	42,294	0	0.0	0	8	48	20.09	20.01	612.00
	107	OL 200HPF	1,284.71	2.95	1,281.76	5,869	0	0.0	0	4	6	21.89	21.84	48.00
	109	OL400 HPF	11,719.47	51.06	11,668.41	76,297	0	0.0	0	18	40	15.36	15.29	387.63
	113	OL 150 HP	4,748.49	11.26	4,737.23	20,410	0	0.0	0	17	30	23.27	23.21	343.27
	116	OL 400 MH	933.24	3.78	929.46	5,700	0	0.0	0	2	3	16.37	16.31	0.00
	211	GS SEC	84,102.04	324.76	83,777.28	530,054	0	1,152.3	77	0	0	15.87	15.81	0.00
	215	GS SEC	427,547.59	2,219.10	425,328.49	3,188,162	0	13,867.6	67	0	0	13.41	13.34	0.00
	217	GS PRI	14,723.25	345.41	14,377.84	107,129	0	293.7	3	0	0	13.74	13.42	0.00
	220	GSCC PRI	382,450.15	1,566.65	380,883.50	3,111,130	0	8,128.7	32	0	0	12.29	12.24	0.00
	236	GSCC SUB	82,997.66	514.14	82,483.52	651,730	0	1,678.4	4	0	0	12.73	12.66	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
230	240	LGS SEC	454,112.92	1,407.97	452,704.95	2,606,755	0	21,500.0	8	0	0	17.42	17.37	0.00
	244	LGS PRI	3,997,278.17	19,320.96	3,977,957.21	32,623,735	0	162,436.0	28	0	0	12.25	12.19	0.00
	248	LGS SUB	671,161.70	4,795.33	666,366.37	7,307,737	0	24,410.0	9	0	0	9.18	9.12	0.00
	250	LGS TRAN	32,105.16	451.38	31,653.78	371,650	0	851.0	1	0	0	8.64	8.52	0.00
	257	LGSPRITOD	450,119.03	2,474.34	447,644.69	5,326,086	2,987,250	8,467.0	2	0	0	8.45	8.40	0.00
	330	CS-IRP PR	704,026.56	495.88	703,530.68	3,897,069	0	29,857.0	1	0	0	18.07	18.05	0.00
	331	CS-IRP ST	3,307,156.54	31,875.35	3,275,281.19	47,782,176	0	132,837.0	2	0	0	6.92	6.85	0.00
	333	CS-IRP	406,251.80	2,522.02	403,729.78	7,197,323	0	16,632.0	0	0	0	5.64	5.61	0.00
	358	IGS PRI	12,705,522.66	51,742.23	12,653,780.43	104,448,915	0	394,420.0	16	0	0	12.16	12.11	0.00
	359	IGS SUB	7,006,755.76	62,674.98	6,944,080.78	83,363,276	0	274,897.0	6	0	0	8.41	8.33	0.00
	360	IGS	1,347,567.60	7,947.59	1,339,620.01	12,546,199	0	57,400.0	1	0	0	10.74	10.68	0.00
	371	IGS	577,712.12	4,425.74	573,286.38	9,792,489	0	16,534.0	1	0	0	5.90	5.85	0.00
Total 230			**32,680,123.56**	**195,207.95**	**32,484,915.61**	**325,008,395**	**2,987,250**	**1,165,361.7**	**256**	**58**	**136**	**10.06**	**10.00**	**1,390.90**
400	093	OL 175 MV	303.68	0.74	302.94	1,756	0	0.0	0	1	2	17.29	17.25	0.00
	094	OL 100 HP	534.65	0.95	533.70	1,966	0	0.0	0	2	4	27.19	27.15	0.00
	097	OL 200 HP	181.05	0.57	180.48	1,020	0	0.0	0	1	1	17.75	17.69	0.00
	107	OL 200HPF	213.07	0.52	212.55	1,027	0	0.0	0	1	1	20.75	20.70	0.00
	109	OL400 HPF	7,006.35	25.85	6,980.50	46,362	0	0.0	0	7	23	15.11	15.06	194.40
	111	OL100 HPP	19,360.52	26.65	19,333.87	44,869	0	0.0	0	19	92	43.15	43.09	0.00
	113	OL 150 HP	756.54	1.32	755.22	2,858	0	0.0	0	2	4	26.47	26.42	129.60
	122	OL150 HPP	2,676.80	2.65	2,674.15	5,463	0	0.0	0	2	8	49.00	48.95	0.00
	131	OL 1000MH	563.44	2.39	561.05	4,605	0	0.0	0	1	1	12.24	12.18	0.00
	204	GS-MTRD	1,614.33	0.04	1,614.29	69	0	0.0	8	0	0	2,339.61	2,339.55	0.00
	211	GS SEC	145,932.05	325.88	145,606.17	570,738	0	441.0	251	0	0	25.57	25.51	0.00
	213	GS-UMR	217.49	0.03	217.46	61	0	0.0	1	0	0	356.54	356.49	0.00
	215	GS SEC	158,688.46	560.70	158,127.76	1,256,762	0	3,915.7	14	0	0	12.63	12.58	0.00
	528	SL	1,628,767.37	6,015.92	1,622,751.45	8,435,679	0	0.0	54	0	0	19.31	19.24	0.00
Total 400			**1,966,815.80**	**6,964.21**	**1,959,851.59**	**10,373,235**	**0**	**4,356.7**	**329**	**36**	**136**	**18.96**	**18.89**	**324.00**

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
Grand Total			552,112,828.04	3,187,694.59	548,925,133.45	5,631,770,318	13,359,429	8,310,627.2	165,462	44,911	53,979	9.80	9.75	287,057.66

State : KY

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											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
011	RSW-LMWH	176,111.60	1,018.06	175,093.54	1,594,093	0	0.0	79	0	0	11.05	10.98	0.00
012	RSW-A	24,466.27	139.53	24,326.74	225,237	0	0.0	10	0	0	10.86	10.80	0.00
013	RSW-B	2,840.55	17.61	2,822.94	26,649	0	0.0	1	0	0	10.66	10.59	0.00
015	RS	108,641,862.69	560,843.25	108,081,019.44	904,328,373	65,150	8,594.1	64,555	0	0	12.01	11.95	0.00
017	RS EMP	908,491.38	5,966.11	902,525.27	7,796,057	0	0.0	413	0	0	11.65	11.58	0.00
022	RSW-RS	131,024,708.16	778,282.47	130,246,425.69	1,108,285,091	37,803	18,604.2	68,766	0	0	11.82	11.75	0.00
028	AORH-W ON	9,800.80	64.35	9,736.45	91,644	62,220	0.0	6	0	0	10.69	10.62	0.00
030	RSW-ONPK	156,089.73	925.67	155,164.06	1,389,927	833,639	0.0	66	0	0	11.23	11.16	0.00
032	RS LM-ON	187,812.31	1,242.93	186,569.38	1,699,768	1,079,326	0.0	82	0	0	11.05	10.98	0.00
034	AORH-ON	1,352.40	8.44	1,343.96	11,520	6,207	0.0	2	0	0	11.74	11.67	0.00
036	RS-TOD-ON	11,744.00	63.98	11,680.02	105,469	65,185	0.0	5	0	0	11.14	11.07	0.00
093	OL 175 MV	100,568.72	299.84	100,268.88	593,367	0	0.0	0	656	690	16.95	16.90	105.60
094	OL 100 HP	2,782,320.62	5,023.20	2,777,297.42	10,337,267	0	0.0	0	19,684	21,297	26.92	26.87	57,076.47
095	OL 400 MV	20,546.95	77.43	20,469.52	151,902	0	0.0	0	57	80	13.53	13.48	25.44
097	OL 200 HP	317,618.55	876.19	316,742.36	1,745,172	0	0.0	0	1,305	1,719	18.20	18.15	10,695.19
098	OL 400 HP	66,120.37	153.04	65,967.33	447,197	0	0.0	0	83	224	14.79	14.75	3,470.40
099	OL175 MVP	1,558.22	3.80	1,554.42	7,854	0	0.0	0	4	9	19.84	19.79	0.00
103	OL 250 HP	489.16	1.04	488.12	2,482	0	0.0	0	1	2	19.71	19.67	0.00
107	OL 200HPF	378,831.04	880.45	377,950.59	1,782,802	0	0.0	0	1,238	1,755	21.25	21.20	10,881.48
109	OL400 HPF	1,237,794.13	4,110.80	1,233,683.33	8,189,853	0	0.0	0	1,714	4,083	15.11	15.06	36,150.68
110	OL 250 MH	36,203.66	83.67	36,119.99	166,950	0	0.0	0	74	138	21.69	21.64	2,001.62
111	OL100 HPP	167,407.25	200.52	167,206.73	386,073	0	0.0	0	206	793	43.36	43.31	1,514.40
113	OL 150 HP	3,376,956.48	8,216.40	3,368,740.08	15,577,261	0	0.0	0	19,523	22,075	21.68	21.63	155,689.92
116	OL 400 MH	300,693.40	734.45	299,958.95	1,787,664	0	0.0	0	295	942	16.82	16.78	8,611.26
120	OL 250HPP	767.05	1.01	766.04	2,540	0	0.0	0	2	2	30.20	30.16	0.00
122	OL150 HPP	23,838.35	23.38	23,814.97	49,005	0	0.0	0	18	69	48.64	48.60	0.00
126	OL 400HPP	1,566.43	1.98	1,564.45	5,640	0	0.0	0	2	3	27.71	27.67	0.00

State : KY

December 2019

											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
130	OL 250MON	1,165.24	1.71	1,163.53	4,453	0	0.0	0	4	4	26.17	26.13	0.00
131	OL 1000MH	53,822.65	212.12	53,610.53	432,494	0	0.0	0	44	94	12.44	12.40	835.20
136	OL 400MON	410.32	1.56	408.76	2,132	0	0.0	0	1	1	19.25	19.17	0.00
204	GS-MTRD	222,517.72	474.95	222,042.77	1,200,175	0	0.0	460	0	0	18.54	18.50	0.00
211	GS SEC	22,895,881.34	80,168.64	22,815,712.70	138,810,964	113,051	196,622.7	22,345	0	0	16.49	16.44	0.00
213	GS-UMR	440,475.22	1,780.82	438,694.40	2,293,718	0	0.0	583	0	0	19.20	19.13	0.00
214	GS - AF	173,318.05	552.40	172,765.65	1,301,689	0	27,602.6	85	0	0	13.31	13.27	0.00
215	GS SEC	57,272,590.39	210,647.01	57,061,943.38	432,933,636	0	1,787,688.3	6,348	0	0	13.23	13.18	0.00
217	GS PRI	391,627.84	1,602.38	390,025.46	2,758,962	0	14,406.8	27	0	0	14.19	14.14	0.00
218	GS M SEC	29,375.58	123.42	29,252.16	222,385	0	732.8	1	0	0	13.21	13.15	0.00
220	GSCC PRI	620,061.70	3,011.25	617,050.45	5,124,246	0	12,823.8	48	0	0	12.10	12.04	0.00
223	GS LM ON	105,830.29	777.27	105,053.02	885,295	541,473	0.0	42	0	0	11.95	11.87	0.00
225	GS LM TOD	39,205.88	155.33	39,050.55	272,526	160,368	0.0	31	0	0	14.39	14.33	0.00
227	EXP GSTOD	834,443.49	1,710.35	832,733.14	6,942,484	5,722,015	0.0	463	0	0	12.02	11.99	0.00
229	GS-TOD	497,405.47	2,206.69	495,198.78	4,014,494	2,384,078	532.8	98	0	0	12.39	12.34	0.00
236	GSCC SUB	108,433.06	508.69	107,924.37	818,985	0	2,497.1	5	0	0	13.24	13.18	0.00
240	LGS SEC	42,889,881.30	161,610.66	42,728,270.64	376,516,709	0	1,056,771.0	541	0	0	11.39	11.35	0.00
242	LGS M SEC	820,604.67	3,989.18	816,615.49	7,555,387	0	17,688.0	7	0	0	10.86	10.81	0.00
244	LGS PRI	8,512,273.97	41,525.35	8,470,748.62	75,807,094	0	296,886.0	64	0	0	11.23	11.17	0.00
246	LGS M PRI	66,973.04	228.16	66,744.88	668,438	0	1,882.0	1	0	0	10.02	9.99	0.00
248	LGS SUB	1,369,753.22	7,348.86	1,362,404.36	16,473,714	0	45,331.0	14	0	0	8.31	8.27	0.00
250	LGS TRAN	231,254.45	-1,140.34	232,394.79	4,459,289	0	5,631.0	1	0	0	5.19	5.21	0.00
251	LGS-LM-TD	202,317.45	946.93	201,370.52	1,784,201	961,600	0.0	7	0	0	11.34	11.29	0.00
256	LGSSECTOD	518,573.16	2,241.18	516,331.98	5,215,258	2,874,864	10,364.0	7	0	0	9.94	9.90	0.00
257	LGSPRITOD	450,119.03	2,474.34	447,644.69	5,326,086	2,987,250	8,467.0	2	0	0	8.45	8.40	0.00
260	PS SEC	13,006,063.39	52,840.44	12,953,222.95	106,220,116	0	396,857.0	156	0	0	12.24	12.19	0.00
264	PS PRI	224,314.33	1,163.37	223,150.96	2,147,036	0	7,465.0	1	0	0	10.45	10.40	0.00

State : KY

December 2019

Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Facility Charge
330	CS-IRP PR	704,026.56	495.88	703,530.68	3,897,069	0	29,857.0	1	0	0	18.07	18.05	0.00
331	CS-IRP ST	10,376,123.55	108,216.57	10,267,906.98	180,310,176	0	354,434.0	3	0	0	5.75	5.69	0.00
333	CS-IRP	406,251.80	2,522.02	403,729.78	7,197,323	0	16,632.0	0	0	0	5.64	5.61	0.00
356	IGS SEC	1,912,870.88	9,923.08	1,902,947.80	19,171,670	0	40,930.0	5	0	0	9.98	9.93	0.00
358	IGS PRI	31,282,371.82	142,352.37	31,140,019.45	342,793,662	0	842,230.0	44	0	0	9.13	9.08	0.00
359	IGS SUB	13,461,528.65	95,756.96	13,365,771.69	150,528,128	0	515,224.0	15	0	0	8.94	8.88	0.00
360	IGS	2,321,160.33	14,007.71	2,307,152.62	21,690,199	0	103,859.0	2	0	0	10.70	10.64	0.00
370	IGS	420,505.61	-8,347.16	428,852.77	7,394,400	-1,720,800	14,014.2	0	0	0	5.69	5.80	0.00
371	IGS	69,838,108.04	700,128.14	69,137,979.90	1,300,513,822	0	1,958,038.0	5	0	0	5.37	5.32	0.00
372	IGS	17,619,737.35	169,331.03	17,450,406.32	320,988,302	-2,814,000	515,094.0	3	0	0	5.49	5.44	0.00
528	SL	1,628,767.37	6,015.92	1,622,751.45	8,435,679	0	0.0	54	0	0	19.31	19.24	0.00
540	MW	204,123.56	869.75	203,253.81	1,871,065	0	2,867.8	9	0	0	10.91	10.86	0.00
KY - Summary		**552,112,828.04**	**3,187,694.59**	**548,925,133.45**	**5,631,770,318**	**13,359,429**	**8,310,627.2**	**165,462**	**44,911**	**53,979**	**9.80**	**9.75**	**287,057.66**

American Electric Power
KENTUCKY POWER COMPANY

TARIFF SUMMARY REVENUE - ALL REVENUE CLASSES

12 MONTHS BILLED AND ACCRUED - MCSR0162 - FINAL

Prepared: 01/08/2020 01:01:49 AM

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December 2019

Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

State : KY

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
010	011	RSW-LMWH	51,560.38	254.11	51,306.27	460,093	0	0.0	30	0	0	11.21	11.15	0.00
	015	RS	55,153,556.87	241,788.65	54,911,768.22	450,028,006	11,534	4,952.5	37,524	0	0	12.26	12.20	0.00
	022	RSW-RS	20,014,145.26	103,493.26	19,910,652.00	165,382,124	0	696.4	12,579	0	0	12.10	12.04	0.00
	036	RS-TOD-ON	1,614.10	17.62	1,596.48	10,850	6,052	0.0	2	0	0	14.88	14.71	0.00
	093	OL 175 MV	52,070.75	157.51	51,913.24	309,376	0	0.0	0	355	358	16.83	16.78	64.80
	094	OL 100 HP	1,084,426.85	1,993.41	1,082,433.44	4,060,678	0	0.0	0	7,883	8,374	26.71	26.66	17,942.17
	095	OL 400 MV	1,510.59	6.33	1,504.26	11,446	0	0.0	0	4	6	13.20	13.14	0.00
	097	OL 200 HP	63,875.02	181.03	63,693.99	363,675	0	0.0	0	332	358	17.56	17.51	1,120.67
	098	OL 400 HP	572.66	1.13	571.53	4,277	0	0.0	0	2	2	13.39	13.36	0.00
	107	OL 200HPF	52,702.40	125.42	52,576.98	257,231	0	0.0	0	212	255	20.49	20.44	863.38
	109	OL400 HPF	50,059.74	163.57	49,896.17	345,946	0	0.0	0	110	173	14.47	14.42	751.02
	110	OL 250 MH	2,905.73	7.35	2,898.38	14,613	0	0.0	0	12	12	19.88	19.83	0.00
	111	OL100 HPP	5,606.79	6.88	5,599.91	13,332	0	0.0	0	16	28	42.06	42.00	64.80
	113	OL 150 HP	932,668.60	2,285.42	930,383.18	4,359,586	0	0.0	0	5,625	6,178	21.39	21.34	37,120.73
	116	OL 400 MH	6,009.22	18.13	5,991.09	36,621	0	0.0	0	13	19	16.41	16.36	210.48
	122	OL150 HPP	612.80	0.88	611.92	1,319	0	0.0	0	2	2	46.46	46.39	0.00
	136	OL 400MON	369.21	1.24	367.97	1,898	0	0.0	0	1	1	19.45	19.39	0.00
	211	GS SEC	1,565.79	-0.93	1,566.72	13,080	0	0.0	0	0	0	11.97	11.98	0.00
010 - Summary			**77,475,832.76**	**350,501.01**	**77,125,331.75**	**625,674,151**	**17,586**	**5,648.9**	**50,135**	**14,566**	**15,766**	**12.38**	**12.33**	**58,138.05**
020	011	RSW-LMWH	124,551.22	763.95	123,787.27	1,134,000	0	0.0	50	0	0	10.98	10.92	0.00
	012	RSW-A	24,466.27	139.53	24,326.74	225,237	0	0.0	10	0	0	10.86	10.80	0.00
	013	RSW-B	2,840.55	17.61	2,822.94	26,649	0	0.0	1	0	0	10.66	10.59	0.00
	015	RS	53,488,305.82	319,054.60	53,169,251.22	454,300,367	53,616	3,641.6	27,031	0	0	11.77	11.70	0.00
	017	RS EMP	908,491.38	5,966.11	902,525.27	7,796,057	0	0.0	413	0	0	11.65	11.58	0.00
	022	RSW-RS	111,010,562.90	674,789.21	110,335,773.69	942,902,967	37,803	17,907.8	56,187	0	0	11.77	11.70	0.00
	028	AORH-W ON	9,800.80	64.35	9,736.45	91,644	62,220	0.0	6	0	0	10.69	10.62	0.00
	030	RSW-ONPK	156,089.73	925.67	155,164.06	1,389,927	833,639	0.0	66	0	0	11.23	11.16	0.00
	032	RS LM-ON	187,812.31	1,242.93	186,569.38	1,699,768	1,079,326	0.0	82	0	0	11.05	10.98	0.00

State : KY

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
020	034	AORH-ON	1,352.40	8.44	1,343.96	11,520	6,207	0.0	2	0	0	11.74	11.67	0.00
	036	RS-TOD-ON	10,129.90	46.36	10,083.54	94,619	59,133	0.0	3	0	0	10.71	10.66	0.00
	093	OL 175 MV	25,282.96	74.65	25,208.31	149,953	0	0.0	0	173	177	16.86	16.81	40.80
	094	OL 100 HP	1,440,263.50	2,582.01	1,437,681.49	5,355,238	0	0.0	0	10,332	11,032	26.89	26.85	33,283.07
	095	OL 400 MV	1,017.68	3.44	1,014.24	7,732	0	0.0	0	4	4	13.16	13.12	0.00
	097	OL 200 HP	88,613.95	245.89	88,368.06	503,305	0	0.0	0	465	496	17.61	17.56	1,837.55
	098	OL 400 HP	3,254.44	-31.41	3,285.85	22,787	0	0.0	0	13	14	14.28	14.42	105.60
	107	OL 200HPF	72,266.83	178.69	72,088.14	347,104	0	0.0	0	304	342	20.82	20.77	2,225.99
	109	OL400 HPF	73,861.84	259.67	73,602.17	500,162	0	0.0	0	193	251	14.77	14.72	2,222.93
	110	OL 250 MH	2,451.57	7.20	2,444.37	12,548	0	0.0	0	11	10	19.54	19.48	9.62
	111	OL100 HPP	21,805.14	25.45	21,779.69	51,448	0	0.0	0	89	107	42.38	42.33	477.60
	113	OL 150 HP	1,930,030.39	4,787.44	1,925,242.95	9,008,546	0	0.0	0	11,682	12,773	21.42	21.37	78,743.56
	116	OL 400 MH	5,511.94	16.39	5,495.55	34,497	0	0.0	0	12	18	15.98	15.93	40.80
	120	OL 250HPP	372.38	0.49	371.89	1,255	0	0.0	0	1	1	29.67	29.63	0.00
	122	OL150 HPP	1,106.94	0.04	1,106.90	2,397	0	0.0	0	5	3	46.18	46.18	0.00
	126	OL 400HPP	437.56	-0.09	437.65	1,596	0	0.0	0	1	1	27.42	27.42	0.00
	130	OL 250MON	523.06	0.70	522.36	2,034	0	0.0	0	2	2	25.72	25.68	0.00
	131	OL 1000MH	2,200.85	9.27	2,191.58	18,360	0	0.0	0	1	4	11.99	11.94	0.00
	211	GS SEC	1,094.33	5.79	1,088.54	5,907	0	0.0	1	0	0	18.53	18.43	0.00
020 - Summary			**169,594,498.64**	**1,011,184.38**	**168,583,314.26**	**1,425,697,624**	**2,131,944**	**21,549.4**	**83,852**	**23,289**	**25,235**	**11.90**	**11.82**	**118,987.52**
211	093	OL 175 MV	13,639.44	40.50	13,598.94	78,769	0	0.0	0	75	90	17.32	17.26	0.00
	094	OL 100 HP	175,607.78	304.19	175,303.59	627,701	0	0.0	0	1,051	1,291	27.98	27.93	3,970.02
	095	OL 400 MV	8,137.78	29.32	8,108.46	60,259	0	0.0	0	26	31	13.50	13.46	0.00
	097	OL 200 HP	92,362.95	250.46	92,112.49	496,410	0	0.0	0	303	484	18.61	18.56	3,711.30
	098	OL 400 HP	18,402.40	90.25	18,312.15	129,870	0	0.0	0	36	67	14.17	14.10	434.40
	099	OL175 MVP	1,383.51	3.18	1,380.33	6,984	0	0.0	0	3	8	19.81	19.76	0.00
	103	OL 250 HP	489.16	1.04	488.12	2,482	0	0.0	0	1	2	19.71	19.67	0.00
	107	OL 200HPF	137,763.48	312.76	137,450.72	641,094	0	0.0	0	406	629	21.49	21.44	2,991.32

State : KY

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
211	109	OL400 HPF	543,353.35	1,815.18	541,538.17	3,597,722	0	0.0	0	746	1,795	15.10	15.05	14,176.41
	110	OL 250 MH	15,693.38	35.85	15,657.53	71,611	0	0.0	0	34	59	21.91	21.86	931.20
	111	OL100 HPP	39,171.65	44.51	39,127.14	88,812	0	0.0	0	34	184	44.11	44.06	567.00
	113	OL 150 HP	336,416.37	755.67	335,660.70	1,468,151	0	0.0	0	1,582	2,079	22.91	22.86	21,853.39
	116	OL 400 MH	164,761.48	337.19	164,424.29	977,320	0	0.0	0	150	521	16.86	16.82	4,731.80
	122	OL150 HPP	8,303.55	9.12	8,294.43	16,993	0	0.0	0	3	24	48.86	48.81	0.00
	126	OL 400HPP	1,128.87	2.07	1,126.80	4,044	0	0.0	0	1	2	27.91	27.86	0.00
	130	OL 250MON	642.18	1.01	641.17	2,419	0	0.0	0	2	2	26.55	26.51	0.00
	131	OL 1000MH	27,147.08	110.91	27,036.17	217,910	0	0.0	0	24	48	12.46	12.41	446.40
	136	OL 400MON	41.11	0.32	40.79	234	0	0.0	0	0	0	17.57	17.43	0.00
	204	GS-MTRD	208,996.60	474.39	208,522.21	1,173,248	0	0.0	406	0	0	17.81	17.77	0.00
	211	GS SEC	16,199,666.76	52,969.61	16,146,697.15	95,356,181	36,913	111,006.6	16,839	0	0	16.99	16.93	0.00
	213	GS-UMR	350,318.24	700.53	349,617.71	1,804,579	0	0.0	448	0	0	19.41	19.37	0.00
	214	GS - AF	3,563.34	-8.90	3,572.24	14,813	0	842.6	6	0	0	24.06	24.12	0.00
	215	GS SEC	27,290,718.41	91,703.02	27,199,015.39	207,721,109	0	835,607.1	3,072	0	0	13.14	13.09	0.00
	217	GS PRI	106,041.58	398.58	105,643.00	818,890	0	2,952.6	7	0	0	12.95	12.90	0.00
	220	GSCC PRI	62,090.79	540.89	61,549.90	534,853	0	1,262.2	3	0	0	11.61	11.51	0.00
	223	GS LM ON	7,917.96	26.26	7,891.70	59,390	31,763	0.0	4	0	0	13.33	13.29	0.00
	225	GS LM TOD	1,357.23	5.82	1,351.41	6,548	3,776	0.0	2	0	0	20.73	20.64	0.00
	227	EXP GSTOD	549,428.60	958.62	548,469.98	4,454,103	3,626,984	0.0	332	0	0	12.34	12.31	0.00
	229	GS-TOD	166,764.70	635.77	166,128.93	1,354,330	826,604	532.8	38	0	0	12.31	12.27	0.00
	236	GSCC SUB	21,694.27	60.74	21,633.53	141,180	0	766.2	1	0	0	15.37	15.32	0.00
	240	LGS SEC	12,217,191.41	42,776.91	12,174,414.50	110,927,068	0	270,344.0	160	0	0	11.01	10.98	0.00
	244	LGS PRI	1,344,452.42	5,777.10	1,338,675.32	13,870,340	0	34,395.0	12	0	0	9.69	9.65	0.00
	248	LGS SUB	329,641.39	1,371.19	328,270.20	4,353,767	0	8,909.0	3	0	0	7.57	7.54	0.00
	256	LGSSECTOD	518,573.16	2,241.18	516,331.98	5,215,258	2,874,864	10,364.0	7	0	0	9.94	9.90	0.00
	356	IGS SEC	1,583,718.34	9,206.30	1,574,512.04	16,795,659	0	33,362.0	4	0	0	9.43	9.37	0.00
	358	IGS PRI	6,898,576.03	38,939.53	6,859,636.50	92,094,104	0	164,691.0	9	0	0	7.49	7.45	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
211	359	IGS SUB	1,292,352.97	7,857.84	1,284,495.13	21,044,833	0	38,265.0	3	0	0	6.14	6.10	0.00
211 - Summary			**70,737,509.72**	**260,778.91**	**70,476,730.81**	**586,229,038**	**7,400,904**	**1,513,300.1**	**21,354**	**4,477**	**7,315**	**12.07**	**12.02**	**54,813.24**
212	093	OL 175 MV	2,122.02	5.38	2,116.64	12,264	0	0.0	0	14	14	17.30	17.26	0.00
	094	OL 100 HP	41,003.05	72.02	40,931.03	145,600	0	0.0	0	237	299	28.16	28.11	1,188.00
	095	OL 400 MV	3,946.87	17.69	3,929.18	28,944	0	0.0	0	9	16	13.64	13.58	0.00
	097	OL 200 HP	27,497.62	74.76	27,422.86	147,010	0	0.0	0	109	145	18.70	18.65	1,208.13
	098	OL 400 HP	7,673.86	13.15	7,660.71	52,066	0	0.0	0	13	25	14.74	14.71	348.00
	099	OL175 MVP	174.71	0.62	174.09	870	0	0.0	0	1	1	20.08	20.01	0.00
	107	OL 200HPF	53,190.19	118.68	53,071.51	246,657	0	0.0	0	159	243	21.56	21.52	1,624.17
	109	OL400 HPF	218,946.06	680.52	218,265.54	1,442,095	0	0.0	0	298	716	15.18	15.14	6,802.72
	110	OL 250 MH	10,280.26	21.82	10,258.44	45,041	0	0.0	0	8	37	22.82	22.78	931.20
	111	OL100 HPP	4,703.47	4.81	4,698.66	10,456	0	0.0	0	6	21	44.98	44.94	145.80
	113	OL 150 HP	97,368.52	216.86	97,151.66	414,191	0	0.0	0	405	584	23.51	23.46	8,326.59
	116	OL 400 MH	56,477.45	165.85	56,311.60	333,799	0	0.0	0	65	176	16.92	16.87	1,821.34
	131	OL 1000MH	15,200.87	54.52	15,146.35	122,892	0	0.0	0	8	26	12.37	12.32	129.60
	211	GS SEC	3,179,071.96	13,037.32	3,166,034.64	21,565,970	0	48,027.5	2,270	0	0	14.74	14.68	0.00
	215	GS SEC	17,486,617.37	68,799.30	17,417,818.07	130,805,742	0	578,599.6	2,095	0	0	13.37	13.32	0.00
	217	GS PRI	115,735.97	526.07	115,209.90	962,351	0	2,719.5	5	0	0	12.03	11.97	0.00
	223	GS LM ON	88,746.82	656.00	88,090.82	741,717	448,912	0.0	34	0	0	11.97	11.88	0.00
	225	GS LM TOD	34,128.47	124.56	34,003.91	240,713	142,114	0.0	26	0	0	14.18	14.13	0.00
	227	EXP GSTOD	285,014.89	751.73	284,263.16	2,488,381	2,095,031	0.0	131	0	0	11.45	11.42	0.00
	229	GS-TOD	294,705.66	1,464.09	293,241.57	2,411,403	1,442,162	0.0	49	0	0	12.22	12.16	0.00
	240	LGS SEC	14,900,297.75	63,523.92	14,836,773.83	133,229,893	0	349,511.0	186	0	0	11.18	11.14	0.00
	242	LGS M SEC	155,849.57	724.73	155,124.84	1,438,327	0	3,365.0	1	0	0	10.84	10.79	0.00
	244	LGS PRI	917,117.29	5,798.88	911,318.41	9,332,092	0	24,893.0	7	0	0	9.83	9.77	0.00
	248	LGS SUB	203,248.44	786.08	202,462.36	2,716,909	0	6,468.0	1	0	0	7.48	7.45	0.00
	251	LGS-LM-TD	90,305.75	774.85	89,530.90	758,932	384,340	0.0	4	0	0	11.90	11.80	0.00
	358	IGS PRI	781,958.40	2,812.88	779,145.52	9,443,986	0	18,439.0	2	0	0	8.38	8.35	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
212 - Summary			**39,071,383.29**	**161,227.09**	**38,910,156.20**	**319,138,301**	**4,512,559**	**1,032,022.6**	**4,812**	**1,331**	**2,304**	**12.24**	**12.19**	**22,525.55**
213	093	OL 175 MV	905.39	2.86	902.53	5,226	0	0.0	0	6	6	17.32	17.27	0.00
	094	OL 100 HP	5,551.78	10.29	5,541.49	20,460	0	0.0	0	25	42	27.13	27.08	0.00
	095	OL 400 MV	1,028.90	3.73	1,025.17	7,614	0	0.0	0	3	4	13.51	13.46	0.00
	097	OL 200 HP	5,710.50	15.17	5,695.33	30,619	0	0.0	0	20	30	18.65	18.60	235.20
	098	OL 400 HP	4,950.28	14.06	4,936.22	32,723	0	0.0	0	5	16	15.13	15.08	348.00
	107	OL 200HPF	19,582.58	45.23	19,537.35	91,471	0	0.0	0	44	89	21.41	21.36	518.40
	109	OL400 HPF	132,764.01	453.18	132,310.83	864,475	0	0.0	0	96	429	15.36	15.31	5,412.93
	110	OL 250 MH	1,070.88	2.14	1,068.74	4,878	0	0.0	0	3	4	21.95	21.91	64.80
	111	OL100 HPP	6,091.83	7.46	6,084.37	14,103	0	0.0	0	4	29	43.20	43.14	0.00
	113	OL 150 HP	11,146.99	21.82	11,125.17	43,297	0	0.0	0	30	60	25.75	25.70	1,703.78
	116	OL 400 MH	25,536.79	88.84	25,447.95	152,951	0	0.0	0	19	78	16.70	16.64	736.20
	131	OL 1000MH	590.41	1.36	589.05	4,184	0	0.0	0	1	1	14.11	14.08	64.80
	211	GS SEC	326,595.92	1,487.87	325,108.05	2,152,090	0	4,310.5	248	0	0	15.18	15.11	0.00
	214	GS - AF	122,735.94	323.55	122,412.39	921,934	0	19,982.8	60	0	0	13.31	13.28	0.00
	215	GS SEC	2,477,858.70	10,606.94	2,467,251.76	18,580,178	0	75,023.1	207	0	0	13.34	13.28	0.00
	223	GS LM ON	6,159.00	83.06	6,075.94	64,212	47,840	0.0	1	0	0	9.59	9.46	0.00
	240	LGS SEC	2,411,743.64	8,712.63	2,403,031.01	20,545,542	0	64,635.0	36	0	0	11.74	11.70	0.00
	260	PS SEC	13,006,063.39	52,840.44	12,953,222.95	106,220,116	0	396,857.0	156	0	0	12.24	12.19	0.00
	264	PS PRI	224,314.33	1,163.37	223,150.96	2,147,036	0	7,465.0	1	0	0	10.45	10.39	0.00
	358	IGS PRI	383,348.88	1,235.69	382,113.19	4,029,531	0	10,449.0	1	0	0	9.51	9.48	0.00
	359	IGS SUB	193,499.05	393.02	193,106.03	1,880,388	0	6,543.0	1	0	0	10.29	10.27	0.00
213 - Summary			**19,367,249.19**	**77,512.71**	**19,289,736.48**	**157,813,028**	**47,840**	**585,265.4**	**711**	**256**	**789**	**12.27**	**12.22**	**9,084.11**
216	093	OL 175 MV	5,001.44	14.03	4,987.41	28,847	0	0.0	0	23	34	17.34	17.29	0.00
	094	OL 100 HP	26,169.05	44.17	26,124.88	93,957	0	0.0	0	118	191	27.85	27.81	563.61
	095	OL 400 MV	3,615.96	11.87	3,604.09	26,772	0	0.0	0	8	14	13.51	13.46	0.00
	097	OL 200 HP	24,304.33	60.76	24,243.57	124,924	0	0.0	0	56	122	19.46	19.41	1,799.40
	098	OL 400 HP	30,704.77	63.79	30,640.98	201,430	0	0.0	0	14	98	15.34	15.31	2,234.40

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Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
216	107	OL 200HPF	37,368.27	84.96	37,283.31	170,881	0	0.0	0	94	168	21.87	21.82	1,610.22
	109	OL400 HPF	141,493.71	482.85	141,010.86	931,856	0	0.0	0	196	464	15.18	15.13	4,528.04
	110	OL 250 MH	2,310.98	5.63	2,305.35	10,952	0	0.0	0	6	9	21.10	21.05	64.80
	111	OL100 HPP	69,372.47	83.48	69,288.99	160,034	0	0.0	0	37	326	43.35	43.30	259.20
	113	OL 150 HP	53,542.34	113.68	53,428.66	217,923	0	0.0	0	149	307	24.57	24.52	6,338.40
	116	OL 400 MH	29,278.84	71.08	29,207.76	172,409	0	0.0	0	22	89	16.98	16.94	1,011.24
	120	OL 250HPP	394.67	0.52	394.15	1,285	0	0.0	0	1	1	30.71	30.67	0.00
	122	OL150 HPP	11,138.26	10.69	11,127.57	22,833	0	0.0	0	6	32	48.78	48.73	0.00
	131	OL 1000MH	4,580.13	18.38	4,561.75	36,877	0	0.0	0	6	8	12.42	12.37	64.80
	204	GS-MTRD	10,429.00	-3.78	10,432.78	18,869	0	0.0	43	0	0	55.27	55.29	0.00
	211	GS SEC	2,288,539.68	10,203.68	2,278,336.00	14,452,912	76,138	26,446.2	2,026	0	0	15.83	15.76	0.00
	213	GS-UMR	89,939.49	1,080.26	88,859.23	489,078	0	0.0	135	0	0	18.39	18.17	0.00
	214	GS - AF	47,018.77	237.75	46,781.02	364,942	0	6,777.2	19	0	0	12.88	12.82	0.00
	215	GS SEC	7,735,072.97	31,425.49	7,703,647.48	58,810,773	0	226,545.6	731	0	0	13.15	13.10	0.00
	217	GS PRI	95,755.07	223.62	95,531.45	485,614	0	6,013.8	4	0	0	19.72	19.67	0.00
	218	GS M SEC	29,375.58	123.42	29,252.16	222,385	0	732.8	1	0	0	13.21	13.15	0.00
	223	GS LM ON	3,006.51	11.95	2,994.56	19,976	12,958	0.0	3	0	0	15.05	14.99	0.00
	225	GS LM TOD	3,720.18	24.95	3,695.23	25,265	14,478	0.0	3	0	0	14.72	14.63	0.00
	229	GS-TOD	35,442.93	98.49	35,344.44	242,761	109,312	0.0	10	0	0	14.60	14.56	0.00
	240	LGS SEC	8,195,458.02	31,787.59	8,163,670.43	73,269,675	0	190,057.0	94	0	0	11.19	11.14	0.00
	242	LGS M SEC	664,755.10	3,264.45	661,490.65	6,117,060	0	14,323.0	6	0	0	10.87	10.81	0.00
	244	LGS PRI	316,448.20	871.20	315,577.00	2,908,622	0	10,804.0	3	0	0	10.88	10.85	0.00
	246	LGS M PRI	66,973.04	228.16	66,744.88	668,438	0	1,882.0	1	0	0	10.02	9.99	0.00
	251	LGS-LM-TD	110,725.97	173.11	110,552.86	1,024,739	576,960	0.0	2	0	0	10.81	10.79	0.00
	358	IGS PRI	2,104,030.51	9,876.95	2,094,153.56	25,582,173	0	51,229.0	4	0	0	8.22	8.19	0.00
	540	MW	204,123.56	869.75	203,253.81	1,871,065	0	2,867.8	9	0	0	10.91	10.86	0.00
216 - Summary			**22,440,089.80**	**91,562.93**	**22,348,526.87**	**188,775,327**	**789,846**	**537,678.4**	**3,094**	**735**	**1,864**	**11.89**	**11.84**	**18,474.11**
221	093	OL 175 MV	1,202.69	4.05	1,198.64	6,936	0	0.0	0	8	8	17.34	17.28	0.00

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221	094	OL 100 HP	7,784.68	14.04	7,770.64	28,069	0	0.0	0	30	57	27.73	27.68	129.60
	095	OL 400 MV	956.83	3.10	953.73	6,763	0	0.0	0	3	4	14.15	14.10	25.44
	097	OL 200 HP	5,861.71	14.74	5,846.97	32,196	0	0.0	0	8	32	18.21	18.16	128.26
	098	OL 400 HP	561.96	2.07	559.89	4,044	0	0.0	0	1	2	13.90	13.84	0.00
	107	OL 200HPF	4,246.86	10.75	4,236.11	20,444	0	0.0	0	12	20	20.77	20.72	0.00
	109	OL400 HPF	56,215.76	171.27	56,044.49	369,126	0	0.0	0	45	183	15.23	15.18	1,626.60
	110	OL 250 MH	1,490.86	3.68	1,487.18	7,307	0	0.0	0	1	6	20.40	20.35	0.00
	111	OL100 HPP	1,295.38	1.28	1,294.10	3,019	0	0.0	0	1	6	42.91	42.87	0.00
	113	OL 150 HP	8,499.43	20.40	8,479.03	35,341	0	0.0	0	25	49	24.05	23.99	871.40
	116	OL 400 MH	12,184.44	33.19	12,151.25	74,367	0	0.0	0	13	39	16.38	16.34	59.40
	131	OL 1000MH	3,539.87	15.29	3,524.58	27,666	0	0.0	0	3	6	12.80	12.74	129.60
	204	GS-MTRD	1,477.79	4.30	1,473.49	7,989	0	0.0	3	0	0	18.50	18.44	0.00
	211	GS SEC	619,661.69	1,639.22	618,022.47	3,814,098	0	4,502.1	604	0	0	16.25	16.20	0.00
	215	GS SEC	1,486,759.46	4,447.24	1,482,312.22	11,043,238	0	47,079.8	141	0	0	13.46	13.42	0.00
	217	GS PRI	59,371.97	108.70	59,263.27	384,978	0	2,427.2	8	0	0	15.42	15.39	0.00
	220	GSCC PRI	150,318.65	754.35	149,564.30	1,277,220	0	2,790.9	10	0	0	11.77	11.71	0.00
	236	GSCC SUB	3,741.13	-66.19	3,807.32	26,075	0	52.5	0	0	0	14.35	14.60	0.00
	240	LGS SEC	3,719,591.98	10,425.51	3,709,166.47	27,966,668	0	128,287.0	48	0	0	13.30	13.26	0.00
	244	LGS PRI	1,582,781.16	8,019.03	1,574,762.13	13,088,830	0	57,614.0	13	0	0	12.09	12.03	0.00
	248	LGS SUB	165,701.69	396.26	165,305.43	2,095,301	0	5,544.0	1	0	0	7.91	7.89	0.00
	250	LGS TRAN	199,149.29	-1,591.72	200,741.01	4,087,639	0	4,780.0	0	0	0	4.87	4.91	0.00
	331	CS-IRP ST	7,068,967.01	76,341.22	6,992,625.79	132,528,000	0	221,597.0	1	0	0	5.33	5.28	0.00
	358	IGS PRI	7,464,300.61	34,246.71	7,430,053.90	95,147,364	0	180,085.0	12	0	0	7.84	7.81	0.00
	359	IGS SUB	4,968,920.87	24,831.12	4,944,089.75	44,239,631	0	195,519.0	5	0	0	11.23	11.18	0.00
	360	IGS	973,592.73	6,060.12	967,532.61	9,144,000	0	46,459.0	1	0	0	10.65	10.58	0.00
	370	IGS	420,505.61	-8,347.16	428,852.77	7,394,400	-1,720,800	14,014.2	0	0	0	5.69	5.80	0.00
	371	IGS	69,260,395.92	695,702.40	68,564,693.52	1,290,721,333	0	1,941,504.0	4	0	0	5.37	5.31	0.00
	372	IGS	17,619,737.35	169,331.03	17,450,406.32	320,988,302	-2,814,000	515,094.0	3	0	0	5.49	5.44	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
221 - Summary			**115,868,815.38**	**1,022,596.00**	**114,846,219.38**	**1,964,570,344**	**-4,534,800**	**3,367,349.7**	**855**	**150**	**412**	**5.90**	**5.85**	**2,970.30**
222	097	OL 200 HP	716.45	1.93	714.52	3,719	0	0.0	0	2	4	19.26	19.21	42.68
	107	OL 200HPF	212.65	0.49	212.16	1,024	0	0.0	0	1	1	20.77	20.72	0.00
	109	OL400 HPF	2,373.84	7.65	2,366.19	15,812	0	0.0	0	5	8	15.01	14.96	48.00
	113	OL 150 HP	1,778.81	2.53	1,776.28	6,958	0	0.0	0	6	10	25.56	25.53	259.20
	211	GS SEC	49,651.12	175.44	49,475.68	349,934	0	736.5	29	0	0	14.19	14.14	0.00
	215	GS SEC	209,327.43	885.22	208,442.21	1,527,672	0	7,049.8	21	0	0	13.70	13.64	0.00
	220	GSCC PRI	25,202.11	149.36	25,052.75	201,043	0	642.0	2	0	0	12.54	12.46	0.00
	229	GS-TOD	492.18	8.34	483.84	6,000	6,000	0.0	0	0	0	8.20	8.06	0.00
	240	LGS SEC	991,485.58	2,976.13	988,509.45	7,971,108	0	32,437.0	9	0	0	12.44	12.40	0.00
	244	LGS PRI	354,196.73	1,738.18	352,458.55	3,983,475	0	6,744.0	1	0	0	8.89	8.85	0.00
	251	LGS-LM-TD	1,285.73	-1.03	1,286.76	530	300	0.0	1	0	0	242.59	242.78	0.00
	356	IGS SEC	329,152.54	716.78	328,435.76	2,376,011	0	7,568.0	1	0	0	13.85	13.82	0.00
	358	IGS PRI	944,634.73	3,498.38	941,136.35	12,047,589	0	22,917.0	1	0	0	7.84	7.81	0.00
222 - Summary			**2,910,509.90**	**10,159.40**	**2,900,350.50**	**28,490,875**	**6,300**	**78,094.3**	**65**	**14**	**22**	**10.22**	**10.18**	**349.88**
230	093	OL 175 MV	40.35	0.12	40.23	240	0	0.0	0	0	0	16.81	16.76	0.00
	094	OL 100 HP	979.28	2.12	977.16	3,598	0	0.0	0	6	7	27.22	27.16	0.00
	095	OL 400 MV	332.34	1.95	330.39	2,372	0	0.0	0	1	2	14.01	13.93	0.00
	097	OL 200 HP	8,494.97	30.88	8,464.09	42,294	0	0.0	0	8	48	20.09	20.01	612.00
	107	OL 200HPF	1,284.71	2.95	1,281.76	5,869	0	0.0	0	4	6	21.89	21.84	48.00
	109	OL400 HPF	11,719.47	51.06	11,668.41	76,297	0	0.0	0	18	40	15.36	15.29	387.63
	113	OL 150 HP	4,748.49	11.26	4,737.23	20,410	0	0.0	0	17	30	23.27	23.21	343.27
	116	OL 400 MH	933.24	3.78	929.46	5,700	0	0.0	0	2	3	16.37	16.31	0.00
	211	GS SEC	84,102.04	324.76	83,777.28	530,054	0	1,152.3	77	0	0	15.87	15.81	0.00
	215	GS SEC	427,547.59	2,219.10	425,328.49	3,188,162	0	13,867.6	67	0	0	13.41	13.34	0.00
	217	GS PRI	14,723.25	345.41	14,377.84	107,129	0	293.7	3	0	0	13.74	13.42	0.00
	220	GSCC PRI	382,450.15	1,566.65	380,883.50	3,111,130	0	8,128.7	32	0	0	12.29	12.24	0.00
	236	GSCC SUB	82,997.66	514.14	82,483.52	651,730	0	1,678.4	4	0	0	12.73	12.66	0.00

State : KY

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
230	240	LGS SEC	454,112.92	1,407.97	452,704.95	2,606,755	0	21,500.0	8	0	0	17.42	17.37	0.00
	244	LGS PRI	3,997,278.17	19,320.96	3,977,957.21	32,623,735	0	162,436.0	28	0	0	12.25	12.19	0.00
	248	LGS SUB	671,161.70	4,795.33	666,366.37	7,307,737	0	24,410.0	9	0	0	9.18	9.12	0.00
	250	LGS TRAN	32,105.16	451.38	31,653.78	371,650	0	851.0	1	0	0	8.64	8.52	0.00
	257	LGSPRITOD	450,119.03	2,474.34	447,644.69	5,326,086	2,987,250	8,467.0	2	0	0	8.45	8.40	0.00
	330	CS-IRP PR	704,026.56	495.88	703,530.68	3,897,069	0	29,857.0	1	0	0	18.07	18.05	0.00
	331	CS-IRP ST	3,307,156.54	31,875.35	3,275,281.19	47,782,176	0	132,837.0	2	0	0	6.92	6.85	0.00
	333	CS-IRP	406,251.80	2,522.02	403,729.78	7,197,323	0	16,632.0	0	0	0	5.64	5.61	0.00
	358	IGS PRI	12,705,522.66	51,742.23	12,653,780.43	104,448,915	0	394,420.0	16	0	0	12.16	12.11	0.00
	359	IGS SUB	7,006,755.76	62,674.98	6,944,080.78	83,363,276	0	274,897.0	6	0	0	8.41	8.33	0.00
	360	IGS	1,347,567.60	7,947.59	1,339,620.01	12,546,199	0	57,400.0	1	0	0	10.74	10.68	0.00
	371	IGS	577,712.12	4,425.74	573,286.38	9,792,489	0	16,534.0	1	0	0	5.90	5.85	0.00
230 - Summary			**32,680,123.56**	**195,207.95**	**32,484,915.61**	**325,008,395**	**2,987,250**	**1,165,361.7**	**256**	**58**	**136**	**10.06**	**10.00**	**1,390.90**
400	093	OL 175 MV	303.68	0.74	302.94	1,756	0	0.0	0	1	2	17.29	17.25	0.00
	094	OL 100 HP	534.65	0.95	533.70	1,966	0	0.0	0	2	4	27.19	27.15	0.00
	097	OL 200 HP	181.05	0.57	180.48	1,020	0	0.0	0	1	1	17.75	17.69	0.00
	107	OL 200HPF	213.07	0.52	212.55	1,027	0	0.0	0	1	1	20.75	20.70	0.00
	109	OL400 HPF	7,006.35	25.85	6,980.50	46,362	0	0.0	0	7	23	15.11	15.06	194.40
	111	OL100 HPP	19,360.52	26.65	19,333.87	44,869	0	0.0	0	19	92	43.15	43.09	0.00
	113	OL 150 HP	756.54	1.32	755.22	2,858	0	0.0	0	2	4	26.47	26.42	129.60
	122	OL150 HPP	2,676.80	2.65	2,674.15	5,463	0	0.0	0	2	8	49.00	48.95	0.00
	131	OL 1000MH	563.44	2.39	561.05	4,605	0	0.0	0	1	1	12.24	12.18	0.00
	204	GS-MTRD	1,614.33	0.04	1,614.29	69	0	0.0	8	0	0	2,339.61	2,339.55	0.00
	211	GS SEC	145,932.05	325.88	145,606.17	570,738	0	441.0	251	0	0	25.57	25.51	0.00
	213	GS-UMR	217.49	0.03	217.46	61	0	0.0	1	0	0	356.54	356.49	0.00
	215	GS SEC	158,688.46	560.70	158,127.76	1,256,762	0	3,915.7	14	0	0	12.63	12.58	0.00
	528	SL	1,628,767.37	6,015.92	1,622,751.45	8,435,679	0	0.0	54	0	0	19.31	19.24	0.00
400 - Summary			**1,966,815.80**	**6,964.21**	**1,959,851.59**	**10,373,235**	**0**	**4,356.7**	**329**	**36**	**136**	**18.96**	**18.89**	**324.00**

State : KY

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
KY - Summary			552,112,828.04	3,187,694.59	548,925,133.45	5,631,770,318	13,359,429	8,310,627.2	165,462	44,911	53,979	9.80	9.75	287,057.66

American Electric Power
KENTUCKY POWER COMPANY

TARIFF SUMMARY REVENUE- BY REVENUE CLASS

12 MONTHS BILLED AND ACCRUED - MCSR0162 - FINAL

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December 2019

Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

American Electric Power
KENTUCKY POWER COMPANY

TARIFF SUMMARY REVENUE- BY REVENUE CLASS

12 MONTHS BILLED AND ACCRUED - MCSR0162 - FINAL

Standard Service Offer

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December 2019

Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

December 2019

Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

December 2019

Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

December 2019

											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
011	RSW-LMWH	174,145.08	1,345.02	172,800.06	1,574,131	0	0.0	79	0	0	11.06	10.98	0.00
012	RSW-A	24,272.21	182.96	24,089.25	223,157	0	0.0	10	0	0	10.88	10.79	0.00
013	RSW-B	2,932.78	28.11	2,904.67	27,460	0	0.0	1	0	0	10.68	10.58	0.00
015	RS	107,693,017.46	748,313.02	106,944,704.44	895,304,780	65,150	8,594.1	64,555	0	0	12.03	11.95	0.00
017	RS EMP	908,482.58	7,846.92	900,635.66	7,786,355	0	0.0	413	0	0	11.67	11.57	0.00
022	RSW-RS	129,911,277.79	1,034,554.51	128,876,723.28	1,097,263,681	37,803	18,604.2	68,766	0	0	11.84	11.75	0.00
028	AORH-W ON	9,859.53	92.96	9,766.57	92,122	62,220	0.0	6	0	0	10.70	10.60	0.00
030	RSW-ONPK	154,588.53	1,289.34	153,299.19	1,372,554	833,639	0.0	66	0	0	11.26	11.17	0.00
032	RS LM-ON	187,539.65	1,710.73	185,828.92	1,696,482	1,079,326	0.0	82	0	0	11.05	10.95	0.00
034	AORH-ON	1,339.21	9.19	1,330.02	11,406	6,207	0.0	2	0	0	11.74	11.66	0.00
036	RS-TOD-ON	11,712.67	99.73	11,612.94	104,782	65,185	0.0	5	0	0	11.18	11.08	0.00
093	OL 175 MV	99,896.18	443.27	99,452.91	588,374	0	0.0	0	656	690	16.98	16.90	105.60
094	OL 100 HP	2,757,378.54	7,289.09	2,750,089.45	10,223,766	0	0.0	0	19,684	21,297	26.97	26.90	57,076.47
095	OL 400 MV	20,421.50	111.16	20,310.34	150,666	0	0.0	0	57	80	13.55	13.48	25.44
097	OL 200 HP	314,365.97	1,251.14	313,114.83	1,723,190	0	0.0	0	1,305	1,719	18.24	18.17	10,695.19
098	OL 400 HP	65,893.24	308.91	65,584.33	445,221	0	0.0	0	83	224	14.80	14.73	3,470.40
099	OL175 MVP	1,544.37	5.84	1,538.53	7,768	0	0.0	0	4	9	19.88	19.81	0.00
103	OL 250 HP	487.65	1.80	485.85	2,472	0	0.0	0	1	2	19.73	19.65	0.00
107	OL 200HPF	375,434.30	1,259.41	374,174.89	1,763,340	0	0.0	0	1,238	1,755	21.29	21.22	10,881.48
109	OL400 HPF	1,227,795.86	5,903.32	1,221,892.54	8,106,832	0	0.0	0	1,714	4,083	15.15	15.07	36,150.68
110	OL 250 MH	35,811.59	118.76	35,692.83	164,757	0	0.0	0	74	138	21.74	21.66	2,001.62
111	OL100 HPP	165,936.19	281.24	165,654.95	382,021	0	0.0	0	206	793	43.44	43.36	1,514.40
113	OL 150 HP	3,343,514.20	11,415.20	3,332,099.00	15,388,432	0	0.0	0	19,523	22,075	21.73	21.65	155,689.92
116	OL 400 MH	298,823.80	1,250.56	297,573.24	1,773,305	0	0.0	0	295	942	16.85	16.78	8,611.26
120	OL 250HPP	749.83	1.74	748.09	2,472	0	0.0	0	2	2	30.33	30.26	0.00
122	OL150 HPP	23,560.44	33.59	23,526.85	48,324	0	0.0	0	18	69	48.76	48.69	0.00
126	OL 400HPP	1,521.57	2.28	1,519.29	5,438	0	0.0	0	2	3	27.98	27.94	0.00

December 2019

											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
130	OL 250MON	1,145.93	2.46	1,143.47	4,360	0	0.0	0	4	4	26.28	26.23	0.00
131	OL 1000MH	52,781.03	284.91	52,496.12	422,360	0	0.0	0	44	94	12.50	12.43	835.20
136	OL 400MON	390.19	1.28	388.91	2,018	0	0.0	0	1	1	19.34	19.27	0.00
204	GS-MTRD	221,342.00	696.99	220,645.01	1,191,977	0	0.0	460	0	0	18.57	18.51	0.00
211	GS SEC	22,688,825.07	106,137.79	22,582,687.28	137,301,213	113,051	196,622.7	22,345	0	0	16.52	16.45	0.00
213	GS-UMR	439,602.39	2,303.79	437,298.60	2,289,691	0	0.0	583	0	0	19.20	19.10	0.00
214	GS - AF	171,961.26	717.76	171,243.50	1,289,349	0	27,602.6	85	0	0	13.34	13.28	0.00
215	GS SEC	56,802,317.28	292,215.82	56,510,101.46	429,293,383	0	1,787,688.3	6,348	0	0	13.23	13.16	0.00
217	GS PRI	388,999.03	2,098.60	386,900.43	2,738,300	0	14,406.8	27	0	0	14.21	14.13	0.00
218	GS M SEC	28,508.33	173.63	28,334.70	217,440	0	732.8	1	0	0	13.11	13.03	0.00
220	GSCC PRI	615,972.24	3,889.05	612,083.19	5,078,955	0	12,823.8	48	0	0	12.13	12.05	0.00
223	GS LM ON	104,670.09	985.45	103,684.64	873,844	541,473	0.0	42	0	0	11.98	11.87	0.00
225	GS LM TOD	39,111.64	199.28	38,912.36	271,580	160,368	0.0	31	0	0	14.40	14.33	0.00
227	EXP GSTOD	803,519.07	1,563.15	801,955.92	6,661,807	5,722,015	0.0	463	0	0	12.06	12.04	0.00
229	GS-TOD	490,558.43	2,946.14	487,612.29	3,956,003	2,384,078	532.8	98	0	0	12.40	12.33	0.00
236	GSCC SUB	108,952.43	642.55	108,309.88	820,050	0	2,497.1	5	0	0	13.29	13.21	0.00
240	LGS SEC	42,623,493.80	236,165.25	42,387,328.55	373,793,217	0	1,056,771.0	541	0	0	11.40	11.34	0.00
242	LGS M SEC	816,270.74	5,316.53	810,954.21	7,510,480	0	17,688.0	7	0	0	10.87	10.80	0.00
244	LGS PRI	8,426,861.11	55,359.66	8,371,501.45	74,920,550	0	296,886.0	64	0	0	11.25	11.17	0.00
246	LGS M PRI	67,004.66	317.67	66,686.99	668,340	0	1,882.0	1	0	0	10.03	9.98	0.00
248	LGS SUB	1,381,438.36	11,363.98	1,370,074.38	16,568,427	0	45,331.0	14	0	0	8.34	8.27	0.00
250	LGS TRAN	233,588.66	-906.50	234,495.16	4,486,639	0	5,631.0	1	0	0	5.21	5.23	0.00
251	LGS-LM-TD	199,071.54	1,231.06	197,840.48	1,752,320	961,600	0.0	7	0	0	11.36	11.29	0.00
256	LGSSECTOD	514,786.48	3,134.03	511,652.45	5,168,032	2,874,864	10,364.0	7	0	0	9.96	9.90	0.00
257	LGSPRITOD	450,167.63	3,064.76	447,102.87	5,321,733	2,987,250	8,467.0	2	0	0	8.46	8.40	0.00
260	PS SEC	12,902,050.58	72,217.28	12,829,833.30	105,257,381	0	396,857.0	156	0	0	12.26	12.19	0.00
264	PS PRI	220,503.03	1,637.80	218,865.23	2,103,900	0	7,465.0	1	0	0	10.48	10.40	0.00

December 2019

											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
330	CS-IRP PR	738,477.73	2,718.69	735,759.04	4,133,500	0	29,857.0	1	0	0	17.87	17.80	0.00
331	CS-IRP ST	10,405,927.76	113,130.66	10,292,797.10	180,781,000	0	354,434.0	3	0	0	5.76	5.69	0.00
333	CS-IRP	380,365.16	1,035.12	379,330.04	6,744,000	0	16,632.0	0	0	0	5.64	5.62	0.00
356	IGS SEC	1,870,191.94	11,804.07	1,858,387.87	18,880,440	0	40,930.0	5	0	0	9.91	9.84	0.00
358	IGS PRI	31,118,936.90	199,675.94	30,919,260.96	340,615,700	0	842,230.0	44	0	0	9.14	9.08	0.00
359	IGS SUB	13,537,039.79	121,353.39	13,415,686.40	151,441,600	0	515,224.0	15	0	0	8.94	8.86	0.00
360	IGS	2,301,899.94	17,800.69	2,284,099.25	21,548,000	0	103,859.0	2	0	0	10.68	10.60	0.00
370	IGS	420,505.61	-8,347.16	428,852.77	7,394,400	-1,720,800	14,014.2	0	0	0	5.69	5.80	0.00
371	IGS	69,826,309.78	708,243.20	69,118,066.58	1,300,168,000	0	1,958,038.0	5	0	0	5.37	5.32	0.00
372	IGS	17,483,578.42	233,008.16	17,250,570.26	318,214,974	-2,814,000	515,094.0	3	0	0	5.49	5.42	0.00
528	SL	1,628,937.63	6,028.02	1,622,909.61	8,436,725	0	0.0	54	0	0	19.31	19.24	0.00
540	MW	202,104.88	1,372.93	200,731.95	1,849,587	0	2,867.8	9	0	0	10.93	10.85	0.00
Grand Total - Summary		**548,520,471.26**	**4,036,733.68**	**544,483,737.58**	**5,596,404,563**	**13,359,429**	**8,310,627.2**	**165,462**	**44,911**	**53,979**	**9.80**	**9.73**	**287,057.66**

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
010	011	RSW-LMWH	51,110.46	338.65	50,771.81	455,627	0	0.0	30	0	0	11.22	11.14	0.00
	015	RS	54,714,486.57	326,589.80	54,387,896.77	445,994,512	11,534	4,952.5	37,524	0	0	12.27	12.19	0.00
	022	RSW-RS	19,862,237.19	138,328.58	19,723,908.61	163,925,877	0	696.4	12,579	0	0	12.12	12.03	0.00
	036	RS-TOD-ON	1,643.02	21.23	1,621.79	11,125	6,052	0.0	2	0	0	14.77	14.58	0.00
	093	OL 175 MV	51,783.96	235.13	51,548.83	307,194	0	0.0	0	355	358	16.86	16.78	64.80
	094	OL 100 HP	1,075,089.44	2,890.48	1,072,198.96	4,017,757	0	0.0	0	7,883	8,374	26.76	26.69	17,942.17
	095	OL 400 MV	1,503.56	8.06	1,495.50	11,376	0	0.0	0	4	6	13.22	13.15	0.00
	097	OL 200 HP	63,369.95	261.35	63,108.60	360,038	0	0.0	0	332	358	17.60	17.53	1,120.67
	098	OL 400 HP	546.82	0.92	545.90	4,050	0	0.0	0	2	2	13.50	13.48	0.00
	107	OL 200HPF	52,429.82	184.64	52,245.18	255,547	0	0.0	0	212	255	20.52	20.44	863.38
	109	OL400 HPF	49,454.32	244.83	49,209.49	340,672	0	0.0	0	110	173	14.52	14.44	751.02
	110	OL 250 MH	2,898.15	11.11	2,887.04	14,562	0	0.0	0	12	12	19.90	19.83	0.00
	111	OL100 HPP	5,583.65	10.04	5,573.61	13,268	0	0.0	0	16	28	42.08	42.01	64.80
	113	OL 150 HP	923,591.80	3,201.91	920,389.89	4,307,617	0	0.0	0	5,625	6,178	21.44	21.37	37,120.73
	116	OL 400 MH	5,762.47	20.27	5,742.20	34,808	0	0.0	0	13	19	16.56	16.50	210.48
	122	OL150 HPP	596.21	1.03	595.18	1,279	0	0.0	0	2	2	46.62	46.53	0.00
	136	OL 400MON	368.94	1.33	367.61	1,896	0	0.0	0	1	1	19.46	19.39	0.00
	211	GS SEC	1,565.79	-0.93	1,566.72	13,080	0	0.0	0	0	0	11.97	11.98	0.00
Total 010			**76,864,022.12**	**472,348.43**	**76,391,673.69**	**620,070,285**	**17,586**	**5,648.9**	**50,135**	**14,566**	**15,766**	**12.40**	**12.32**	**58,138.05**
020	011	RSW-LMWH	123,034.62	1,006.37	122,028.25	1,118,504	0	0.0	50	0	0	11.00	10.91	0.00
	012	RSW-A	24,272.21	182.96	24,089.25	223,157	0	0.0	10	0	0	10.88	10.79	0.00
	013	RSW-B	2,932.78	28.11	2,904.67	27,460	0	0.0	1	0	0	10.68	10.58	0.00
	015	RS	52,978,530.89	421,723.22	52,556,807.67	449,310,268	53,616	3,641.6	27,031	0	0	11.79	11.70	0.00
	017	RS EMP	908,482.58	7,846.92	900,635.66	7,786,355	0	0.0	413	0	0	11.67	11.57	0.00
	022	RSW-RS	110,049,040.60	896,225.93	109,152,814.67	933,337,804	37,803	17,907.8	56,187	0	0	11.79	11.69	0.00
	028	AORH-W ON	9,859.53	92.96	9,766.57	92,122	62,220	0.0	6	0	0	10.70	10.60	0.00
	030	RSW-ONPK	154,588.53	1,289.34	153,299.19	1,372,554	833,639	0.0	66	0	0	11.26	11.17	0.00
	032	RS LM-ON	187,539.65	1,710.73	185,828.92	1,696,482	1,079,326	0.0	82	0	0	11.05	10.95	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
020	034	AORH-ON	1,339.21	9.19	1,330.02	11,406	6,207	0.0	2	0	0	11.74	11.66	0.00
	036	RS-TOD-ON	10,069.65	78.50	9,991.15	93,657	59,133	0.0	3	0	0	10.75	10.67	0.00
	093	OL 175 MV	25,117.23	111.64	25,005.59	148,704	0	0.0	0	173	177	16.89	16.82	40.80
	094	OL 100 HP	1,427,140.10	3,753.90	1,423,386.20	5,295,327	0	0.0	0	10,332	11,032	26.95	26.88	33,283.07
	095	OL 400 MV	1,002.16	5.36	996.80	7,584	0	0.0	0	4	4	13.21	13.14	0.00
	097	OL 200 HP	87,862.10	358.12	87,503.98	497,915	0	0.0	0	465	496	17.65	17.57	1,837.55
	098	OL 400 HP	3,752.01	12.90	3,739.11	26,898	0	0.0	0	13	14	13.95	13.90	105.60
	107	OL 200HPF	71,689.06	252.08	71,436.98	343,633	0	0.0	0	304	342	20.86	20.79	2,225.99
	109	OL400 HPF	73,353.84	378.84	72,975.00	495,598	0	0.0	0	193	251	14.80	14.72	2,222.93
	110	OL 250 MH	2,417.97	10.11	2,407.86	12,333	0	0.0	0	11	10	19.61	19.52	9.62
	111	OL100 HPP	21,614.01	35.13	21,578.88	50,901	0	0.0	0	89	107	42.46	42.39	477.60
	113	OL 150 HP	1,910,665.70	6,600.93	1,904,064.77	8,897,708	0	0.0	0	11,682	12,773	21.47	21.40	78,743.56
	116	OL 400 MH	5,446.97	23.21	5,423.76	33,991	0	0.0	0	12	18	16.02	15.96	40.80
	120	OL 250HPP	367.51	0.87	366.64	1,236	0	0.0	0	1	1	29.73	29.66	0.00
	122	OL150 HPP	1,079.66	0.47	1,079.19	2,325	0	0.0	0	5	3	46.44	46.42	0.00
	126	OL 400HPP	402.86	-0.61	403.47	1,438	0	0.0	0	1	1	28.02	28.06	0.00
	130	OL 250MON	505.98	0.72	505.26	1,952	0	0.0	0	2	2	25.92	25.88	0.00
	131	OL 1000MH	2,182.26	13.00	2,169.26	18,160	0	0.0	0	1	4	12.02	11.95	0.00
	211	GS SEC	1,157.22	17.16	1,140.06	6,729	0	0.0	1	0	0	17.20	16.94	0.00
Total 020			**168,085,446.89**	**1,341,768.06**	**166,743,678.83**	**1,410,912,201**	**2,131,944**	**21,549.4**	**83,852**	**23,289**	**25,235**	**11.91**	**11.82**	**118,987.52**
211	093	OL 175 MV	13,496.46	56.45	13,440.01	77,760	0	0.0	0	75	90	17.36	17.28	0.00
	094	OL 100 HP	174,008.57	441.18	173,567.39	620,847	0	0.0	0	1,051	1,291	28.03	27.96	3,970.02
	095	OL 400 MV	8,034.80	39.93	7,994.87	59,322	0	0.0	0	26	31	13.54	13.48	0.00
	097	OL 200 HP	90,958.42	355.56	90,602.86	487,222	0	0.0	0	303	484	18.67	18.60	3,711.30
	098	OL 400 HP	19,035.39	167.45	18,867.94	134,983	0	0.0	0	36	67	14.10	13.98	434.40
	099	OL175 MVP	1,371.84	4.98	1,366.86	6,912	0	0.0	0	3	8	19.85	19.78	0.00
	103	OL 250 HP	487.65	1.80	485.85	2,472	0	0.0	0	1	2	19.73	19.65	0.00
	107	OL 200HPF	136,319.88	454.80	135,865.08	632,973	0	0.0	0	406	629	21.54	21.46	2,991.32

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
211	109	OL400 HPF	539,158.79	2,612.98	536,545.81	3,562,827	0	0.0	0	746	1,795	15.13	15.06	14,176.41
	110	OL 250 MH	15,509.57	49.58	15,459.99	70,596	0	0.0	0	34	59	21.97	21.90	931.20
	111	OL100 HPP	38,947.11	68.29	38,878.82	88,213	0	0.0	0	34	184	44.15	44.07	567.00
	113	OL 150 HP	333,392.13	1,074.37	332,317.76	1,452,187	0	0.0	0	1,582	2,079	22.96	22.88	21,853.39
	116	OL 400 MH	165,212.01	699.36	164,512.65	979,760	0	0.0	0	150	521	16.86	16.79	4,731.80
	122	OL150 HPP	8,222.10	12.27	8,209.83	16,794	0	0.0	0	3	24	48.96	48.89	0.00
	126	OL 400HPP	1,118.71	2.89	1,115.82	4,000	0	0.0	0	1	2	27.97	27.90	0.00
	130	OL 250MON	639.95	1.74	638.21	2,408	0	0.0	0	2	2	26.58	26.50	0.00
	131	OL 1000MH	26,810.81	159.09	26,651.72	214,546	0	0.0	0	24	48	12.50	12.42	446.40
	136	OL 400MON	21.25	-0.05	21.30	122	0	0.0	0	0	0	17.42	17.46	0.00
	204	GS-MTRD	207,707.40	690.58	207,016.82	1,164,731	0	0.0	406	0	0	17.83	17.77	0.00
	211	GS SEC	16,074,095.47	71,462.42	16,002,633.05	94,493,160	36,913	111,006.6	16,839	0	0	17.01	16.94	0.00
	213	GS-UMR	347,508.03	990.95	346,517.08	1,787,138	0	0.0	448	0	0	19.44	19.39	0.00
	214	GS - AF	3,846.53	3.59	3,842.94	16,274	0	842.6	6	0	0	23.64	23.61	0.00
	215	GS SEC	27,113,539.60	129,889.67	26,983,649.93	206,265,829	0	835,607.1	3,072	0	0	13.14	13.08	0.00
	217	GS PRI	104,500.36	540.10	103,960.26	808,740	0	2,952.6	7	0	0	12.92	12.85	0.00
	220	GSCC PRI	63,864.32	787.28	63,077.04	548,900	0	1,262.2	3	0	0	11.63	11.49	0.00
	223	GS LM ON	7,762.92	29.14	7,733.78	58,145	31,763	0.0	4	0	0	13.35	13.30	0.00
	225	GS LM TOD	1,341.80	5.69	1,336.11	6,416	3,776	0.0	2	0	0	20.91	20.82	0.00
	227	EXP GSTOD	527,730.59	812.19	526,918.40	4,260,375	3,626,984	0.0	332	0	0	12.39	12.37	0.00
	229	GS-TOD	164,246.20	898.99	163,347.21	1,333,279	826,604	532.8	38	0	0	12.32	12.25	0.00
	236	GSCC SUB	21,251.05	88.95	21,162.10	136,500	0	766.2	1	0	0	15.57	15.50	0.00
	240	LGS SEC	12,130,447.51	63,522.26	12,066,925.25	110,029,939	0	270,344.0	160	0	0	11.02	10.97	0.00
	244	LGS PRI	1,338,677.06	8,739.07	1,329,937.99	13,785,430	0	34,395.0	12	0	0	9.71	9.65	0.00
	248	LGS SUB	330,076.74	2,239.37	327,837.37	4,352,950	0	8,909.0	3	0	0	7.58	7.53	0.00
	256	LGSSECTOD	514,786.48	3,134.03	511,652.45	5,168,032	2,874,864	10,364.0	7	0	0	9.96	9.90	0.00
	356	IGS SEC	1,580,058.01	11,900.11	1,568,157.90	16,752,240	0	33,362.0	4	0	0	9.43	9.36	0.00
	358	IGS PRI	6,874,689.16	48,734.11	6,825,955.05	91,596,600	0	164,691.0	9	0	0	7.51	7.45	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
211	359	IGS SUB	1,294,478.09	12,826.95	1,281,651.14	20,990,200	0	38,265.0	3	0	0	6.17	6.11	0.00
Total 211			**70,273,352.76**	**363,498.12**	**69,909,854.64**	**581,968,822**	**7,400,904**	**1,513,300.1**	**21,354**	**4,477**	**7,315**	**12.08**	**12.01**	**54,813.24**
212	093	OL 175 MV	2,098.61	8.82	2,089.79	12,096	0	0.0	0	14	14	17.35	17.28	0.00
	094	OL 100 HP	40,639.16	101.75	40,537.41	144,011	0	0.0	0	237	299	28.22	28.15	1,188.00
	095	OL 400 MV	3,928.61	22.87	3,905.74	28,767	0	0.0	0	9	16	13.66	13.58	0.00
	097	OL 200 HP	27,169.91	102.70	27,067.21	144,883	0	0.0	0	109	145	18.75	18.68	1,208.13
	098	OL 400 HP	7,408.52	17.49	7,391.03	49,836	0	0.0	0	13	25	14.87	14.83	348.00
	099	OL175 MVP	172.53	0.86	171.67	856	0	0.0	0	1	1	20.16	20.05	0.00
	107	OL 200HPF	52,596.78	165.10	52,431.68	243,329	0	0.0	0	159	243	21.62	21.55	1,624.17
	109	OL400 HPF	217,011.99	1,011.24	216,000.75	1,426,252	0	0.0	0	298	716	15.22	15.14	6,802.72
	110	OL 250 MH	10,158.23	31.44	10,126.79	44,390	0	0.0	0	8	37	22.88	22.81	931.20
	111	OL100 HPP	4,615.68	6.17	4,609.51	10,237	0	0.0	0	6	21	45.09	45.03	145.80
	113	OL 150 HP	96,137.21	299.78	95,837.43	407,790	0	0.0	0	405	584	23.58	23.50	8,326.59
	116	OL 400 MH	56,090.27	243.07	55,847.20	331,011	0	0.0	0	65	176	16.95	16.87	1,821.34
	131	OL 1000MH	14,637.32	62.31	14,575.01	117,496	0	0.0	0	8	26	12.46	12.40	129.60
	211	GS SEC	3,143,480.02	17,062.47	3,126,417.55	21,278,501	0	48,027.5	2,270	0	0	14.77	14.69	0.00
	215	GS SEC	17,336,785.49	95,487.30	17,241,298.19	129,730,718	0	578,599.6	2,095	0	0	13.36	13.29	0.00
	217	GS PRI	115,744.91	737.74	115,007.17	962,100	0	2,719.5	5	0	0	12.03	11.95	0.00
	223	GS LM ON	87,827.39	840.60	86,986.79	732,414	448,912	0.0	34	0	0	11.99	11.88	0.00
	225	GS LM TOD	34,057.99	163.83	33,894.16	239,988	142,114	0.0	26	0	0	14.19	14.12	0.00
	227	EXP GSTOD	275,788.48	750.96	275,037.52	2,401,432	2,095,031	0.0	131	0	0	11.48	11.45	0.00
	229	GS-TOD	292,195.89	1,956.44	290,239.45	2,385,867	1,442,162	0.0	49	0	0	12.25	12.16	0.00
	240	LGS SEC	14,798,731.58	89,922.15	14,708,809.43	132,185,576	0	349,511.0	186	0	0	11.20	11.13	0.00
	242	LGS M SEC	154,989.73	1,004.65	153,985.08	1,430,000	0	3,365.0	1	0	0	10.84	10.77	0.00
	244	LGS PRI	910,241.48	7,613.84	902,627.64	9,241,200	0	24,893.0	7	0	0	9.85	9.77	0.00
	248	LGS SUB	200,320.97	1,371.80	198,949.17	2,671,375	0	6,468.0	1	0	0	7.50	7.45	0.00
	251	LGS-LM-TD	89,884.05	838.12	89,045.93	755,340	384,340	0.0	4	0	0	11.90	11.79	0.00
	358	IGS PRI	773,308.37	5,223.86	768,084.51	9,337,200	0	18,439.0	2	0	0	8.28	8.23	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
Total 212			**38,746,021.17**	**225,047.36**	**38,520,973.81**	**316,312,665**	**4,512,559**	**1,032,022.6**	**4,812**	**1,331**	**2,304**	**12.25**	**12.18**	**22,525.55**
213	093	OL 175 MV	899.53	3.78	895.75	5,184	0	0.0	0	6	6	17.35	17.28	0.00
	094	OL 100 HP	5,463.05	14.18	5,448.87	20,068	0	0.0	0	25	42	27.22	27.15	0.00
	095	OL 400 MV	1,026.10	5.39	1,020.71	7,584	0	0.0	0	3	4	13.53	13.46	0.00
	097	OL 200 HP	5,671.41	21.52	5,649.89	30,360	0	0.0	0	20	30	18.68	18.61	235.20
	098	OL 400 HP	4,859.60	23.04	4,836.56	32,000	0	0.0	0	5	16	15.19	15.11	348.00
	107	OL 200HPF	19,343.55	65.30	19,278.25	90,099	0	0.0	0	44	89	21.47	21.40	518.40
	109	OL400 HPF	131,906.45	637.31	131,269.14	857,476	0	0.0	0	96	429	15.38	15.31	5,412.93
	110	OL 250 MH	1,059.81	3.47	1,056.34	4,816	0	0.0	0	3	4	22.01	21.93	64.80
	111	OL100 HPP	6,067.29	10.19	6,057.10	14,036	0	0.0	0	4	29	43.23	43.15	0.00
	113	OL 150 HP	10,991.51	31.39	10,960.12	42,555	0	0.0	0	30	60	25.83	25.76	1,703.78
	116	OL 400 MH	24,670.11	109.74	24,560.37	146,628	0	0.0	0	19	78	16.82	16.75	736.20
	131	OL 1000MH	593.10	1.62	591.48	4,206	0	0.0	0	1	1	14.10	14.06	64.80
	211	GS SEC	318,079.45	1,732.26	316,347.19	2,087,392	0	4,310.5	248	0	0	15.24	15.16	0.00
	214	GS - AF	120,722.16	413.36	120,308.80	905,156	0	19,982.8	60	0	0	13.34	13.29	0.00
	215	GS SEC	2,455,065.07	14,478.47	2,440,586.60	18,407,777	0	75,023.1	207	0	0	13.34	13.26	0.00
	223	GS LM ON	6,113.46	98.58	6,014.88	63,520	47,840	0.0	1	0	0	9.62	9.47	0.00
	240	LGS SEC	2,391,125.93	11,830.92	2,379,295.01	20,342,044	0	64,635.0	36	0	0	11.75	11.70	0.00
	260	PS SEC	12,902,050.58	72,217.28	12,829,833.30	105,257,381	0	396,857.0	156	0	0	12.26	12.19	0.00
	264	PS PRI	220,503.03	1,637.80	218,865.23	2,103,900	0	7,465.0	1	0	0	10.48	10.40	0.00
	358	IGS PRI	379,463.49	1,875.16	377,588.33	3,988,200	0	10,449.0	1	0	0	9.51	9.47	0.00
	359	IGS SUB	192,110.72	708.53	191,402.19	1,868,300	0	6,543.0	1	0	0	10.28	10.24	0.00
Total 213			**19,197,785.40**	**105,919.29**	**19,091,866.11**	**156,278,682**	**47,840**	**585,265.4**	**711**	**256**	**789**	**12.28**	**12.22**	**9,084.11**
216	093	OL 175 MV	4,950.81	20.46	4,930.35	28,488	0	0.0	0	23	34	17.38	17.31	0.00
	094	OL 100 HP	25,833.05	62.61	25,770.44	92,533	0	0.0	0	118	191	27.92	27.85	563.61
	095	OL 400 MV	3,591.73	18.89	3,572.84	26,537	0	0.0	0	8	14	13.53	13.46	0.00
	097	OL 200 HP	24,087.14	86.36	24,000.78	123,583	0	0.0	0	56	122	19.49	19.42	1,799.40
	098	OL 400 HP	29,733.81	84.22	29,649.59	193,454	0	0.0	0	14	98	15.37	15.33	2,234.40

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
216	107	OL 200HPF	37,125.73	117.69	37,008.04	169,561	0	0.0	0	94	168	21.90	21.83	1,610.22
	109	OL400 HPF	140,375.82	659.49	139,716.33	922,721	0	0.0	0	196	464	15.21	15.14	4,528.04
	110	OL 250 MH	2,290.86	7.82	2,283.04	10,836	0	0.0	0	6	9	21.14	21.07	64.80
	111	OL100 HPP	68,621.23	117.02	68,504.21	157,950	0	0.0	0	37	326	43.44	43.37	259.20
	113	OL 150 HP	53,130.10	155.51	52,974.59	215,876	0	0.0	0	149	307	24.61	24.54	6,338.40
	116	OL 400 MH	28,751.19	105.42	28,645.77	168,738	0	0.0	0	22	89	17.04	16.98	1,011.24
	120	OL 250HPP	382.32	0.87	381.45	1,236	0	0.0	0	1	1	30.93	30.86	0.00
	122	OL150 HPP	11,012.27	16.30	10,995.97	22,528	0	0.0	0	6	32	48.88	48.81	0.00
	131	OL 1000MH	4,508.34	26.11	4,482.23	36,172	0	0.0	0	6	8	12.46	12.39	64.80
	204	GS-MTRD	10,561.06	0.63	10,560.43	19,201	0	0.0	43	0	0	55.00	55.00	0.00
	211	GS SEC	2,261,586.61	12,694.80	2,248,891.81	14,238,704	76,138	26,446.2	2,026	0	0	15.88	15.79	0.00
	213	GS-UMR	91,878.66	1,312.81	90,565.85	502,493	0	0.0	135	0	0	18.28	18.02	0.00
	214	GS - AF	47,392.57	300.81	47,091.76	367,919	0	6,777.2	19	0	0	12.88	12.80	0.00
	215	GS SEC	7,656,935.49	41,583.62	7,615,351.87	58,197,526	0	226,545.6	731	0	0	13.16	13.09	0.00
	217	GS PRI	96,939.56	275.37	96,664.19	484,400	0	6,013.8	4	0	0	20.01	19.96	0.00
	218	GS M SEC	28,508.33	173.63	28,334.70	217,440	0	732.8	1	0	0	13.11	13.03	0.00
	223	GS LM ON	2,966.32	17.13	2,949.19	19,765	12,958	0.0	3	0	0	15.01	14.92	0.00
	225	GS LM TOD	3,711.85	29.76	3,682.09	25,176	14,478	0.0	3	0	0	14.74	14.63	0.00
	229	GS-TOD	33,624.16	82.37	33,541.79	230,857	109,312	0.0	10	0	0	14.56	14.53	0.00
	240	LGS SEC	8,144,607.67	45,303.23	8,099,304.44	72,734,336	0	190,057.0	94	0	0	11.20	11.14	0.00
	242	LGS M SEC	661,281.01	4,311.88	656,969.13	6,080,480	0	14,323.0	6	0	0	10.88	10.80	0.00
	244	LGS PRI	313,252.68	1,518.73	311,733.95	2,899,280	0	10,804.0	3	0	0	10.80	10.75	0.00
	246	LGS M PRI	67,004.66	317.67	66,686.99	668,340	0	1,882.0	1	0	0	10.03	9.98	0.00
	251	LGS-LM-TD	107,938.69	393.67	107,545.02	996,480	576,960	0.0	2	0	0	10.83	10.79	0.00
	358	IGS PRI	2,104,195.20	15,339.33	2,088,855.87	25,507,800	0	51,229.0	4	0	0	8.25	8.19	0.00
	540	MW	202,104.88	1,372.93	200,731.95	1,849,587	0	2,867.8	9	0	0	10.93	10.85	0.00
Total 216			**22,268,883.80**	**126,507.14**	**22,142,376.66**	**187,209,997**	**789,846**	**537,678.4**	**3,094**	**735**	**1,864**	**11.90**	**11.83**	**18,474.11**
221	093	OL 175 MV	1,199.44	5.04	1,194.40	6,912	0	0.0	0	8	8	17.35	17.28	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
221	094	OL 100 HP	7,702.19	20.73	7,681.46	27,707	0	0.0	0	30	57	27.80	27.72	129.60
	095	OL 400 MV	961.41	5.73	955.68	6,776	0	0.0	0	3	4	14.19	14.10	25.44
	097	OL 200 HP	5,797.83	23.33	5,774.50	31,752	0	0.0	0	8	32	18.26	18.19	128.26
	098	OL 400 HP	557.09	2.89	554.20	4,000	0	0.0	0	1	2	13.93	13.86	0.00
	107	OL 200HPF	4,211.95	14.39	4,197.56	20,240	0	0.0	0	12	20	20.81	20.74	0.00
	109	OL400 HPF	55,449.23	253.25	55,195.98	362,980	0	0.0	0	45	183	15.28	15.21	1,626.60
	110	OL 250 MH	1,477.00	5.23	1,471.77	7,224	0	0.0	0	1	6	20.45	20.37	0.00
	111	OL100 HPP	1,254.83	2.12	1,252.71	2,904	0	0.0	0	1	6	43.21	43.14	0.00
	113	OL 150 HP	8,373.68	28.59	8,345.09	34,732	0	0.0	0	25	49	24.11	24.03	871.40
	116	OL 400 MH	11,959.54	45.42	11,914.12	72,684	0	0.0	0	13	39	16.45	16.39	59.40
	131	OL 1000MH	3,492.27	19.51	3,472.76	27,240	0	0.0	0	3	6	12.82	12.75	129.60
	204	GS-MTRD	1,477.58	5.74	1,471.84	7,977	0	0.0	3	0	0	18.52	18.45	0.00
	211	GS SEC	611,991.20	2,077.05	609,914.15	3,752,731	0	4,502.1	604	0	0	16.31	16.25	0.00
	215	GS SEC	1,460,777.88	6,319.11	1,454,458.77	10,844,220	0	47,079.8	141	0	0	13.47	13.41	0.00
	217	GS PRI	56,185.39	116.93	56,068.46	367,800	0	2,427.2	8	0	0	15.28	15.24	0.00
	220	GSCC PRI	148,793.79	1,103.89	147,689.90	1,260,480	0	2,790.9	10	0	0	11.80	11.72	0.00
	236	GSCC SUB	4,651.14	-4.84	4,655.98	33,250	0	52.5	0	0	0	13.99	14.00	0.00
	240	LGS SEC	3,691,124.15	16,810.59	3,674,313.56	27,727,050	0	128,287.0	48	0	0	13.31	13.25	0.00
	244	LGS PRI	1,559,844.76	10,934.14	1,548,910.62	12,885,100	0	57,614.0	13	0	0	12.11	12.02	0.00
	248	LGS SUB	165,501.82	439.27	165,062.55	2,093,000	0	5,544.0	1	0	0	7.91	7.89	0.00
	250	LGS TRAN	199,149.29	-1,591.72	200,741.01	4,087,639	0	4,780.0	0	0	0	4.87	4.91	0.00
	331	CS-IRP ST	7,068,967.01	76,341.22	6,992,625.79	132,528,000	0	221,597.0	1	0	0	5.33	5.28	0.00
	358	IGS PRI	7,496,875.66	61,074.81	7,435,800.85	95,450,600	0	180,085.0	12	0	0	7.85	7.79	0.00
	359	IGS SUB	4,924,967.28	27,218.16	4,897,749.12	44,114,300	0	195,519.0	5	0	0	11.16	11.10	0.00
	360	IGS	973,592.73	6,060.12	967,532.61	9,144,000	0	46,459.0	1	0	0	10.65	10.58	0.00
	370	IGS	420,505.61	-8,347.16	428,852.77	7,394,400	-1,720,800	14,014.2	0	0	0	5.69	5.80	0.00
	371	IGS	69,247,937.50	700,881.10	68,547,056.40	1,290,424,000	0	1,941,504.0	4	0	0	5.37	5.31	0.00
	372	IGS	17,483,578.42	233,008.16	17,250,570.26	318,214,974	-2,814,000	515,094.0	3	0	0	5.49	5.42	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
Total 221			**115,618,357.67**	**1,132,872.80**	**114,485,484.87**	**1,960,934,672**	**-4,534,800**	**3,367,349.7**	**855**	**150**	**412**	**5.90**	**5.84**	**2,970.30**
222	097	OL 200 HP	711.15	2.55	708.60	3,685	0	0.0	0	2	4	19.30	19.23	42.68
	107	OL 200HPF	210.59	0.72	209.87	1,012	0	0.0	0	1	1	20.81	20.74	0.00
	109	OL400 HPF	2,343.17	9.70	2,333.47	15,563	0	0.0	0	5	8	15.06	14.99	48.00
	113	OL 150 HP	1,755.38	4.46	1,750.92	6,839	0	0.0	0	6	10	25.67	25.60	259.20
	211	GS SEC	49,125.88	228.85	48,897.03	344,777	0	736.5	29	0	0	14.25	14.18	0.00
	215	GS SEC	202,325.55	1,000.04	201,325.51	1,476,062	0	7,049.8	21	0	0	13.71	13.64	0.00
	220	GSCC PRI	24,946.17	161.19	24,784.98	198,600	0	642.0	2	0	0	12.56	12.48	0.00
	229	GS-TOD	492.18	8.34	483.84	6,000	6,000	0.0	0	0	0	8.20	8.06	0.00
	240	LGS SEC	1,015,080.36	6,553.77	1,008,526.59	8,165,816	0	32,437.0	9	0	0	12.43	12.35	0.00
	244	LGS PRI	349,561.95	3,262.82	346,299.13	3,926,400	0	6,744.0	1	0	0	8.90	8.82	0.00
	251	LGS-LM-TD	1,248.80	-0.73	1,249.53	500	300	0.0	1	0	0	249.76	249.91	0.00
	356	IGS SEC	290,133.93	-96.04	290,229.97	2,128,200	0	7,568.0	1	0	0	13.63	13.64	0.00
	358	IGS PRI	922,426.86	6,217.82	916,209.04	11,702,400	0	22,917.0	1	0	0	7.88	7.83	0.00
Total 222			**2,860,361.97**	**17,353.49**	**2,843,008.48**	**27,975,854**	**6,300**	**78,094.3**	**65**	**14**	**22**	**10.22**	**10.16**	**349.88**
230	093	OL 175 MV	50.37	0.70	49.67	308	0	0.0	0	0	0	16.35	16.13	0.00
	094	OL 100 HP	975.02	2.83	972.19	3,580	0	0.0	0	6	7	27.24	27.16	0.00
	095	OL 400 MV	373.13	4.93	368.20	2,720	0	0.0	0	1	2	13.72	13.54	0.00
	097	OL 200 HP	8,558.10	38.94	8,519.16	42,740	0	0.0	0	8	48	20.02	19.93	612.00
	107	OL 200HPF	1,296.35	3.98	1,292.37	5,934	0	0.0	0	4	6	21.85	21.78	48.00
	109	OL400 HPF	11,782.90	62.74	11,720.16	76,767	0	0.0	0	18	40	15.35	15.27	387.63
	113	OL 150 HP	4,729.50	16.20	4,713.30	20,312	0	0.0	0	17	30	23.28	23.20	343.27
	116	OL 400 MH	931.24	4.07	927.17	5,685	0	0.0	0	2	3	16.38	16.31	0.00
	211	GS SEC	83,405.04	423.93	82,981.11	523,197	0	1,152.3	77	0	0	15.94	15.86	0.00
	215	GS SEC	421,986.64	2,680.57	419,306.07	3,144,852	0	13,867.6	67	0	0	13.42	13.33	0.00
	217	GS PRI	15,628.81	428.46	15,200.35	115,260	0	293.7	3	0	0	13.56	13.19	0.00
	220	GSCC PRI	378,367.96	1,836.69	376,531.27	3,070,975	0	8,128.7	32	0	0	12.32	12.26	0.00
	236	GSCC SUB	83,050.24	558.44	82,491.80	650,300	0	1,678.4	4	0	0	12.77	12.69	0.00

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
230	240	LGS SEC	452,376.60	2,222.33	450,154.27	2,608,456	0	21,500.0	8	0	0	17.34	17.26	0.00
	244	LGS PRI	3,955,283.18	23,291.06	3,931,992.12	32,183,140	0	162,436.0	28	0	0	12.29	12.22	0.00
	248	LGS SUB	685,538.83	7,313.54	678,225.29	7,451,102	0	24,410.0	9	0	0	9.20	9.10	0.00
	250	LGS TRAN	34,439.37	685.22	33,754.15	399,000	0	851.0	1	0	0	8.63	8.46	0.00
	257	LGSPRITOD	450,167.63	3,064.76	447,102.87	5,321,733	2,987,250	8,467.0	2	0	0	8.46	8.40	0.00
	330	CS-IRP PR	738,477.73	2,718.69	735,759.04	4,133,500	0	29,857.0	1	0	0	17.87	17.80	0.00
	331	CS-IRP ST	3,336,960.75	36,789.44	3,300,171.31	48,253,000	0	132,837.0	2	0	0	6.92	6.84	0.00
	333	CS-IRP	380,365.16	1,035.12	379,330.04	6,744,000	0	16,632.0	0	0	0	5.64	5.62	0.00
	358	IGS PRI	12,567,978.16	61,210.85	12,506,767.31	103,032,900	0	394,420.0	16	0	0	12.20	12.14	0.00
	359	IGS SUB	7,125,483.70	80,599.75	7,044,883.95	84,468,800	0	274,897.0	6	0	0	8.44	8.34	0.00
	360	IGS	1,328,307.21	11,740.57	1,316,566.64	12,404,000	0	57,400.0	1	0	0	10.71	10.61	0.00
	371	IGS	578,372.28	7,362.10	571,010.18	9,744,000	0	16,534.0	1	0	0	5.94	5.86	0.00
Total 230			**32,644,885.90**	**244,095.91**	**32,400,789.99**	**324,406,261**	**2,987,250**	**1,165,361.7**	**256**	**58**	**136**	**10.06**	**9.99**	**1,390.90**
400	093	OL 175 MV	299.77	1.25	298.52	1,728	0	0.0	0	1	2	17.35	17.28	0.00
	094	OL 100 HP	527.96	1.43	526.53	1,936	0	0.0	0	2	4	27.27	27.20	0.00
	097	OL 200 HP	179.96	0.71	179.25	1,012	0	0.0	0	1	1	17.78	17.71	0.00
	107	OL 200HPF	210.59	0.71	209.88	1,012	0	0.0	0	1	1	20.81	20.74	0.00
	109	OL400 HPF	6,959.35	32.94	6,926.41	45,976	0	0.0	0	7	23	15.14	15.07	194.40
	111	OL100 HPP	19,232.39	32.28	19,200.11	44,512	0	0.0	0	19	92	43.21	43.13	0.00
	113	OL 150 HP	747.19	2.06	745.13	2,816	0	0.0	0	2	4	26.53	26.46	129.60
	122	OL150 HPP	2,650.20	3.52	2,646.68	5,398	0	0.0	0	2	8	49.10	49.03	0.00
	131	OL 1000MH	556.93	3.27	553.66	4,540	0	0.0	0	1	1	12.27	12.20	0.00
	204	GS-MTRD	1,595.96	0.04	1,595.92	68	0	0.0	8	0	0	2,347.00	2,346.94	0.00
	211	GS SEC	144,338.39	439.78	143,898.61	562,942	0	441.0	251	0	0	25.64	25.56	0.00
	213	GS-UMR	215.70	0.03	215.67	60	0	0.0	1	0	0	359.50	359.45	0.00
	215	GS SEC	154,901.56	777.04	154,124.52	1,226,399	0	3,915.7	14	0	0	12.63	12.57	0.00
	528	SL	1,628,937.63	6,028.02	1,622,909.61	8,436,725	0	0.0	54	0	0	19.31	19.24	0.00
Total 400			**1,961,353.58**	**7,323.08**	**1,954,030.50**	**10,335,124**	**0**	**4,356.7**	**329**	**36**	**136**	**18.98**	**18.91**	**324.00**

American Electric Power
KENTUCKY POWER COMPANY

TARIFF SUMMARY REVENUE- BY REVENUE CLASS

12 MONTHS BILLED + ESTIMATED - MCSR0162 - FINAL

Prepared: 01/08/2020 01:01:49 AM

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December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
Grand Total			548,520,471.26	4,036,733.68	544,483,737.58	5,596,404,563	13,359,429	8,310,627.2	165,462	44,911	53,979	9.80	9.73	287,057.66

State : KY

December 2019

Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization		Facility Charge
											Incl Fuel	Excl Fuel	
011	RSW-LMWH	174,145.08	1,345.02	172,800.06	1,574,131	0	0.0	79	0	0	11.06	10.98	0.00
012	RSW-A	24,272.21	182.96	24,089.25	223,157	0	0.0	10	0	0	10.88	10.79	0.00
013	RSW-B	2,932.78	28.11	2,904.67	27,460	0	0.0	1	0	0	10.68	10.58	0.00
015	RS	107,693,017.46	748,313.02	106,944,704.44	895,304,780	65,150	8,594.1	64,555	0	0	12.03	11.95	0.00
017	RS EMP	908,482.58	7,846.92	900,635.66	7,786,355	0	0.0	413	0	0	11.67	11.57	0.00
022	RSW-RS	129,911,277.79	1,034,554.51	128,876,723.28	1,097,263,681	37,803	18,604.2	68,766	0	0	11.84	11.75	0.00
028	AORH-W ON	9,859.53	92.96	9,766.57	92,122	62,220	0.0	6	0	0	10.70	10.60	0.00
030	RSW-ONPK	154,588.53	1,289.34	153,299.19	1,372,554	833,639	0.0	66	0	0	11.26	11.17	0.00
032	RS LM-ON	187,539.65	1,710.73	185,828.92	1,696,482	1,079,326	0.0	82	0	0	11.05	10.95	0.00
034	AORH-ON	1,339.21	9.19	1,330.02	11,406	6,207	0.0	2	0	0	11.74	11.66	0.00
036	RS-TOD-ON	11,712.67	99.73	11,612.94	104,782	65,185	0.0	5	0	0	11.18	11.08	0.00
093	OL 175 MV	99,896.18	443.27	99,452.91	588,374	0	0.0	0	656	690	16.98	16.90	105.60
094	OL 100 HP	2,757,378.54	7,289.09	2,750,089.45	10,223,766	0	0.0	0	19,684	21,297	26.97	26.90	57,076.47
095	OL 400 MV	20,421.50	111.16	20,310.34	150,666	0	0.0	0	57	80	13.55	13.48	25.44
097	OL 200 HP	314,365.97	1,251.14	313,114.83	1,723,190	0	0.0	0	1,305	1,719	18.24	18.17	10,695.19
098	OL 400 HP	65,893.24	308.91	65,584.33	445,221	0	0.0	0	83	224	14.80	14.73	3,470.40
099	OL175 MVP	1,544.37	5.84	1,538.53	7,768	0	0.0	0	4	9	19.88	19.81	0.00
103	OL 250 HP	487.65	1.80	485.85	2,472	0	0.0	0	1	2	19.73	19.65	0.00
107	OL 200HPF	375,434.30	1,259.41	374,174.89	1,763,340	0	0.0	0	1,238	1,755	21.29	21.22	10,881.48
109	OL400 HPF	1,227,795.86	5,903.32	1,221,892.54	8,106,832	0	0.0	0	1,714	4,083	15.15	15.07	36,150.68
110	OL 250 MH	35,811.59	118.76	35,692.83	164,757	0	0.0	0	74	138	21.74	21.66	2,001.62
111	OL100 HPP	165,936.19	281.24	165,654.95	382,021	0	0.0	0	206	793	43.44	43.36	1,514.40
113	OL 150 HP	3,343,514.20	11,415.20	3,332,099.00	15,388,432	0	0.0	0	19,523	22,075	21.73	21.65	155,689.92
116	OL 400 MH	298,823.80	1,250.56	297,573.24	1,773,305	0	0.0	0	295	942	16.85	16.78	8,611.26
120	OL 250HPP	749.83	1.74	748.09	2,472	0	0.0	0	2	2	30.33	30.26	0.00
122	OL150 HPP	23,560.44	33.59	23,526.85	48,324	0	0.0	0	18	69	48.76	48.69	0.00
126	OL 400HPP	1,521.57	2.28	1,519.29	5,438	0	0.0	0	2	3	27.98	27.89	0.00

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											Realization		
Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
130	OL 250MON	1,145.93	2.46	1,143.47	4,360	0	0.0	0	4	4	26.28	26.23	0.00
131	OL 1000MH	52,781.03	284.91	52,496.12	422,360	0	0.0	0	44	94	12.50	12.43	835.20
136	OL 400MON	390.19	1.28	388.91	2,018	0	0.0	0	1	1	19.34	19.27	0.00
204	GS-MTRD	221,342.00	696.99	220,645.01	1,191,977	0	0.0	460	0	0	18.57	18.51	0.00
211	GS SEC	22,688,825.07	106,137.79	22,582,687.28	137,301,213	113,051	196,622.7	22,345	0	0	16.52	16.45	0.00
213	GS-UMR	439,602.39	2,303.79	437,298.60	2,289,691	0	0.0	583	0	0	19.20	19.10	0.00
214	GS - AF	171,961.26	717.76	171,243.50	1,289,349	0	27,602.6	85	0	0	13.34	13.28	0.00
215	GS SEC	56,802,317.28	292,215.82	56,510,101.46	429,293,383	0	1,787,688.3	6,348	0	0	13.23	13.16	0.00
217	GS PRI	388,999.03	2,098.60	386,900.43	2,738,300	0	14,406.8	27	0	0	14.21	14.13	0.00
218	GS M SEC	28,508.33	173.63	28,334.70	217,440	0	732.8	1	0	0	13.11	13.03	0.00
220	GSCC PRI	615,972.24	3,889.05	612,083.19	5,078,955	0	12,823.8	48	0	0	12.13	12.05	0.00
223	GS LM ON	104,670.09	985.45	103,684.64	873,844	541,473	0.0	42	0	0	11.98	11.87	0.00
225	GS LM TOD	39,111.64	199.28	38,912.36	271,580	160,368	0.0	31	0	0	14.40	14.33	0.00
227	EXP GSTOD	803,519.07	1,563.15	801,955.92	6,661,807	5,722,015	0.0	463	0	0	12.06	12.04	0.00
229	GS-TOD	490,558.43	2,946.14	487,612.29	3,956,003	2,384,078	532.8	98	0	0	12.40	12.33	0.00
236	GSCC SUB	108,952.43	642.55	108,309.88	820,050	0	2,497.1	5	0	0	13.29	13.21	0.00
240	LGS SEC	42,623,493.80	236,165.25	42,387,328.55	373,793,217	0	1,056,771.0	541	0	0	11.40	11.34	0.00
242	LGS M SEC	816,270.74	5,316.53	810,954.21	7,510,480	0	17,688.0	7	0	0	10.87	10.80	0.00
244	LGS PRI	8,426,861.11	55,359.66	8,371,501.45	74,920,550	0	296,886.0	64	0	0	11.25	11.17	0.00
246	LGS M PRI	67,004.66	317.67	66,686.99	668,340	0	1,882.0	1	0	0	10.03	9.98	0.00
248	LGS SUB	1,381,438.36	11,363.98	1,370,074.38	16,568,427	0	45,331.0	14	0	0	8.34	8.27	0.00
250	LGS TRAN	233,588.66	-906.50	234,495.16	4,486,639	0	5,631.0	1	0	0	5.21	5.23	0.00
251	LGS-LM-TD	199,071.54	1,231.06	197,840.48	1,752,320	961,600	0.0	7	0	0	11.36	11.29	0.00
256	LGSSECTOD	514,786.48	3,134.03	511,652.45	5,168,032	2,874,864	10,364.0	7	0	0	9.96	9.90	0.00
257	LGSPRITOD	450,167.63	3,064.76	447,102.87	5,321,733	2,987,250	8,467.0	2	0	0	8.46	8.40	0.00
260	PS SEC	12,902,050.58	72,217.28	12,829,833.30	105,257,381	0	396,857.0	156	0	0	12.26	12.19	0.00
264	PS PRI	220,503.03	1,637.80	218,865.23	2,103,900	0	7,465.0	1	0	0	10.48	10.41	0.00

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Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Facility Charge
330	CS-IRP PR	738,477.73	2,718.69	735,759.04	4,133,500	0	29,857.0	1	0	0	17.87	17.80	0.00
331	CS-IRP ST	10,405,927.76	113,130.66	10,292,797.10	180,781,000	0	354,434.0	3	0	0	5.76	5.69	0.00
333	CS-IRP	380,365.16	1,035.12	379,330.04	6,744,000	0	16,632.0	0	0	0	5.64	5.62	0.00
356	IGS SEC	1,870,191.94	11,804.07	1,858,387.87	18,880,440	0	40,930.0	5	0	0	9.91	9.84	0.00
358	IGS PRI	31,118,936.90	199,675.94	30,919,260.96	340,615,700	0	842,230.0	44	0	0	9.14	9.08	0.00
359	IGS SUB	13,537,039.79	121,353.39	13,415,686.40	151,441,600	0	515,224.0	15	0	0	8.94	8.86	0.00
360	IGS	2,301,899.94	17,800.69	2,284,099.25	21,548,000	0	103,859.0	2	0	0	10.68	10.60	0.00
370	IGS	420,505.61	-8,347.16	428,852.77	7,394,400	-1,720,800	14,014.2	0	0	0	5.69	5.80	0.00
371	IGS	69,826,309.78	708,243.20	69,118,066.58	1,300,168,000	0	1,958,038.0	5	0	0	5.37	5.32	0.00
372	IGS	17,483,578.42	233,008.16	17,250,570.26	318,214,974	-2,814,000	515,094.0	3	0	0	5.49	5.42	0.00
528	SL	1,628,937.63	6,028.02	1,622,909.61	8,436,725	0	0.0	54	0	0	19.31	19.24	0.00
540	MW	202,104.88	1,372.93	200,731.95	1,849,587	0	2,867.8	9	0	0	10.93	10.85	0.00
KY - Summary		**548,520,471.26**	**4,036,733.68**	**544,483,737.58**	**5,596,404,563**	**13,359,429**	**8,310,627.2**	**165,462**	**44,911**	**53,979**	**9.80**	**9.73**	**287,057.66**

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Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

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December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
010	011	RSW-LMWH	51,110.46	338.65	50,771.81	455,627	0	0.0	30	0	0	11.22	11.14	0.00
	015	RS	54,714,486.57	326,589.80	54,387,896.77	445,994,512	11,534	4,952.5	37,524	0	0	12.27	12.19	0.00
	022	RSW-RS	19,862,237.19	138,328.58	19,723,908.61	163,925,877	0	696.4	12,579	0	0	12.12	12.03	0.00
	036	RS-TOD-ON	1,643.02	21.23	1,621.79	11,125	6,052	0.0	2	0	0	14.77	14.58	0.00
	093	OL 175 MV	51,783.96	235.13	51,548.83	307,194	0	0.0	0	355	358	16.86	16.78	64.80
	094	OL 100 HP	1,075,089.44	2,890.48	1,072,198.96	4,017,757	0	0.0	0	7,883	8,374	26.76	26.69	17,942.17
	095	OL 400 MV	1,503.56	8.06	1,495.50	11,376	0	0.0	0	4	6	13.22	13.15	0.00
	097	OL 200 HP	63,369.95	261.35	63,108.60	360,038	0	0.0	0	332	358	17.60	17.53	1,120.67
	098	OL 400 HP	546.82	0.92	545.90	4,050	0	0.0	0	2	2	13.50	13.48	0.00
	107	OL 200HPF	52,429.82	184.64	52,245.18	255,547	0	0.0	0	212	255	20.52	20.44	863.38
	109	OL400 HPF	49,454.32	244.83	49,209.49	340,672	0	0.0	0	110	173	14.52	14.44	751.02
	110	OL 250 MH	2,898.15	11.11	2,887.04	14,562	0	0.0	0	12	12	19.90	19.83	0.00
	111	OL100 HPP	5,583.65	10.04	5,573.61	13,268	0	0.0	0	16	28	42.08	42.01	64.80
	113	OL 150 HP	923,591.80	3,201.91	920,389.89	4,307,617	0	0.0	0	5,625	6,178	21.44	21.37	37,120.73
	116	OL 400 MH	5,762.47	20.27	5,742.20	34,808	0	0.0	0	13	19	16.56	16.50	210.48
	122	OL150 HPP	596.21	1.03	595.18	1,279	0	0.0	0	2	2	46.62	46.53	0.00
	136	OL 400MON	368.94	1.33	367.61	1,896	0	0.0	0	1	1	19.46	19.39	0.00
	211	GS SEC	1,565.79	-0.93	1,566.72	13,080	0	0.0	0	0	0	11.97	11.98	0.00
010 - Summary			**76,864,022.12**	**472,348.43**	**76,391,673.69**	**620,070,285**	**17,586**	**5,648.9**	**50,135**	**14,566**	**15,766**	**12.40**	**12.32**	**58,138.05**
020	011	RSW-LMWH	123,034.62	1,006.37	122,028.25	1,118,504	0	0.0	50	0	0	11.00	10.91	0.00
	012	RSW-A	24,272.21	182.96	24,089.25	223,157	0	0.0	10	0	0	10.88	10.79	0.00
	013	RSW-B	2,932.78	28.11	2,904.67	27,460	0	0.0	1	0	0	10.68	10.58	0.00
	015	RS	52,978,530.89	421,723.22	52,556,807.67	449,310,268	53,616	3,641.6	27,031	0	0	11.79	11.70	0.00
	017	RS EMP	908,482.58	7,846.92	900,635.66	7,786,355	0	0.0	413	0	0	11.67	11.57	0.00
	022	RSW-RS	110,049,040.60	896,225.93	109,152,814.67	933,337,804	37,803	17,907.8	56,187	0	0	11.79	11.69	0.00
	028	AORH-W ON	9,859.53	92.96	9,766.57	92,122	62,220	0.0	6	0	0	10.70	10.60	0.00
	030	RSW-ONPK	154,588.53	1,289.34	153,299.19	1,372,554	833,639	0.0	66	0	0	11.26	11.17	0.00
	032	RS LM-ON	187,539.65	1,710.73	185,828.92	1,696,482	1,079,326	0.0	82	0	0	11.05	10.95	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
020	034	AORH-ON	1,339.21	9.19	1,330.02	11,406	6,207	0.0	2	0	0	11.74	11.66	0.00
	036	RS-TOD-ON	10,069.65	78.50	9,991.15	93,657	59,133	0.0	3	0	0	10.75	10.67	0.00
	093	OL 175 MV	25,117.23	111.64	25,005.59	148,704	0	0.0	0	173	177	16.89	16.82	40.80
	094	OL 100 HP	1,427,140.10	3,753.90	1,423,386.20	5,295,327	0	0.0	0	10,332	11,032	26.95	26.88	33,283.07
	095	OL 400 MV	1,002.16	5.36	996.80	7,584	0	0.0	0	4	4	13.21	13.14	0.00
	097	OL 200 HP	87,862.10	358.12	87,503.98	497,915	0	0.0	0	465	496	17.65	17.57	1,837.55
	098	OL 400 HP	3,752.01	12.90	3,739.11	26,898	0	0.0	0	13	14	13.95	13.90	105.60
	107	OL 200HPF	71,689.06	252.08	71,436.98	343,633	0	0.0	0	304	342	20.86	20.79	2,225.99
	109	OL400 HPF	73,353.84	378.84	72,975.00	495,598	0	0.0	0	193	251	14.80	14.72	2,222.93
	110	OL 250 MH	2,417.97	10.11	2,407.86	12,333	0	0.0	0	11	10	19.61	19.52	9.62
	111	OL100 HPP	21,614.01	35.13	21,578.88	50,901	0	0.0	0	89	107	42.46	42.39	477.60
	113	OL 150 HP	1,910,665.70	6,600.93	1,904,064.77	8,897,708	0	0.0	0	11,682	12,773	21.47	21.40	78,743.56
	116	OL 400 MH	5,446.97	23.21	5,423.76	33,991	0	0.0	0	12	18	16.02	15.96	40.80
	120	OL 250HPP	367.51	0.87	366.64	1,236	0	0.0	0	1	1	29.73	29.66	0.00
	122	OL150 HPP	1,079.66	0.47	1,079.19	2,325	0	0.0	0	5	3	46.44	46.42	0.00
	126	OL 400HPP	402.86	-0.61	403.47	1,438	0	0.0	0	1	1	28.02	28.06	0.00
	130	OL 250MON	505.98	0.72	505.26	1,952	0	0.0	0	2	2	25.92	25.88	0.00
	131	OL 1000MH	2,182.26	13.00	2,169.26	18,160	0	0.0	0	1	4	12.02	11.95	0.00
	211	GS SEC	1,157.22	17.16	1,140.06	6,729	0	0.0	1	0	0	17.20	16.94	0.00
020 - Summary			**168,085,446.89**	**1,341,768.06**	**166,743,678.83**	**1,410,912,201**	**2,131,944**	**21,549.4**	**83,852**	**23,289**	**25,235**	**11.91**	**11.82**	**118,987.52**
211	093	OL 175 MV	13,496.46	56.45	13,440.01	77,760	0	0.0	0	75	90	17.36	17.28	0.00
	094	OL 100 HP	174,008.57	441.18	173,567.39	620,847	0	0.0	0	1,051	1,291	28.03	27.96	3,970.02
	095	OL 400 MV	8,034.80	39.93	7,994.87	59,322	0	0.0	0	26	31	13.54	13.48	0.00
	097	OL 200 HP	90,958.42	355.56	90,602.86	487,222	0	0.0	0	303	484	18.67	18.60	3,711.30
	098	OL 400 HP	19,035.39	167.45	18,867.94	134,983	0	0.0	0	36	67	14.10	13.98	434.40
	099	OL175 MVP	1,371.84	4.98	1,366.86	6,912	0	0.0	0	3	8	19.85	19.78	0.00
	103	OL 250 HP	487.65	1.80	485.85	2,472	0	0.0	0	1	2	19.73	19.65	0.00
	107	OL 200HPF	136,319.88	454.80	135,865.08	632,973	0	0.0	0	406	629	21.54	21.46	2,991.32

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
211	109	OL400 HPF	539,158.79	2,612.98	536,545.81	3,562,827	0	0.0	0	746	1,795	15.13	15.06	14,176.41
	110	OL 250 MH	15,509.57	49.58	15,459.99	70,596	0	0.0	0	34	59	21.97	21.90	931.20
	111	OL100 HPP	38,947.11	68.29	38,878.82	88,213	0	0.0	0	34	184	44.15	44.07	567.00
	113	OL 150 HP	333,392.13	1,074.37	332,317.76	1,452,187	0	0.0	0	1,582	2,079	22.96	22.88	21,853.39
	116	OL 400 MH	165,212.01	699.36	164,512.65	979,760	0	0.0	0	150	521	16.86	16.79	4,731.80
	122	OL150 HPP	8,222.10	12.27	8,209.83	16,794	0	0.0	0	3	24	48.96	48.89	0.00
	126	OL 400HPP	1,118.71	2.89	1,115.82	4,000	0	0.0	0	1	2	27.97	27.90	0.00
	130	OL 250MON	639.95	1.74	638.21	2,408	0	0.0	0	2	2	26.58	26.50	0.00
	131	OL 1000MH	26,810.81	159.09	26,651.72	214,546	0	0.0	0	24	48	12.50	12.42	446.40
	136	OL 400MON	21.25	-0.05	21.30	122	0	0.0	0	0	0	17.42	17.46	0.00
	204	GS-MTRD	207,707.40	690.58	207,016.82	1,164,731	0	0.0	406	0	0	17.83	17.77	0.00
	211	GS SEC	16,074,095.47	71,462.42	16,002,633.05	94,493,160	36,913	111,006.6	16,839	0	0	17.01	16.94	0.00
	213	GS-UMR	347,508.03	990.95	346,517.08	1,787,138	0	0.0	448	0	0	19.44	19.39	0.00
	214	GS - AF	3,846.53	3.59	3,842.94	16,274	0	842.6	6	0	0	23.64	23.61	0.00
	215	GS SEC	27,113,539.60	129,889.67	26,983,649.93	206,265,829	0	835,607.1	3,072	0	0	13.14	13.08	0.00
	217	GS PRI	104,500.36	540.10	103,960.26	808,740	0	2,952.6	7	0	0	12.92	12.85	0.00
	220	GSCC PRI	63,864.32	787.28	63,077.04	548,900	0	1,262.2	3	0	0	11.63	11.49	0.00
	223	GS LM ON	7,762.92	29.14	7,733.78	58,145	31,763	0.0	4	0	0	13.35	13.30	0.00
	225	GS LM TOD	1,341.80	5.69	1,336.11	6,416	3,776	0.0	2	0	0	20.91	20.82	0.00
	227	EXP GSTOD	527,730.59	812.19	526,918.40	4,260,375	3,626,984	0.0	332	0	0	12.39	12.37	0.00
	229	GS-TOD	164,246.20	898.99	163,347.21	1,333,279	826,604	532.8	38	0	0	12.32	12.25	0.00
	236	GSCC SUB	21,251.05	88.95	21,162.10	136,500	0	766.2	1	0	0	15.57	15.50	0.00
	240	LGS SEC	12,130,447.51	63,522.26	12,066,925.25	110,029,939	0	270,344.0	160	0	0	11.02	10.97	0.00
	244	LGS PRI	1,338,677.06	8,739.07	1,329,937.99	13,785,430	0	34,395.0	12	0	0	9.71	9.65	0.00
	248	LGS SUB	330,076.74	2,239.37	327,837.37	4,352,950	0	8,909.0	3	0	0	7.58	7.53	0.00
	256	LGSSECTOD	514,786.48	3,134.03	511,652.45	5,168,032	2,874,864	10,364.0	7	0	0	9.96	9.90	0.00
	356	IGS SEC	1,580,058.01	11,900.11	1,568,157.90	16,752,240	0	33,362.0	4	0	0	9.43	9.36	0.00
	358	IGS PRI	6,874,689.16	48,734.11	6,825,955.05	91,596,600	0	164,691.0	9	0	0	7.51	7.45	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
211	359	IGS SUB	1,294,478.09	12,826.95	1,281,651.14	20,990,200	0	38,265.0	3	0	0	6.17	6.11	0.00
211 - Summary			**70,273,352.76**	**363,498.12**	**69,909,854.64**	**581,968,822**	**7,400,904**	**1,513,300.1**	**21,354**	**4,477**	**7,315**	**12.08**	**12.01**	**54,813.24**
212	093	OL 175 MV	2,098.61	8.82	2,089.79	12,096	0	0.0	0	14	14	17.35	17.28	0.00
	094	OL 100 HP	40,639.16	101.75	40,537.41	144,011	0	0.0	0	237	299	28.22	28.15	1,188.00
	095	OL 400 MV	3,928.61	22.87	3,905.74	28,767	0	0.0	0	9	16	13.66	13.58	0.00
	097	OL 200 HP	27,169.91	102.70	27,067.21	144,883	0	0.0	0	109	145	18.75	18.68	1,208.13
	098	OL 400 HP	7,408.52	17.49	7,391.03	49,836	0	0.0	0	13	25	14.87	14.83	348.00
	099	OL175 MVP	172.53	0.86	171.67	856	0	0.0	0	1	1	20.16	20.05	0.00
	107	OL 200HPF	52,596.78	165.10	52,431.68	243,329	0	0.0	0	159	243	21.62	21.55	1,624.17
	109	OL400 HPF	217,011.99	1,011.24	216,000.75	1,426,252	0	0.0	0	298	716	15.22	15.14	6,802.72
	110	OL 250 MH	10,158.23	31.44	10,126.79	44,390	0	0.0	0	8	37	22.88	22.81	931.20
	111	OL100 HPP	4,615.68	6.17	4,609.51	10,237	0	0.0	0	6	21	45.09	45.03	145.80
	113	OL 150 HP	96,137.21	299.78	95,837.43	407,790	0	0.0	0	405	584	23.58	23.50	8,326.59
	116	OL 400 MH	56,090.27	243.07	55,847.20	331,011	0	0.0	0	65	176	16.95	16.87	1,821.34
	131	OL 1000MH	14,637.32	62.31	14,575.01	117,496	0	0.0	0	8	26	12.46	12.40	129.60
	211	GS SEC	3,143,480.02	17,062.47	3,126,417.55	21,278,501	0	48,027.5	2,270	0	0	14.77	14.69	0.00
	215	GS SEC	17,336,785.49	95,487.30	17,241,298.19	129,730,718	0	578,599.6	2,095	0	0	13.36	13.29	0.00
	217	GS PRI	115,744.91	737.74	115,007.17	962,100	0	2,719.5	5	0	0	12.03	11.95	0.00
	223	GS LM ON	87,827.39	840.60	86,986.79	732,414	448,912	0.0	34	0	0	11.99	11.88	0.00
	225	GS LM TOD	34,057.99	163.83	33,894.16	239,988	142,114	0.0	26	0	0	14.19	14.12	0.00
	227	EXP GSTOD	275,788.48	750.96	275,037.52	2,401,432	2,095,031	0.0	131	0	0	11.48	11.45	0.00
	229	GS-TOD	292,195.89	1,956.44	290,239.45	2,385,867	1,442,162	0.0	49	0	0	12.25	12.16	0.00
	240	LGS SEC	14,798,731.58	89,922.15	14,708,809.43	132,185,576	0	349,511.0	186	0	0	11.20	11.13	0.00
	242	LGS M SEC	154,989.73	1,004.65	153,985.08	1,430,000	0	3,365.0	1	0	0	10.84	10.77	0.00
	244	LGS PRI	910,241.48	7,613.84	902,627.64	9,241,200	0	24,893.0	7	0	0	9.85	9.77	0.00
	248	LGS SUB	200,320.97	1,371.80	198,949.17	2,671,375	0	6,468.0	1	0	0	7.50	7.45	0.00
	251	LGS-LM-TD	89,884.05	838.12	89,045.93	755,340	384,340	0.0	4	0	0	11.90	11.79	0.00
	358	IGS PRI	773,308.37	5,223.86	768,084.51	9,337,200	0	18,439.0	2	0	0	8.28	8.23	0.00

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
212 - Summary			**38,746,021.17**	**225,047.36**	**38,520,973.81**	**316,312,665**	**4,512,559**	**1,032,022.6**	**4,812**	**1,331**	**2,304**	**12.25**	**12.18**	**22,525.55**
213	093	OL 175 MV	899.53	3.78	895.75	5,184	0	0.0	0	6	6	17.35	17.28	0.00
	094	OL 100 HP	5,463.05	14.18	5,448.87	20,068	0	0.0	0	25	42	27.22	27.15	0.00
	095	OL 400 MV	1,026.10	5.39	1,020.71	7,584	0	0.0	0	3	4	13.53	13.46	0.00
	097	OL 200 HP	5,671.41	21.52	5,649.89	30,360	0	0.0	0	20	30	18.68	18.61	235.20
	098	OL 400 HP	4,859.60	23.04	4,836.56	32,000	0	0.0	0	5	16	15.19	15.11	348.00
	107	OL 200HPF	19,343.55	65.30	19,278.25	90,099	0	0.0	0	44	89	21.47	21.40	518.40
	109	OL400 HPF	131,906.45	637.31	131,269.14	857,476	0	0.0	0	96	429	15.38	15.31	5,412.93
	110	OL 250 MH	1,059.81	3.47	1,056.34	4,816	0	0.0	0	3	4	22.01	21.93	64.80
	111	OL100 HPP	6,067.29	10.19	6,057.10	14,036	0	0.0	0	4	29	43.23	43.15	0.00
	113	OL 150 HP	10,991.51	31.39	10,960.12	42,555	0	0.0	0	30	60	25.83	25.76	1,703.78
	116	OL 400 MH	24,670.11	109.74	24,560.37	146,628	0	0.0	0	19	78	16.82	16.75	736.20
	131	OL 1000MH	593.10	1.62	591.48	4,206	0	0.0	0	1	1	14.10	14.06	64.80
	211	GS SEC	318,079.45	1,732.26	316,347.19	2,087,392	0	4,310.5	248	0	0	15.24	15.16	0.00
	214	GS - AF	120,722.16	413.36	120,308.80	905,156	0	19,982.8	60	0	0	13.34	13.29	0.00
	215	GS SEC	2,455,065.07	14,478.47	2,440,586.60	18,407,777	0	75,023.1	207	0	0	13.34	13.26	0.00
	223	GS LM ON	6,113.46	98.58	6,014.88	63,520	47,840	0.0	1	0	0	9.62	9.47	0.00
	240	LGS SEC	2,391,125.93	11,830.92	2,379,295.01	20,342,044	0	64,635.0	36	0	0	11.75	11.70	0.00
	260	PS SEC	12,902,050.58	72,217.28	12,829,833.30	105,257,381	0	396,857.0	156	0	0	12.26	12.19	0.00
	264	PS PRI	220,503.03	1,637.80	218,865.23	2,103,900	0	7,465.0	1	0	0	10.48	10.40	0.00
	358	IGS PRI	379,463.49	1,875.16	377,588.33	3,988,200	0	10,449.0	1	0	0	9.51	9.47	0.00
	359	IGS SUB	192,110.72	708.53	191,402.19	1,868,300	0	6,543.0	1	0	0	10.28	10.24	0.00
213 - Summary			**19,197,785.40**	**105,919.29**	**19,091,866.11**	**156,278,682**	**47,840**	**585,265.4**	**711**	**256**	**789**	**12.28**	**12.22**	**9,084.11**
216	093	OL 175 MV	4,950.81	20.46	4,930.35	28,488	0	0.0	0	23	34	17.38	17.31	0.00
	094	OL 100 HP	25,833.05	62.61	25,770.44	92,533	0	0.0	0	118	191	27.92	27.85	563.61
	095	OL 400 MV	3,591.73	18.89	3,572.84	26,537	0	0.0	0	8	14	13.53	13.46	0.00
	097	OL 200 HP	24,087.14	86.36	24,000.78	123,583	0	0.0	0	56	122	19.49	19.42	1,799.40
	098	OL 400 HP	29,733.81	84.22	29,649.59	193,454	0	0.0	0	14	98	15.37	15.33	2,234.40

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												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
216	107	OL 200HPF	37,125.73	117.69	37,008.04	169,561	0	0.0	0	94	168	21.90	21.83	1,610.22
	109	OL400 HPF	140,375.82	659.49	139,716.33	922,721	0	0.0	0	196	464	15.21	15.14	4,528.04
	110	OL 250 MH	2,290.86	7.82	2,283.04	10,836	0	0.0	0	6	9	21.14	21.07	64.80
	111	OL100 HPP	68,621.23	117.02	68,504.21	157,950	0	0.0	0	37	326	43.44	43.37	259.20
	113	OL 150 HP	53,130.10	155.51	52,974.59	215,876	0	0.0	0	149	307	24.61	24.54	6,338.40
	116	OL 400 MH	28,751.19	105.42	28,645.77	168,738	0	0.0	0	22	89	17.04	16.98	1,011.24
	120	OL 250HPP	382.32	0.87	381.45	1,236	0	0.0	0	1	1	30.93	30.86	0.00
	122	OL150 HPP	11,012.27	16.30	10,995.97	22,528	0	0.0	0	6	32	48.88	48.81	0.00
	131	OL 1000MH	4,508.34	26.11	4,482.23	36,172	0	0.0	0	6	8	12.46	12.39	64.80
	204	GS-MTRD	10,561.06	0.63	10,560.43	19,201	0	0.0	43	0	0	55.00	55.00	0.00
	211	GS SEC	2,261,586.61	12,694.80	2,248,891.81	14,238,704	76,138	26,446.2	2,026	0	0	15.88	15.79	0.00
	213	GS-UMR	91,878.66	1,312.81	90,565.85	502,493	0	0.0	135	0	0	18.28	18.02	0.00
	214	GS - AF	47,392.57	300.81	47,091.76	367,919	0	6,777.2	19	0	0	12.88	12.80	0.00
	215	GS SEC	7,656,935.49	41,583.62	7,615,351.87	58,197,526	0	226,545.6	731	0	0	13.16	13.09	0.00
	217	GS PRI	96,939.56	275.37	96,664.19	484,400	0	6,013.8	4	0	0	20.01	19.96	0.00
	218	GS M SEC	28,508.33	173.63	28,334.70	217,440	0	732.8	1	0	0	13.11	13.03	0.00
	223	GS LM ON	2,966.32	17.13	2,949.19	19,765	12,958	0.0	3	0	0	15.01	14.92	0.00
	225	GS LM TOD	3,711.85	29.76	3,682.09	25,176	14,478	0.0	3	0	0	14.74	14.63	0.00
	229	GS-TOD	33,624.16	82.37	33,541.79	230,857	109,312	0.0	10	0	0	14.56	14.53	0.00
	240	LGS SEC	8,144,607.67	45,303.23	8,099,304.44	72,734,336	0	190,057.0	94	0	0	11.20	11.14	0.00
	242	LGS M SEC	661,281.01	4,311.88	656,969.13	6,080,480	0	14,323.0	6	0	0	10.88	10.80	0.00
	244	LGS PRI	313,252.68	1,518.73	311,733.95	2,899,280	0	10,804.0	3	0	0	10.80	10.75	0.00
	246	LGS M PRI	67,004.66	317.67	66,686.99	668,340	0	1,882.0	1	0	0	10.03	9.98	0.00
	251	LGS-LM-TD	107,938.69	393.67	107,545.02	996,480	576,960	0.0	2	0	0	10.83	10.79	0.00
	358	IGS PRI	2,104,195.20	15,339.33	2,088,855.87	25,507,800	0	51,229.0	4	0	0	8.25	8.19	0.00
	540	MW	202,104.88	1,372.93	200,731.95	1,849,587	0	2,867.8	9	0	0	10.93	10.85	0.00
216 - Summary			**22,268,883.80**	**126,507.14**	**22,142,376.66**	**187,209,997**	**789,846**	**537,678.4**	**3,094**	**735**	**1,864**	**11.90**	**11.83**	**18,474.11**
221	093	OL 175 MV	1,199.44	5.04	1,194.40	6,912	0	0.0	0	8	8	17.35	17.28	0.00

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Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
221	094	OL 100 HP	7,702.19	20.73	7,681.46	27,707	0	0.0	0	30	57	27.80	27.72	129.60
	095	OL 400 MV	961.41	5.73	955.68	6,776	0	0.0	0	3	4	14.19	14.10	25.44
	097	OL 200 HP	5,797.83	23.33	5,774.50	31,752	0	0.0	0	8	32	18.26	18.19	128.26
	098	OL 400 HP	557.09	2.89	554.20	4,000	0	0.0	0	1	2	13.93	13.86	0.00
	107	OL 200HPF	4,211.95	14.39	4,197.56	20,240	0	0.0	0	12	20	20.81	20.74	0.00
	109	OL400 HPF	55,449.23	253.25	55,195.98	362,980	0	0.0	0	45	183	15.28	15.21	1,626.60
	110	OL 250 MH	1,477.00	5.23	1,471.77	7,224	0	0.0	0	1	6	20.45	20.37	0.00
	111	OL100 HPP	1,254.83	2.12	1,252.71	2,904	0	0.0	0	1	6	43.21	43.14	0.00
	113	OL 150 HP	8,373.68	28.59	8,345.09	34,732	0	0.0	0	25	49	24.11	24.03	871.40
	116	OL 400 MH	11,959.54	45.42	11,914.12	72,684	0	0.0	0	13	39	16.45	16.39	59.40
	131	OL 1000MH	3,492.27	19.51	3,472.76	27,240	0	0.0	0	3	6	12.82	12.75	129.60
	204	GS-MTRD	1,477.58	5.74	1,471.84	7,977	0	0.0	3	0	0	18.52	18.45	0.00
	211	GS SEC	611,991.20	2,077.05	609,914.15	3,752,731	0	4,502.1	604	0	0	16.31	16.25	0.00
	215	GS SEC	1,460,777.88	6,319.11	1,454,458.77	10,844,220	0	47,079.8	141	0	0	13.47	13.41	0.00
	217	GS PRI	56,185.39	116.93	56,068.46	367,800	0	2,427.2	8	0	0	15.28	15.24	0.00
	220	GSCC PRI	148,793.79	1,103.89	147,689.90	1,260,480	0	2,790.9	10	0	0	11.80	11.72	0.00
	236	GSCC SUB	4,651.14	-4.84	4,655.98	33,250	0	52.5	0	0	0	13.99	14.00	0.00
	240	LGS SEC	3,691,124.15	16,810.59	3,674,313.56	27,727,050	0	128,287.0	48	0	0	13.31	13.25	0.00
	244	LGS PRI	1,559,844.76	10,934.14	1,548,910.62	12,885,100	0	57,614.0	13	0	0	12.11	12.02	0.00
	248	LGS SUB	165,501.82	439.27	165,062.55	2,093,000	0	5,544.0	1	0	0	7.91	7.89	0.00
	250	LGS TRAN	199,149.29	-1,591.72	200,741.01	4,087,639	0	4,780.0	0	0	0	4.87	4.91	0.00
	331	CS-IRP ST	7,068,967.01	76,341.22	6,992,625.79	132,528,000	0	221,597.0	1	0	0	5.33	5.28	0.00
	358	IGS PRI	7,496,875.66	61,074.81	7,435,800.85	95,450,600	0	180,085.0	12	0	0	7.85	7.79	0.00
	359	IGS SUB	4,924,967.28	27,218.16	4,897,749.12	44,114,300	0	195,519.0	5	0	0	11.16	11.10	0.00
	360	IGS	973,592.73	6,060.12	967,532.61	9,144,000	0	46,459.0	1	0	0	10.65	10.58	0.00
	370	IGS	420,505.61	-8,347.16	428,852.77	7,394,400	-1,720,800	14,014.2	0	0	0	5.69	5.80	0.00
	371	IGS	69,247,937.50	700,881.10	68,547,056.40	1,290,424,000	0	1,941,504.0	4	0	0	5.37	5.31	0.00
	372	IGS	17,483,578.42	233,008.16	17,250,570.26	318,214,974	-2,814,000	515,094.0	3	0	0	5.49	5.42	0.00

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Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
221 - Summary			**115,618,357.67**	**1,132,872.80**	**114,485,484.87**	**1,960,934,672**	**-4,534,800**	**3,367,349.7**	**855**	**150**	**412**	**5.90**	**5.84**	**2,970.30**
222	097	OL 200 HP	711.15	2.55	708.60	3,685	0	0.0	0	2	4	19.30	19.23	42.68
	107	OL 200HPF	210.59	0.72	209.87	1,012	0	0.0	0	1	1	20.81	20.74	0.00
	109	OL400 HPF	2,343.17	9.70	2,333.47	15,563	0	0.0	0	5	8	15.06	14.99	48.00
	113	OL 150 HP	1,755.38	4.46	1,750.92	6,839	0	0.0	0	6	10	25.67	25.60	259.20
	211	GS SEC	49,125.88	228.85	48,897.03	344,777	0	736.5	29	0	0	14.25	14.18	0.00
	215	GS SEC	202,325.55	1,000.04	201,325.51	1,476,062	0	7,049.8	21	0	0	13.71	13.64	0.00
	220	GSCC PRI	24,946.17	161.19	24,784.98	198,600	0	642.0	2	0	0	12.56	12.48	0.00
	229	GS-TOD	492.18	8.34	483.84	6,000	6,000	0.0	0	0	0	8.20	8.06	0.00
	240	LGS SEC	1,015,080.36	6,553.77	1,008,526.59	8,165,816	0	32,437.0	9	0	0	12.43	12.35	0.00
	244	LGS PRI	349,561.95	3,262.82	346,299.13	3,926,400	0	6,744.0	1	0	0	8.90	8.82	0.00
	251	LGS-LM-TD	1,248.80	-0.73	1,249.53	500	300	0.0	1	0	0	249.76	249.91	0.00
	356	IGS SEC	290,133.93	-96.04	290,229.97	2,128,200	0	7,568.0	1	0	0	13.63	13.64	0.00
	358	IGS PRI	922,426.86	6,217.82	916,209.04	11,702,400	0	22,917.0	1	0	0	7.88	7.83	0.00
222 - Summary			**2,860,361.97**	**17,353.49**	**2,843,008.48**	**27,975,854**	**6,300**	**78,094.3**	**65**	**14**	**22**	**10.22**	**10.16**	**349.88**
230	093	OL 175 MV	50.37	0.70	49.67	308	0	0.0	0	0	0	16.35	16.13	0.00
	094	OL 100 HP	975.02	2.83	972.19	3,580	0	0.0	0	6	7	27.24	27.16	0.00
	095	OL 400 MV	373.13	4.93	368.20	2,720	0	0.0	0	1	2	13.72	13.54	0.00
	097	OL 200 HP	8,558.10	38.94	8,519.16	42,740	0	0.0	0	8	48	20.02	19.93	612.00
	107	OL 200HPF	1,296.35	3.98	1,292.37	5,934	0	0.0	0	4	6	21.85	21.78	48.00
	109	OL400 HPF	11,782.90	62.74	11,720.16	76,767	0	0.0	0	18	40	15.35	15.27	387.63
	113	OL 150 HP	4,729.50	16.20	4,713.30	20,312	0	0.0	0	17	30	23.28	23.20	343.27
	116	OL 400 MH	931.24	4.07	927.17	5,685	0	0.0	0	2	3	16.38	16.31	0.00
	211	GS SEC	83,405.04	423.93	82,981.11	523,197	0	1,152.3	77	0	0	15.94	15.86	0.00
	215	GS SEC	421,986.64	2,680.57	419,306.07	3,144,852	0	13,867.6	67	0	0	13.42	13.33	0.00
	217	GS PRI	15,628.81	428.46	15,200.35	115,260	0	293.7	3	0	0	13.56	13.19	0.00
	220	GSCC PRI	378,367.96	1,836.69	376,531.27	3,070,975	0	8,128.7	32	0	0	12.32	12.26	0.00
	236	GSCC SUB	83,050.24	558.44	82,491.80	650,300	0	1,678.4	4	0	0	12.77	12.69	0.00

State : KY

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
230	240	LGS SEC	452,376.60	2,222.33	450,154.27	2,608,456	0	21,500.0	8	0	0	17.34	17.26	0.00
	244	LGS PRI	3,955,283.18	23,291.06	3,931,992.12	32,183,140	0	162,436.0	28	0	0	12.29	12.22	0.00
	248	LGS SUB	685,538.83	7,313.54	678,225.29	7,451,102	0	24,410.0	9	0	0	9.20	9.10	0.00
	250	LGS TRAN	34,439.37	685.22	33,754.15	399,000	0	851.0	1	0	0	8.63	8.46	0.00
	257	LGSPRITOD	450,167.63	3,064.76	447,102.87	5,321,733	2,987,250	8,467.0	2	0	0	8.46	8.40	0.00
	330	CS-IRP PR	738,477.73	2,718.69	735,759.04	4,133,500	0	29,857.0	1	0	0	17.87	17.80	0.00
	331	CS-IRP ST	3,336,960.75	36,789.44	3,300,171.31	48,253,000	0	132,837.0	2	0	0	6.92	6.84	0.00
	333	CS-IRP	380,365.16	1,035.12	379,330.04	6,744,000	0	16,632.0	0	0	0	5.64	5.62	0.00
	358	IGS PRI	12,567,978.16	61,210.85	12,506,767.31	103,032,900	0	394,420.0	16	0	0	12.20	12.14	0.00
	359	IGS SUB	7,125,483.70	80,599.75	7,044,883.95	84,468,800	0	274,897.0	6	0	0	8.44	8.34	0.00
	360	IGS	1,328,307.21	11,740.57	1,316,566.64	12,404,000	0	57,400.0	1	0	0	10.71	10.61	0.00
	371	IGS	578,372.28	7,362.10	571,010.18	9,744,000	0	16,534.0	1	0	0	5.94	5.86	0.00
230 - Summary			**32,644,885.90**	**244,095.91**	**32,400,789.99**	**324,406,261**	**2,987,250**	**1,165,361.7**	**256**	**58**	**136**	**10.06**	**9.99**	**1,390.90**
400	093	OL 175 MV	299.77	1.25	298.52	1,728	0	0.0	0	1	2	17.35	17.28	0.00
	094	OL 100 HP	527.96	1.43	526.53	1,936	0	0.0	0	2	4	27.27	27.20	0.00
	097	OL 200 HP	179.96	0.71	179.25	1,012	0	0.0	0	1	1	17.78	17.71	0.00
	107	OL 200HPF	210.59	0.71	209.88	1,012	0	0.0	0	1	1	20.81	20.74	0.00
	109	OL400 HPF	6,959.35	32.94	6,926.41	45,976	0	0.0	0	7	23	15.14	15.07	194.40
	111	OL100 HPP	19,232.39	32.28	19,200.11	44,512	0	0.0	0	19	92	43.21	43.13	0.00
	113	OL 150 HP	747.19	2.06	745.13	2,816	0	0.0	0	2	4	26.53	26.46	129.60
	122	OL150 HPP	2,650.20	3.52	2,646.68	5,398	0	0.0	0	2	8	49.10	49.03	0.00
	131	OL 1000MH	556.93	3.27	553.66	4,540	0	0.0	0	1	1	12.27	12.20	0.00
	204	GS-MTRD	1,595.96	0.04	1,595.92	68	0	0.0	8	0	0	2,347.00	2,346.94	0.00
	211	GS SEC	144,338.39	439.78	143,898.61	562,942	0	441.0	251	0	0	25.64	25.56	0.00
	213	GS-UMR	215.70	0.03	215.67	60	0	0.0	1	0	0	359.50	359.45	0.00
	215	GS SEC	154,901.56	777.04	154,124.52	1,226,399	0	3,915.7	14	0	0	12.63	12.57	0.00
	528	SL	1,628,937.63	6,028.02	1,622,909.61	8,436,725	0	0.0	54	0	0	19.31	19.24	0.00
400 - Summary			**1,961,353.58**	**7,323.08**	**1,954,030.50**	**10,335,124**	**0**	**4,356.7**	**329**	**36**	**136**	**18.98**	**18.91**	**324.00**

State : KY

December 2019

												Realization		
Rev Class	Tariff		Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
KY - Summary			548,520,471.26	4,036,733.68	544,483,737.58	5,596,404,563	13,359,429	8,310,627.2	165,462	44,911	53,979	9.80	9.73	287,057.66

American Electric Power
KENTUCKY POWER COMPANY

TARIFF SUMMARY REVENUE- BY REVENUE CLASS

12 MONTHS BILLED + ESTIMATED - MCSR0162 - FINAL

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December 2019

Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

American Electric Power
KENTUCKY POWER COMPANY

TARIFF SUMMARY REVENUE- BY REVENUE CLASS

12 MONTHS BILLED + ESTIMATED - MCSR0162 - FINAL

Standard Service Offer

Prepared: 01/08/2020

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December 2019

											Realization		
Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Incl Fuel	Excl Fuel	Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

December 2019

Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

December 2019

Rev Class	Tariff	Revenue	Fuel Clause	Revenue Excl Fuel Clause	Metered KWH	Off Pk KWH	Billing Demand	# Of Cust Incl	# Of Cust Excl	# Of Lamps	Realization Incl Fuel	Realization Excl Fuel	Realization Facility Charge
Grand Total		0.00	0.00	0.00	0	0	0.0	0	0	0	0.00	0.00	0.00

KENTUCKY POWER BILLING ANALYSIS
PER BOOKS
TEST YEAR ENDED MARCH 31, 2020

NO. OF CUSTOMERS BY TARIFF

Tariff	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	12M Mar 2020 Total	Annualized 12M Total	Customer Count Difference	Customer % Difference
11	79	77	79	80	80	80	81	80	83	86	91	95	991	1,140	149	15.03532%
12	10	10	10	10	10	10	10	10	10	10	10	11	121	132	11	9.09091%
13	2	1	1	1	1	1	1	1	1	1	1	1	13	12	(1)	-7.69231%
14	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00000%
15	64,570	64,449	64,395	64,461	64,462	64,553	64,500	64,550	64,662	64,710	64,650	64,720	774,682	776,640	1,958	0.25275%
17	422	414	412	405	402	396	391	390	388	387	387	384	4,778	4,608	(170)	-3.55797%
18	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00000%
22	68,967	68,835	68,677	68,630	68,593	68,532	68,478	68,422	68,546	68,489	68,375	68,385	822,929	820,620	(2,309)	-0.28058%
62	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00000%
RS	134,050	133,786	133,574	133,587	133,548	133,572	133,461	133,453	133,690	133,683	133,514	133,596	1,603,514	1,603,152	(362)	-0.02258%
28	6	6	6	6	6	6	6	6	6	6	6	6	72	72	-	0.00000%
30	66	65	65	65	66	66	66	66	64	66	67	65	787	780	(7)	-0.88945%
32	83	83	83	83	80	79	80	79	79	79	79	79	966	948	(18)	-1.86335%
34	2	2	2	2	2	2	2	2	2	2	2	2	24	24	-	0.00000%
RS LMTOD	157	156	156	156	154	153	154	153	151	153	154	152	1,849	1,824	(25)	-1.35208%
36	5	5	5	5	5	5	5	5	5	5	5	6	61	72	11	18.03279%
RS TOD	5	5	5	5	5	5	5	5	5	5	5	6	61	72	11	18.03279%
RS TOTAL	**134,212**	**133,947**	**133,735**	**133,748**	**133,707**	**133,730**	**133,620**	**133,611**	**133,846**	**133,841**	**133,673**	**133,754**	**1,605,424**	**1,605,048**	**(376)**	**-0.02342%**
211	22,369	22,364	22,343	22,432	22,382	22,380	22,319	22,309	22,309	22,336	22,244	22,223	268,010	266,676	(1,334)	-0.49774%
212	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
215	6,399	6,364	6,337	6,353	6,332	6,313	6,319	6,311	6,313	6,304	6,309	6,316	75,970	75,792	(178)	-0.23430%
216	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
218	1	1	1	1	1	1	1	1	1	1	1	1	12	12	-	0.00000%
GS-SEC	28,769	28,729	28,681	28,786	28,715	28,694	28,639	28,621	28,623	28,641	28,554	28,540	343,992	342,480	(1,512)	-0.43955%
204	487	456	456	456	456	456	456	456	456	456	456	456	5,503	5,472	(31)	-0.56333%
213	583	583	583	583	583	582	581	581	583	583	580	580	6,985	6,960	(25)	-0.35791%
GS-NM	1,070	1,039	1,039	1,039	1,039	1,038	1,037	1,037	1,039	1,039	1,036	1,036	12,488	12,432	(56)	-0.44843%
227	429	485	491	490	492	490	490	490	489	492	491	491	5,820	5,892	72	1.23711%
SGS TOD	429	485	491	490	492	490	490	490	489	492	491	491	5,820	5,892	72	1.23711%
214	87	85	85	85	84	84	84	84	83	84	83	85	1,013	1,020	7	0.69102%
GS-AF	87	85	85	85	84	84	84	84	83	84	83	85	1,013	1,020	7	0.69102%
223	42	42	42	42	42	42	42	42	42	42	42	42	504	504	-	0.00000%
225	31	31	31	31	31	31	31	31	31	31	31	31	372	372	-	0.00000%
GSLMTOD	73	73	73	73	73	73	73	73	73	73	73	73	876	876	-	0.00000%
229	95	96	98	98	100	101	101	101	102	102	102	102	1,198	1,224	26	2.17028%
MGSTOD	95	96	98	98	100	101	101	101	102	102	102	102	1,198	1,224	26	2.17028%
217	25	26	28	28	29	28	28	28	28	28	28	28	332	336	4	1.20482%
220	44	45	47	46	47	48	50	57	50	50	46	47	577	564	(13)	-2.25303%
GS-PRI	69	71	75	74	76	76	78	85	78	78	74	75	909	900	(9)	-0.99010%
236	7	5	4	4	4	4	4	4	4	5	3	6	54	72	18	33.33333%
GS-SUB	7	5	4	4	4	4	4	4	4	5	3	6	54	72	18	33.33333%
GS TOTAL	**30,599**	**30,583**	**30,546**	**30,649**	**30,583**	**30,560**	**30,506**	**30,495**	**30,491**	**30,514**	**30,416**	**30,408**	**366,350**	**364,896**	**(1,454)**	**-0.39689%**
240	544	544	538	537	537	537	535	536	536	529	520	522	6,415	6,264	(151)	-2.35386%
242	7	7	7	7	7	7	7	7	7	7	7	7	84	84	-	0.00000%
LGS-SEC	551	551	545	544	544	544	542	543	543	536	527	529	6,499	6,348	(151)	-2.32343%
251	7	7	7	7	7	7	7	7	7	7	7	7	84	84	-	0.00000%
LGSLMTOD	7	7	7	7	7	7	7	7	7	7	7	7	84	84	-	0.00000%
256	7	7	7	7	7	7	7	7	7	7	7	7	84	84	-	0.00000%
LGS-SEC TOD	7	7	7	7	7	7	7	7	7	7	7	7	84	84	-	0.00000%
257	2	2	1	3	2	1	2	3	2	2	1	2	23	24	1	4.34783%
LGS-PRI TOD	2	2	1	3	2	1	2	3	2	2	1	2	23	24	1	4.34783%
244	64	65	61	69	63	63	61	64	61	57	52	53	733	636	(92)	-12.55116%

KENTUCKY POWER BILLING ANALYSIS
PER BOOKS
TEST YEAR ENDED MARCH 31, 2020

NO. OF CUSTOMERS BY TARIFF

Tariff	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	12M Mar 2020 Total	Annualized 12M Total	Customer Count Difference	Customer % Difference
246	1	1	1	1	1	1	1	1	1	1	1	1	12	12	-	0.00000%
LGS-PRI	65	66	62	70	64	64	62	65	62	58	53	54	745	648	(92)	-12.34899%
248	15	14	11	15	13	13	13	12	14	14	11	12	157	144	(12)	-7.64331%
LGS-SUB	15	14	11	15	13	13	13	12	14	14	11	12	157	144	(12)	-7.64331%
250	1	1	1	1	1	1	-	-	2	1	1	1	11	12	1	9.09091%
LGS-TRAN	1	1	1	1	1	1	-	-	2	1	1	1	11	12	1	9.09091%
LGS TOTAL	**648**	**648**	**634**	**647**	**638**	**637**	**633**	**637**	**637**	**625**	**607**	**612**	**7,603**	**7,344**	**(253)**	**-3.32763%**
260	156	156	155	155	155	155	156	153	154	154	152	153	1,854	1,836	(18)	-0.97087%
PS-SEC	156	156	155	155	155	155	156	153	154	154	152	153	1,854	1,836	(18)	-0.97087%
264	1	1	1	1	1	1	1	1	1	1	1	1	12	12	-	0.00000%
PS-PRI	1	1	1	1	1	1	1	1	1	1	1	1	12	12	-	0.00000%
PS TOTAL	**157**	**157**	**156**	**156**	**156**	**156**	**157**	**154**	**155**	**155**	**153**	**154**	**1,866**	**1,848**	**(18)**	**-0.96463%**
356	4	5	5	5	5	5	5	5	5	5	5	5	59	60	1	1.69492%
IGS-SEC	4	5	5	5	5	5	5	5	5	5	5	5	59	60	1	1.69492%
330	1	1	1	1	2	1	1	1	1	1	1	1	13	12	-	0.00000%
358	43	43	43	46	44	45	43	45	49	42	43	42	528	504	(23)	-4.35606%
370	-	-	-	-	1	1	2	1	1	1	1	1	9	12	3	33.33333%
IGS-PRI	44	44	44	47	47	47	46	47	51	44	45	44	550	528	(20)	-3.63636%
331	3	3	3	3	3	3	3	2	2	1	1	1	28	12	(15)	-53.57143%
333	-	-	-	-	-	-	-	1	1	1	1	1	5	12	7	140.00000%
359	16	16	15	14	13	13	13	13	15	13	12	12	165	144	(20)	-12.12121%
371	5	5	5	5	5	5	5	5	5	5	5	5	60	60	-	0.00000%
IGS-SUB	24	24	23	22	21	21	21	21	23	20	19	19	258	228	(28)	-10.85271%
332	-	-	-	-	-	-	-	-	-	-	1	1	2	12	10	500.00000%
360	2	2	2	2	2	2	2	2	2	2	2	2	24	24	-	0.00000%
372	3	3	3	3	3	3	2	2	2	2	1	1	28	12	(15)	-53.57143%
IGS-TRAN	5	5	5	5	5	5	4	4	4	4	4	4	54	48	(5)	-9.25926%
IGS TOTAL	**77**	**78**	**77**	**79**	**78**	**78**	**76**	**77**	**83**	**73**	**73**	**72**	**921**	**864**	**(52)**	**-5.64604%**
93	696	690	684	692	680	678	683	672	676	674	668	646	8,139	7,752	(387)	-4.75488%
94	21,354	21,363	21,272	21,267	21,314	21,235	21,180	21,210	21,153	21,209	21,153	21,115	254,825	253,380	(1,445)	-0.56706%
95	82	81	84	81	81	80	80	76	76	76	75	75	947	900	(47)	-4.96304%
97	1,741	1,724	1,723	1,717	1,714	1,710	1,699	1,731	1,644	1,693	1,691	1,690	20,477	20,280	(197)	-0.96205%
98	221	221	222	223	227	229	227	229	230	231	229	230	2,719	2,760	41	1.50791%
99	9	9	9	9	9	10	9	9	9	9	9	9	109	108	(1)	-0.91743%
103	2	2	2	2	2	2	2	2	2	2	2	2	24	24	-	0.00000%
107	1,749	1,746	1,764	1,754	1,757	1,752	1,750	1,747	1,760	1,741	1,743	1,729	20,992	20,748	(244)	-1.16235%
109	4,100	4,090	4,095	4,100	4,072	4,090	4,103	3,953	4,038	4,042	4,064	3,962	48,709	47,544	(1,165)	-2.39176%
110	137	138	138	138	139	129	137	145	139	139	143	153	1,675	1,836	161	9.61194%
111	802	804	800	794	795	797	775	775	774	843	787	793	9,539	9,516	(23)	-0.24112%
113	22,047	22,029	22,109	22,060	22,065	22,064	22,149	22,107	22,185	22,178	22,143	22,251	265,387	267,012	1,625	0.61231%
116	940	936	964	949	942	948	940	934	947	943	931	935	11,309	11,220	(89)	-0.78698%
120	2	2	2	2	2	2	2	2	2	2	2	2	24	24	-	0.00000%
122	71	71	71	71	70	70	71	49	68	67	67	67	813	804	(9)	-1.10701%
126	3	3	3	3	3	3	3	3	3	3	3	3	36	36	-	0.00000%
130	3	4	4	4	4	4	4	4	4	4	4	4	47	48	1	2.12766%
131	95	95	95	95	95	95	95	95	97	99	97	98	1,151	1,176	25	2.17202%
136	1	1	1	1	1	1	1	1	2	2	2	5	19	60	41	215.78947%
OL	54,055	54,009	54,042	53,962	53,972	53,899	53,910	53,744	53,809	53,957	53,813	53,769	646,941	645,228	(1,713)	-0.26478%
528	11,910	11,920	11,918	11,914	11,901	11,901	11,902	11,960	11,936	11,937	11,936	11,943	143,078	143,316	238	0.16634%
SL	11,910	11,920	11,918	11,914	11,901	11,901	11,902	11,960	11,936	11,937	11,936	11,943	143,078	143,316	238	0.16634%
540	9	9	9	9	9	9	9	9	9	9	9	9	108	108	-	0.00000%
MW	9	9	9	9	9	9	9	9	9	9	9	9	108	108	-	0.00000%
TOTAL - Excluding OL and SL	**165,702**	**165,422**	**165,157**	**165,288**	**165,171**	**165,170**	**165,001**	**164,983**	**165,221**	**165,217**	**164,931**	**165,009**	**1,982,272**	**1,980,108**	**(2,153)**	**-0.10861%**

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_16 Provide a copy of each cost-of-service study and billing analysis filed with the utility's rate application in Excel spreadsheet format with all formulas intact and unprotected and with all columns and rows accessible.

RESPONSE

Please refer to KPCO_R_KPSC_2_16_Attachment1, KPCO_R_KPSC_2_16_Attachment2, and KPCO_R_KPSC_2_16_Attachment3 for the requested information.

Witness: Jason M. Stegall

Witness: Alex E. Vaughan

Witness: Jaclyn N. Cost

Kentucky Power Company
KPSC Case No. 2020-00174
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Order Dated June 30, 2020

DATA REQUEST

KPSC 2_17 Provide the following expense account data:
a. A schedule, in comparative form, showing the total company and Kentucky operating expense account balance for the test year and each of the three most recent calendar years preceding the test year for each account or subaccount included in the utility's annual report (FERC Form 1, pages 320-323). Show the percentage of increase or decrease of each year over the prior year.
b. A listing, with descriptions, of all activities, initiatives, or programs undertaken or continued by Kentucky Power since its last general rate case for the purpose of minimizing costs or improving the efficiency of its operations or maintenance activities. Include all quantifiable realized and projected savings.

RESPONSE

a. - b.) See the Company's response to KPSC 2-1.

Witness: Brian K. West

Kentucky Power Company
KPSC Case No. 2020-00174
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Order Dated June 30, 2020

DATA REQUEST

KPSC 2_18 Provide a schedule, in the format provides in Schedule F of electric operations net income, per kWh sold, per company books for the test year and three calendar years preceding the test year.

RESPONSE

Please refer to KPCO_R_KPSC_2_18_Attachment1 for the requested information.

Witness: Heather M. Whitney

Kentucky Power Company
KPSC Case No. 2020-00174
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Order Dated June 30, 2020

DATA REQUEST

KPSC 2_19 Provide the comparative operating statistics for total company as shown in Schedule G.

RESPONSE

Please see KPCO_R_KPSC_2_19_Attachment1 for the requested comparative operating statistics.

Witness: Heather M. Whitney

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_20 Provide the information requested in Schedule H for budgeted and actual numbers of full- and part-time employees by employee group, by month, and by year; and regular wages, overtime wages, and total wages by employee group, by month, for the test year and three most recent calendar years preceding the test year. Explain any variance exceeding five percent.

RESPONSE

Refer to KPCO_R_KPSC_2_20_Attachment1 for the information requested in Schedule H pages 1 and 2.
Refer to KPCO_R_KPSC_2_20_Attachment2 for the information requested in Schedule H page 3. The Company does not capture wage information by employee group for the budget. Monthly variances in total that exceed 5% during the periods provided are mainly attributable to open positions, differences between calendar month and payroll cycle, storm outage work, unplanned outages, and timing differences of planned outage work when compared to budget.

Witness: Everett G. Phillips

Witness: Brian K. West

Kentucky Power Company
KPSC Case No. 2020-00174
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Order Dated June 30, 2020

DATA REQUEST

KPSC 2_21 State whether the utility, through an outside consultant or otherwise, performed a study or survey to compare its wages, salaries, benefits, and other compensation to those of other utilities in the region or to other local or regional enterprises since the utility's last base rate case.
a. If comparison were performed, provide the results of the study or survey, including all workpapers, and discuss the results of such comparisons. State whether any adjustments to wages, salaries, benefits, and other compensation in the rate application are consistent with the results of such comparisons.
b. If comparisons were not performed, explain why not.

RESPONSE

a. The Company compares its employee compensation information to utility and general industrial companies on an as needed basis. In particular, the Company compares market compensation for individual or a small group of positions whenever 1. new positions are created; 2. a compensation review is requested by AEP management, or 3. when the HR department initiates a review because of rapidly changing market wages or recruiting and retention difficulties. These market compensation comparisons allow the Company to determine appropriate matches of particular positions to market and grades for the positions that gave rise to the analyses. These comparisons lead to discussions with AEP management, but do not result in written reports.
Please refer to KPCO_R_KPSC_2_22_ConfidentialAttachment6 for the market compensation surveys that the Company has relied upon.
In addition, the HR Committee of the Board of Directors annually conducts an executive compensation study covering approximately 25 executive positions. This study is conducted by the HR Committee's external compensation consultant. These studies include non-public compensation information for individual executives.
AEP has also participated in benefits surveys performed by Aon. The Company utilizes the results of such studies to benchmark its benefit plans for reasonableness in terms of plan design and value as compared to other non-affiliated utility employers. It is standard practice in designing benefit plans to rely on resources such as survey data to gauge the reasonableness of employee benefit plans.
Please refer to KPCO_R_KPSC_2_21_ConfidentialAttachment1 for the Aon survey.
b. Not applicable.

Witness: Kimberly K. Kaiser

Redacted in its Entirety

Benefit Index®
2019 Salaried Benefits

American Electric Power Company

June 2019

Aon Empower Results®

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_22 Provide the most recent wage, compensation, and employee benefits studies, analyses, or surveys conducted since the utility's last base rate case or that are currently utilized by the utility.

RESPONSE

Please see KPCO_R_KPSC_2_22_ConfidentialAttachment1, KPCO_R_KPSC_2_22_ConfidentialAttachment2, KPCO_R_KPSC_2_22_ConfidentialAttachment3, and KPCO_R_KPSC_2_22_ConfidentialAttachment4.
The HR Committee of the Board of Directors annually conducts an executive compensation study covering approximately 25 executive positions. These studies are conducted by the HR Committee's external compensation consultant. Please refer to: KPCO_R_KPSC_2_22_ConfidentialAttachment5
The market compensation surveys are voluminous and are subject to the Company's motion to deviate. Please refer to:
KPCO_R_KPSC_2_22_ConfidentialAttachment6
AEP has participated in periodic benefits surveys performed by Aon and Willis Towers Watson. The Company uses these results to benchmark its benefit plans for reasonableness in terms of plan design and value as compared to other non-affiliated utility employers. It is standard practice in benefits design work to rely on resources such as survey data to gauge the reasonableness of employee benefit plans. Please refer to KPCO_R_KPSC_2_22_ConfidentialAttachment7 and KPCO_R_KPSC_2_22_ConfidentialAttachment8.
KPCO_R_2_22_ConfidentialAttachments1-6 are over 20,000 pages and are Proprietary documents of the third parties that performed the surveys. AEP has received signed release agreements from the survey authors to allow Commission Staff to view these documents. As part of the agreement with the authors and has been standard practice historically, AEP will make the surveys available for viewing by the Commission Staff and intervenors who enter into a non-disclosure agreement at the offices of Stites & Harbison PLLC, 421 West Main Street, Frankfort, KY 40602, by appointment.

Witness: Kimberly K. Kaiser

Documents redacted in their entirety

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_23 For each employee group, state the amount, percentage increase, and effective dates for general wage increases and, separately, for merit increases granted or to be granted in the past two calendar years and the historical test period.

RESPONSE

Please refer to KPCO_R_KPSC_2_23_Attachment1 which provides merit and general increases group by Equal Employment Opportunity (EEO) job category. Some EEO job categories are listed more than once because different groups of employees within the EEO category received increases on different dates.
The amounts shown as general wage increases include wage equalization increases and market equity adjustments that are not separately identifiable. The objectives of these increases were to equalize the base rates for journey level physical/craft positions across AEP's system, and to bring these rates to the competitive market median over an indefinite multiple year period.

Witness: Kimberly K. Kaiser

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_24 Provide a schedule reflecting the salaries and other compensation of each executive officer for the base period and three most recent calendar years. Include the percentage annual increase and the effective date of each increase, the job title, duty and responsibility of each officer, the number of employees who report to each officer, and to whom each officer reports. For employees elected to executive officer status since the test year in the utility's most recent rate case, provide the salaries for the persons they replaced.

RESPONSE

Please refer to KPCO_R_KPSC_2_24_ConfidentialAttachment1 for the requested information. It includes the requested information for executive officers of Kentucky Power and AEP as defined in Section 16 of the Securities and Exchange Act. Compensation is included in the year paid or deferred.

Witness: Kimberly K. Kaiser

Kentucky Power Company
KPSC Case No. 2020-00174
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Order Dated June 30, 2020

DATA REQUEST

KPSC 2_25 Provide a listing of all health care plan categories, dental plan categories, and vision plan categories available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees (e.g., single, family). Include the associated employee contribution rates and employer contribution rates of the total premium cost for each category, and each plan's deductible(s) amounts.

RESPONSE

Please see KPCO_R_KPSC_2_25_Attachment1 and KPCO_R_KPSC_2_25_Attachment2 for the requested information.

Witness: Andrew R. Carlin

January 1, 2020 - December 31, 2020

PARTICIPANT MEDICAL CONTRIBUTIONS

The pre-tax monthly cost to active full-time employees is calculated based on a percentage of the total cost of coverage. The pre-tax monthly costs to active part-time employees are two and one-half times the monthly costs of active full-time employees.

MEDICAL PLAN SURCHARGES

Spousal Surcharge

Effective January 1, 2014, if an active employee covers his/her spouse/domestic partner on AEP's medical plan, and that spouse/domestic partner has access to medical coverage through his/her employer, the employee will be assessed a surcharge of $50.00 per month.

Tobacco Surcharge

Effective January 1, 2015, employees who use tobacco and nicotine products will have a surcharge, in the amount of $50.00 per month, assessed when they elect coverage under AEP's medical plan.

January 1, 2020 – December 31, 2020

GROUP MEDICAL PLANS

Health Savings Account (HSA) Plan Options	HSA Basic		HSA Plus	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Company Annual Contribution to HSA	NA	NA	participant only: $500 participant + spouse or participant + child(ren): $750 participant + family: $1,000	
Annual Deductible (includes medical, prescription and behavioral health)	$2,800/participant $5,600/participant + spouse $5,600/participant + 1 child $8,400/participant + children $8,400/participant + family	$4,000/participant $8,000/participant + spouse $8,000/participant + 1 child $12,000/participant + children $12,000/participant + family	$2,000/participant $3,000/participant + spouse $3,000/participant + child(ren) $4,000/participant + family	$3,000/participant $4,500/participant + spouse $4,500/participant + child(ren) $6,000/participant + family
Annual out-of-pocket maximum	$4,000/participant $8,000/participant + spouse $8,000/participant + 1 child $12,000/participant + child(ren) $12,000/participant + family	$8,000/participant $16,000/participant + spouse$16,000/participant + 1 child $24,000/participant + child(ren) $24,000/participant + family	$4,000/participant $6,000/participant + spouse $6,000/participant + child(ren) $8,000/participant + family	$6,000/participant $9,000/participant + spouse $9,000/participant + child(ren) $12,000/participant + family
Co-Insurance	10% after deductible	30% after deductible	15% after deductible	30% after deductible
Preventive Care	$0%; no deductible	30% after deductible	$0%; no deductible	30% after deductible
Prescription Coverage	10% after deductible		15% after deductible	
2020 Full-Time Employee Monthly Cost	Participant only $ 35.47 Participant + spouse/domestic partner $100.93 Participant + child(ren) $ 77.63 Participant + family $143.10		Participant only $92.31 Participant + spouse: $236.42 Participant + child(ren) $185.14 Participant + family $329.26	

January 1, 2020– December 31, 2020

HRA Plan				
		Participant Only	**Participant + Spouse or Participant + Child(ren)**	**Participant + Family**
Health Reimbursement Account (HRA)	AEP Annual Allocation	$1,000	$1,500	$2,000
Traditional Health Coverage (Prescription coverage same as any other medical expense)	Annual Deductible (includes medical, prescription drug and behavioral health)	$1,500	$2,250	$3,000
	Then, employee pays coinsurance for covered services	15% for in-network providers 30% for out-of-network providers		
	Annual Out-of-Pocket Maximum	$4,000 if in-network $6,500 if out-of-network	$6,000 if in-network $9,750 if out-of-network	$8,000 if in-network $13,000 if out-of-network
Annual Preventive (not applied to Company's HRA allocation)	In-network: 0%; no deductible Out-of-network: 30% after deductible Participant Only $146.12 Participant + spouse/domestic partner $364.68 Participant + child(ren) $286.90 Participant + family $505.47			

Live Health Online

Live Health Online provides employees and their eligible dependents with 24/7/365 access to US board-certified physicians by online video. Live Health Online can diagnose, recommend treatment and prescribe medication when appropriate, including sinus problem, bronchitis, allergies, poison ivy, cold and flu symptoms, urinary tract infection, respiratory infection and more. The cost to participants for each physician consultation is $59, $80 for behavioral health therapist, $95 for psychologist, and $150 for psychiatrist initial consultation and $75 for follow up consultations.

This program is available to participants enrolled in an AEP health plan.

Wellness Program

Healthy living habits are an essential ingredient for healthy employees. For that reason, AEP sponsors a number of programs, including incentives, and initiatives designed to help employees achieve and maintain a healthy lifestyle. All active employees (regardless of whether they are enrolled in a medical plan) are eligible to participate in the following wellness programs along with spouses and domestic partners of active employees who are covered under an AEP medical plan. Rewards are offered for annual well check, dental exams, eye exam or skin cancer screening, and financial wellbeing coaching calls, diabetes prevention program, and healthy living challenges during the year.

January 1, 2020 – December 31, 2020

GROUP DENTAL

DPPO option

Coverage Level	Participant Only	Participant + Spouse	Participant + Child(ren)	Participant + Family
Deductible (does not apply to preventive service)	$50/individual	$50/individual	$50/individual $150/family	$150/Family
Annual Maximum	$1,750 per covered person			
Coinsurance				
Preventive	100%			
Basic Services	80% after deductible			
Major Services	50% after deductible			
Orthodontia	50% up to a lifetime maximum of $1,750 per covered child			

DMO Option

A DMO option is available to employees who live within the same zip code area as a network DMO dentist. Similar to a medical Health Maintenance Organization (HMO), the DMO provides dental service through a group of network dentist. The DMO offers no deductibles or annual maximum, no co-pay for covered preventive services and low, fixed co-pays on other dental services.

The pre-tax monthly costs to active part-time employees are two and one-half times the monthly costs to active full-time employees. The monthly costs to certain grandfathered retirees and surviving dependents are the same as active employees. The monthly cost to most other retirees and eligible surviving dependents are 100% of the total cost of coverage.

Employee Monthly Contribution	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
DPPO Plan	$12.08	$24.04	$34.51	$46.58
DMO Plan	$ 8.84	$18.12	$20.43	$29.71

VISION PLAN

AEP offers comprehensive employee paid vision coverage for eye care and vision correction. AEP's Comprehensive Vision Plan provides coverage through the Fidelity Security Life Insurance Company for eye exams, contacts (including disposable contacts) and eyeglass lenses and frames. It also offers discounts on special features, such as scratch-resistant lenses, laser eye surgery and more. Vision care discounts are also available through the Anthem medical plans.

Vision plan participants can take advantage of the discounted retinal-imaging exam option; in addition, members who have Type 1 or Type 2 diabetes are eligible for a follow-up exam and additional testing two times per benefit year.

Benefits are provided through EyeMed Vision Care's Access national network of private practice optometrists, ophthalmologists, opticians and retailers, such as Sears Optical, Target Optical, most Pearle Vision locations and LensCrafters.

Employee Contribution	Employee Only $ 6.82/mth	Employee + Spouse $12.93/mth	Employee + Child(ren) $13.61/mth	Employee + Family $20.41/mth

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DATA REQUEST

KPSC 2_26 Provide all current labor contracts and the most recent labor contracts previously in effect.

RESPONSE

Please refer to KPCO_R_KPSC_2_26_Attachment1 for the requested information.

Witness: Kimberly K. Kaiser

Kentucky Power Company
KPSC Case No. 2020-00174
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DATA REQUEST

KPSC 2_27 Provide each medical insurance policy that the utility currently maintains.

RESPONSE

Please refer to KPCO_R_KPSC_2_27_Attachment1 and KPCO_R_KPSC_2_27_Attachment2 for the requested information.

Witness: Andrew R. Carlin

Updates to the 2016 Benefit Plan Summary Plan Descriptions (2020 Release – Active Employees, Retirees and Surviving Dependents)

To: AEP System Benefit Plan Participants and Covered Family Members

Please note: *Every effort has been made to ensure this information is accurate. However, the plans are governed by legal documents and insurance contracts. If there is any difference between the information in this update and plan documents, the plan documents will rule.*

Summary Plan Descriptions (SPDs) for various benefit plans were issued in 2016. Updates to those SPDs have been issued to summarize changes made for 2017 and 2018. This document describes provisions of the SPDs that have been added or changed to those 2016 Summary Plan Descriptions listed below (including their updates) that affect AEP active employees, retirees and surviving dependents. Please keep this document with those Summary Plan Descriptions and updates. We have tried to include page references to the affected SPDs or update.

The 2016 Summary Plan Descriptions affected by the changes described in this notice are as follows:

- **American Electric Power (AEP) System Comprehensive Medical Plan – HSA Plan Options – Summary Plan Description for Active Employees, Retirees and Surviving Dependents Under Age 65 – Issued 2016**
- **American Electric Power (AEP) System Comprehensive Medical Plan – HRA Plan Option – Summary Plan Description for Active Employees, Retirees and Surviving Dependents Under Age 65 – Issued 2016**
- **American Electric Power (AEP) Comprehensive Medical Plan - Summary Plan Description for Retirees & Surviving Dependents Age 65 and Older - Issued 2016**

1. Change to the description of eligible dependents

- AEP Comprehensive Medical Plan – HSA SPD (page 9)
- AEP Comprehensive Medical Plan – HRA SPD (page 8)
- AEP Comprehensive Medical Plan – Over 65 Retirees and Survivors (page 3)

Because the tax law has not offered individuals the opportunity to take a personal exemption deduction for their dependent children since 2018, we have changed the way the AEP Comprehensive Medical Plan describes children who may be covered by a member by reason of the employee's acting as the child's guardian. Effective since January 1, 2018, an employee's or retiree's eligible dependent children include those who are the employee's or retiree's dependent for federal income tax purposes, provided that neither natural parent of the child lives with the child *and* the employee or retiree is acting as the child's guardian.

Effective January 1, 2020, employees and retirees are permitted to cover their same-sex or different-sex partner and eligible dependent children. To be considered eligible for enrollment, the employee or retiree and their domestic partner must satisfy **all** of the following requirements:

- Must share the same permanent residence
- Must be each other's sole domestic partner and intend to remain so indefinitely

- Must have resided in the same household for at least 12 months
- Must both be at least eighteen (18) year and mentally competent to consent to a contract
- Must not be currently married to or legally separated from anyone else nor had another domestic partner within 12 months prior to designating each other as domestic partners
- Must not be in the relationship solely for the purpose of obtaining benefits coverage
- Must be financially interdependent as documented by three (3) of the following:
    - Joint ownership or lease of real property
    - Joint ownership of a motor vehicle
    - Joint bank account or credit account
    - Designation as the primary beneficiary for life insurance, retirement benefit or will
    - Assigned durable property power of attorney or healthcare power of attorney
    - Driver's license listing a common address
- Must have an approved Affidavit of Domestic Partnership on file with the AEP Benefits Center.

Note: Upon the termination of a marriage or domestic partnership, it is your responsibility to inform the AEP Benefits Center regarding the change in eligibility for your former spouse/ domestic partner. Failure to do so within 60 days after the date the marriage/domestic partnership ends will not prevent their loss of coverage retroactively, but will result in their loss of eligibility to elect COBRA continuation coverage.

2. 30 visits per incidence limit on Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)

- AEP Comprehensive Medical Plan – HSA SPD (pages 38 and 60)
- AEP Comprehensive Medical Plan – HRA SPD (page 38)

The AEP Comprehensive Medical Plan has provided coverage 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. Beginning January 1, 2019, the AEP medical plan limits visits for occupational therapy, physical therapy and speech therapy to 30 visits, per incidence. In addition, see item #6 below regarding expanded access to services related to diagnosis and treatment of developmental delays and learning disabilities effective January 1, 2019.

3. Certain pharmacy prescribed medications that are classified as "specialty" will be required to use the specialty mail-order pharmacy, Accredo, and manufacturer provided assistance will not be applied to the Plan deductible or out of pocket maximum

- AEP Comprehensive Medical Plan – HSA SPD (page 89)
- AEP Comprehensive Medical Plan – HRA SPD (page 69)

Starting January 1, 2019, members prescribed certain medications that are classified as "specialty" are required to use the specialty mail-order pharmacy, Accredo, the first time the medication is dispensed. Accredo specialty pharmacy serves patients with complex and chronic health

conditions, including cancer, hepatitis C, HIV, bleeding disorders and multiple sclerosis. Treatment for these conditions can be difficult, and this change ensures that well-trained clinicians specific to these conditions are able to support the member as well as connect them with payment-assistance programs, if available. Additional benefits such as nutritional counseling, social worker support, coordination of care and training on proper medication administration are available through Accredo. As a part of this program, to the extent that manufacturer-funded patient assistance is provided for these specialty drugs, the member will not be given credit for those amounts as out-of-pocket expenses and therefore will not be applied to their Plan's applicable deductible and out-of-pocket maximums. Contact Express Scripts at 1-800-841-3045 for more details.

4. Implement additional Formulary Exclusions

- AEP Comprehensive Medical Plan – HSA SPD (page 91)
- AEP Comprehensive Medical Plan – HRA SPD (page 69)

The AEP Comprehensive Medical Plan does exclude from coverage certain drugs for which appropriate clinical alternatives are available at substantially lower costs. Effective January 1, 2019, the following medications were explicitly added to the exclusion list: Rayos, Duexis, Jublia, Doxepin HCL, Fortamet, Santyl, Vimovo, and Kerydin. The drugs listed by the Plan as limited or excluded could change from time to time. Please continue to call the Express Scripts Member Services at the number listed on the back of your Identification Card to inquire about the limitations and exclusions then applicable.

5. Requirement for Accreditation of Out-of-Network Residential Treatment Centers (RTC), Partial Hospitalization (PHP) and Intensive Outpatient Therapy (IOP) relating to Behavioral Health

- AEP Comprehensive Medical Plan – HSA SPD (page 93)
- AEP Comprehensive Medical Plan – HRA SPD (page 71)

The 2016 SPDs for the AEP Comprehensive Medical Plan describe the requirement that out-of-network Residential Treatment Centers (RTC), and facilities that provide Partial Hospitalization (PHP) and Intensive Outpatient Therapy (IOP) must be duly licensed to be considered able to provide covered services. Effective January 1, 2019, out-of-network Residential Treatment Centers, and out-of-network facilities that provide Partial Hospitalization or Intensive Outpatient Therapy Services will not be covered unless the RTC, PHP, or IOP facility is both licensed and accredited.

6. Access to expanded services related to diagnosis and treatment of developmental delays and learning disabilities effective January 1, 2019

- AEP Comprehensive Medical Plan – HSA SPD (pages 80 and 98)
- AEP Comprehensive Medical Plan – HRA SPD (page 76)
- Update - 2018 Release – Item 5 (description of Coverage for Autism and Developmental Delays)

The 2016 SPDs describe the following among the limitations and exclusions under the AEP Comprehensive Medical Plan: 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. In addition to the expansion of services described in the 2018 release related to the 2016 SPDs, effective January 1, 2019, plan participants have access to office visits, labs, x-rays, and outpatient services related to the diagnosis and treatment of developmental delays and learning disabilities, including physical, occupational and speech therapy.

7. Changes to the AEP Benefits Center mailing address and web address

- AEP Comprehensive Medical Plan – HSA SPD (page 17)
- AEP Comprehensive Medical Plan – HRA SPD (page 17)
- AEP Comprehensive Medical Plan – Over 65 Retiree & Survivors SPD (page 48)

The AEP Benefits Center is available to assist you with questions regarding your eligibility, enrollment and participation in the Plan. Effective 07/01/2019, you may access the newly redesigned AEP Benefits Center website at **www.aepbenefits.com** or by mail at the following address:

AEP Benefits Center
Box 310552
Des Moines, IA 50331-0552

8. Change to HSA Basic Plan Deductible limits

- AEP Comprehensive Medical Plan – HSA SPD (pages 5, 19)
- AEP Comprehensive Medical Plan – HRA SPD (page 4)

Effective January 1, 2020, the annual in-network, embedded deductibles* for the HSA Basic Plan are as follows:

- Participant Only: $2,800
- Participant + Spouse/Domestic Partner: $5,600
- Participant + 1 Child: $5, 600
- Participant + Children: $8,400
- Family: $8,400

9. Changes to list of Participating AEP System Companies

- AEP Comprehensive Medical Plan – HSA SPD (page 8)
- AEP Comprehensive Medical Plan – HRA SPD (page 8)
- AEP Comprehensive Medical Plan – Over 65 Retiree & Survivors SPD (page 4)

Eligibility to participate in the American Electric Power System Comprehensive Medical Plan depends, in part, on employment with a Participating AEP System Company. AEP Energy, Inc. was added to the list of Participating AEP System Companies effective as of January 1, 2020. Also, AEP Texas Central Company and AEP Texas North Company were merged and became part of AEP Texas, Inc. effective December 31, 2016. Inclusion of any company in the list of Participating AEP System Companies may change for various reasons, including an amendment to the plan, or disposition of AEP's interest in the company. 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.

10. Applied Behavior Analysis treatment for autism no longer excluded effective January 1, 2017

- AEP Comprehensive Medical Plan – HRA SPD (page 77)
- AEP Comprehensive Medical Plan – HSA SPD (page 98)

The AEP Comprehensive Medical Plan no longer excludes coverage for medically necessary claims incurred on or after January 1, 2017, for Applied Behavior Analysis (ABA) for the treatment of autism. The medical plan will continue to exclude other services, treatment, educational testing or training related to learning disabilities or developmental delays, although speech therapy is allowed for developmental delays.

Participants will be required to obtain precertification in order to receive benefits for covered ABA treatment. If precertification is not obtained, claims for these benefits will be denied. However, claims may be reopened and any services found to be medically necessary may be covered.

11. FirstCare HMO Plan no longer offered effective January 1, 2017

- AEP Comprehensive Medical Plan - HRA SPD (pages 1, 5 – 6 & 10)
- AEP Comprehensive Medical Plan - HSA SPD (pages 1, 6 & 10)

The FirstCare HMO medical plan that had been available to employees in some areas of Texas was eliminated effective December 31, 2016.

12. Revised annual limitation on chiropractic visits and massage therapy effective January 1, 2017

- AEP Comprehensive Medical Plan - HRA Option (page 38)
- AEP Comprehensive Medical Plan – HSA SPD (pages 38 & 60)

Effective January 1, 2017, the annual limitation of 15 visits for Chiropractic care is replaced with a 15 Visit Maximum on spinal manipulations and massage therapy. Massage therapy continues to be covered when performed by a licensed provider.

13. Qualified Health Expense (QHE) form no longer required for Health Reimbursement Account (HRA) Plan participant behavioral health claims effective January 1, 2017

- AEP Comprehensive Medical Plan - HRA SPD (page 46)

Prior to January 1, 2017, Anthem may have required you to file 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 Qualified Health Expense (QHE) form to get reimbursed from your HRA. The QHE form is no longer required for covered claims incurred on or after January 1, 2017, for behavioral health benefits (i.e., mental health/substance abuse services).

14. Anthem became the administrator of the Employee Assistance Program (EAP) services and behavioral health benefits effective January 1, 2018

- AEP Comprehensive Medical Plan – HRA SPD (primarily pages 70 - 75)
- AEP Comprehensive Medical Plan – HSA SPD (primarily pages 91 - 97)

Effective January 1, 2018, Anthem has replaced Magellan Healthcare Inc. as the company responsible for administration of the Employee Assistance Program (EAP) and of the behavioral health benefits offered under the Medical Plan. Please consider all references in the Medical Plan SPDs to Magellan as replaced by Anthem. Your access to the EAP and the benefits offered under the Medical Plan for behavioral health are the same as those described in the SPDs except as follows:

Precertification
Please refer to the guidance regarding "Health Care Management – Precertification" staring on page 47 of the HRA SPD and page 69 of the HSA SPD. That discussion is supplemented by the section entitled "Precertification" in the Behavioral Health Benefits area of the SPDs (see page 71 of the HRA SPD and page 93 of the HSA SPD). The list of the services specified there should be replaced with the following as examples for purposes of treatment of covered Behavioral Health/Substance Abuse services:

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Residential Care
- Partial Hospitalization (PHP)
- Intensive Outpatient Therapy (IOP)
- ABA- Applied Behavioral Analysis

If precertification is not obtained, claims for these benefits will be denied. However, claims may be reopened and any services found to be medically necessary may be covered.

Call Anthem at the number specified on your AEP medical ID card for "Pre Certification" to precertify behavioral health services.

Coverage for Autism and Developmental Delays

The Medical Plan continues to provide coverage for attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD), including intellectual disability and developmental delays; however, the plan has excluded the use of certain therapies for treatment of these conditions. Therefore, although the plan provides coverage for Physical Therapy, Occupational Therapy and Speech Therapy services when used for treatment of a congenital defect, condition, sickness or injury, only Speech Therapy services are covered for developmental delays.

That said, beginning January 1, 2018, the plan began providing coverage for Physical Therapy and Occupational Therapy in addition to Speech Therapy services when used for treatment of Autism. Coverage for Physical Therapy and Occupational Therapy continues to be excluded for other developmental delays.

15. LiveHealth Online (LHO) replaced Teladoc as telehealth provider effective January 1, 2018

- AEP Comprehensive Medical Plan - HRA SPD (page 37)
- AEP Comprehensive Medical Plan - HSA SPD (pages 37 & 59)

Prior to January 1, 2018, telehealth services were available only through Teladoc. Effective beginning January 1, 2018, LiveHealth Online (LHO) has replaced Teladoc as AEP's sole telehealth provider. Teladoc is no longer a covered telehealth provider under the AEP medical plans. You may contact LiveHealth Online by calling 1-888-LiveHealth (1-888-548-3432). You may register or log in on its website at www.livehealthonline.com.

16. Prescription drug Exclusive Home Delivery program expanded effective January 1, 2018

- AEP Comprehensive Medical Plan - HRA SPD (page 67)
- AEP Comprehensive Medical Plan - HSA SPD (page 89)

Prior to January 1, 2018, participants were subject to limits on prescriptions filled at a retail pharmacy. There was an Exclusive Home Delivery program that limited the filling of prescriptions for maintenance medications to up to three times at a participating retail pharmacy. After the third fill, participants were required to fill their maintenance medications through Express Scripts Pharmacy mail order. If a participant had continued to fill these prescriptions at a retail pharmacy, they would have paid the entire cost of the medication and that cost was not reimbursed from their HRA balance, if applicable, or applied toward their deductible or annual out-of-pocket maximum.

Effective for prescriptions filled on or after January 1, 2018, prescriptions for such maintenance medications can be filled either through the Express Scripts Pharmacy or at a CVS pharmacy (including CVS pharmacies within a Target store).

17. Certain generic statins added to preventive drug program effective January 1, 2018

- AEP Comprehensive Medical Plan - HRA SPD (page 67)
- AEP Comprehensive Medical Plan - HSA SPD (page 89)

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 otherwise described in the SPD will apply.

Effective January 1, 2018, the list of preventive medication was expanded to include some generic low to moderate-dose statins for the treatment of high cholesterol for plan members ages 40–75. Please note that not all members and statins qualify to receive their prescription at no cost. Members should contact Express Scripts directly to determine if the statin they are taking is included as preventive and available at no cost.

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

18. Subrogation not applicable to Critical Illness or Accident Insurance coverage

- AEP Comprehensive Medical Plan - HRA SPD (page 94)
- AEP Comprehensive Medical Plan - HSA SPD (page 116)

The Medical Plan currently includes a provision reserving the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The Company has made arrangements for employees to be able to purchase Group Critical Illness Insurance coverage and Accident Insurance coverage through Securian Life Insurance Company. To ensure that the Medical Plan remains clear on this point, please understand that its provisions for Subrogation and Reimbursement do not extend to payments that may be issued pursuant the Critical Illness Insurance or Accident Insurance issued under a group policy for employees of the AEP Participating System Companies and their dependents.

AEP AMERICAN® ELECTRIC POWER

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American Electric Power (AEP) System Comprehensive Medical Plan

HRA Plan Option

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.

What's Here:

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.

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

*** 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 Pus 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.

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

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

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

***** Blue Distinction and Blue Distinction Plus –** 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.

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

*** Embedded deductible –** a covered individual within a family can satisfy the amount shown as the Participant Only annual deductible, and Coinsurance will be applied to additional Covered Expenses incurred by that individual. Remaining family members' claims will be used 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**.

FirstCare HMO Plan Option Summary	
Plan features (in-network)	**You pay**
Annual medical deductible	No deductible
Annual medical out-of-pocket maximum (includes medical coinsurance and copays; does not include prescription drugs)	$3,000 participant/$6,000 family
Office visit – primary care provider	$20 copay
Office visit – specialist	$30 copay
Coinsurance	15%
Annual preventive maximum	No limit
Emergency room	15% coinsurance
Urgent care	$50 copay
Routine lab/X-rays	No copay
Chiropractic care	$30 copay; medical director authorization required
Annual prescription deductible	Retail: $50 individual/$150 family; Mail: $0
Annual prescription out-of-pocket maximum	$1,000 individual /$3,000 family includes annual prescription deductible)
Generic prescription benefit	Retail: $10 copay; Mail: $20 copay
Brand-name prescription benefit	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**. 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 your may be late or need to cancel.
- Understand your health problems as well as your 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**) 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:

HRA Allocation	
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:

Deductible	In-Network	Out-of-Network
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
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Acupuncture	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
ADD/ADHD • Attention Deficit Disorders includes Intellectual Disability, Developmental Delays and Learning Disabilities.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Allergy Care		
Testing and Treatment – Physician or Specialist Physician	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Biofeedback	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Blood Processing and Storage	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Consultation, Second Opinion • Includes Family Planning.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Dental & Oral Surgery/TMJ Services		
Accidental Injury • Covered for treatment of an injury to sound and natural teeth. • Only if treatment is completed within 12 months of the accident. • Care must commence within 90 days of accident.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Oral Surgery – Subject to Medical Necessity – excludes appliances and orthodontic treatment. • Dental Anesthesia is covered only if related to a payable oral surgery. • DOES NOT include removal of impacted teeth.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
TMJ – Subject to Medical Necessity • Covered for medical treatment (surgical and non-surgical). • Excludes appliances and orthodontic treatment.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Diabetes Maintenance		
Diabetes Education/Diabetic Nutritional Counseling Outpatient Institutional • Nutritional Counseling for Diabetes. • May be covered at 100% under certain circumstances – refer to Preventive Care Benefits. • Covered for medical conditions that require a special diet. • Includes gestational. • Diabetic Supply – Covered only for glucometer or insulin infusion pump.	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	
Diagnostic Physician's Services		
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. • Covered at the In Network benefit level.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Dialysis/Hemodialysis Therapy	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Emergency Room, Urgent Care, and Ambulance Services		
Emergency room for an Emergency Medical Condition • 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). • Quick Care Options. • All other services.	Deductible then 15% Coinsurance	Covered at the In Network benefit level (See note below)
Use of the emergency room for non-Emergency Medical Conditions • Applies to non-emergency Medical Condition diagnoses (as defined by Prudent Layperson). • Quick Care Options. • All other services.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Urgent Care clinic visit • All other services.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Ambulance Services (when Medically Necessary) • Land/Air (Air Ambulance will suspend for Medical Necessity).	Deductible then 15% Coinsurance	Covered at the In Network benefit level at Billed Charges. (See note below)
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: 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
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Eye Care		
Office visit – medical eye care exams (treatment of disease or Injury to the eye)		
• Physician / Specialist Physician Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Treatment other than office visit	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Glasses/Contacts after Cataract Surgery – Limited to one (1) occurrence: includes initial frames, lenses or contacts following Cataract surgery.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Hearing Care		
Office visit – Audiometric exam/hearing evaluation test		
• Physician / Specialist Physician Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Treatment other than office visit	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Cochlear Implants	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Hearing devices/hearing aids, including exams and hearing aid accessories. • No coverage for hearing loss due to age.	Not Covered	Not Covered
High Diagnostic Imaging		
• Includes MRI/MRA/CAT/PET/SPECT. • Hospital Based Provider services rendered by non-par providers are covered at the In-Network benefit level.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Home Health Care Services • Includes Private Duty Nursing and Home Infusion therapy (Services do NOT count toward the Home Health visit maximum.)	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)	
Hospice Care Services • Respite Care is Not Covered. • Bereavement Counseling is Not Covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Hospital Inpatient Services – Precertification Required		
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
Hospital Inpatient Services – Precertification Required (cont'd)		
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
Note: 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
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Infusion Therapy	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Maternity Care (Dependent Daughters are covered) & Other Reproductive Services		
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
Note: 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 • Includes Therapeutic and Elective Abortion. • Dependent Daughters are covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Outpatient Professional/Office Professional Visit • Includes Therapeutic and Elective Abortion. • Dependent Daughters are covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Infertility Services • Treatment for underlying medical conditions are covered as medical. • Covered for services to diagnose infertility only.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Maternity Care (Dependent Daughters are covered) & Other Reproductive Services (cont'd)		
• Treatment of infertility is not covered (except artificial insemination). Artificial Insemination is limited to 6 attempts per lifetime.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Invitro Fertilization – Includes in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, and reversal of voluntary sterilization.) are Not covered.	Not Covered	Not Covered
Sterilization Services that do not qualify as "Preventive Care" benefits (Precertification Required for Inpatient procedures)	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.		
• Vasectomy Reversals are Not Covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Contraceptives – that do not qualify as "Preventive Care" benefits • Spermicide, vaginal ring, hormone patch Depo - Estradiol Cypionate. • Covered for birth control as well as medical conditions.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Medical Supplies and Equipment		
Medical Supplies	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Durable Medical Equipment (DME) • (Purchase & Rental)	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Orthotics • Foot (Foot Orthotics based on Medical Necessity) and shoe	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Medical Supplies and Equipment (cont'd)		
Prosthetic Appliances (external) • Wigs/Toupees limited to one per Benefit Period, subject to Medical Necessity.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Nutritional Counseling for Non-Diabetes • May be considered Preventive Care Benefits under certain circumstances. • Eating Disorders are covered. • Covered for medical conditions that require a special diet.	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	
Nutritional Counseling for Eating Disorders	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Outpatient Hospital/Facility Services		
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
Physician Services (Home and Office Visits)		
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
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Physician Services (Home and Office Visits) (cont'd)		
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
Prescription Drugs (other than Preventive Care)		
Generic	Deductible then 15% Coinsurance	Deductible then 15% Coinsurance
Brand-name	Deductible then 15% Coinsurance	Deductible then 15% Coinsurance
Preventive Services (regardless of Provider or setting where Preventive care is provided)	Covered at 100%	Deductible then 30% Coinsurance
Contraceptives — qualify as "Preventive Care" benefit • 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). – Covered based on the diagnosis restriction within the "Preventive Care" benefits.	Covered at 100%	Deductible then 30% Coinsurance
Other Preventive Services		
Routine eye exams	Not Covered	Not Covered
Routine hearing exams • Limited to one per calendar year.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Routine Foot Care • Foot Orthotics may be covered as DME.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Note: Preventive Care treatment generally applied to Covered Services only when claim submitted with a "well" diagnosis.		
Retail Health Clinics	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Skilled Nursing Facility	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Maximum days	120 days per calendar year combined Network and Out-of-Network.	
Surgical Services	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Bariatric Surgery	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Blue Distinction Bariatric Services Benefit: 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.		
Designated BD Bariatric COE: For the Covered Bariatric Procedure, you will pay 5% of the Maximum Allowable Amount for Bariatric Surgery facility.		
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.		
Out of Network Bariatric provider: You will pay 30% of the Maximum Allowable Amount for a Bariatric procedure performed at an Out-of-Network facility.		
Transportation and Lodging – Distance the patient must live from the surgical facility to use this benefit: 50 Miles. **Lodging allowance:** $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.		
Participation in Anthem BD Bariatric Specialty Care Management Program is required for benefits to be considered.		

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Blue Distinction Centers+/Blue Distinction Centers Transplant Surgery Benefit			
Designated BDC+ Provider for Transplant Surgery Procedures	**Designated BDC Provider for Transplant Surgery procedures**	**PAR (Network) Transplant Provider (non-BDC+/BD Provider)**	**Non-PAR (Out-of-Network) Transplant Provider**
Benefit Limits for Covered Transplant Procedure:			
For the Covered **Transplant** Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **Transplant** Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC** 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 **Transplant** Procedure, you will pay 15% of the Maximum Allowable Amount when using a **PAR**, 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 **Transplant** Procedure, you will pay 30% of the Maximum Allowable Amount when using a **non-PAR** 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).
Deductibles			
Applicable Deductibles apply	Applicable Deductibles apply	Applicable Deductibles apply.	Applicable Deductibles apply.

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

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Benefit Limits for Covered Cardiac Procedure:			
For the Covered Cardiac Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **BDC** 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 **PAR**, 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 **non-PAR**, 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).
Deductibles			
Normal Deductibles apply.	Normal Deductibles apply.	Normal Deductibles apply.	Out-of-Network Deductibles will apply.

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

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Blue Distinction Orthopedic Surgery Benefit		
Designated BDC+ Provider for Knee/Hip Replacements & Spine Surgery Procedures	**Designated BDC Provider for Knee/Hip Replacements & Spine Surgery procedures**	**PAR (Network) Orthopedic Provider (non-BDC+/BD Provider)**	**Non-PAR (Out-of-Network) Orthopedic Provider**
Benefit Limits for Covered Orthopedic Procedure:			
For the Covered Orthopedic Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **BDC** 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 **PAR**, 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 **non-PAR**, 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).
Deductibles			
Normal Deductibles apply.	Normal Deductibles apply.	Normal Deductibles apply.	Out-of-Network Deductibles will apply.

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Travel Reimbursement			
Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required.	Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required.	Not Covered	Not Covered
Lodging allowance: $50 per day for single occupancy/$100 per day for double occupancy. Meals are not covered.	**Lodging allowance:** $50 per day for single occupancy/$100 per day for double occupancy. Meals are not covered.		
Reimbursed at 100% as long as orthopedic procedure is covered and performed at BDC facility.	Reimbursed at 100% as long as orthopedic procedure is covered and performed at BDC facility.		
Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion.	Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion.		
Facility must be 50 miles from member's residence.	Facility must be 50 miles from member's residence.		
Telehealth Visits			
• Includes Teladoc. • All other providers are NOT Covered. Please contact Customer Service for additional information.		Deductible then 15% Coinsurance	Not Covered

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Therapy Services (Outpatient)		
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	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
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.		
Chiropractic Care	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
– Maximum per calendar year	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.	
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
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Transgender Surgery	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
Transplants			
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. **The Center of Excellence requirements do not apply to** Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** 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.)			

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
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 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.
Covered Transplant Procedure during the Transplant Benefit Period	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, **you are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.**			
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)	Deductible then 5% Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Includes unrelated donor search up to $30,000 per transplant.			

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	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.
Eligible Travel and Lodging – • 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. • Transportation for two companions if the patient is a minor child. • Travel is reimbursed for patient and companion.	Covered at 100%	Covered at 100%	Not Covered
All Other Covered Transplant Services	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**;

Magellan: **www.magellanhealth.com**; and

Express Scripts: **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 - SCPs), 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.[1]
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** or **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**), select "Locate a Pharmacy" from the "Manage Prescriptions" menu and search by ZIP code or city and state.

[1] 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** or **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**, 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**. 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**. 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 Poviders. 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**.

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**, 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**. 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.

ACT OF WAR/MILITARY DUTY:
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.
CUSTODIAL/CONVALESCENT CARE:
Services for Custodial Care.
Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
DENTAL SERVICES:
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.

ELIGIBILITY:
Charges for treatment received before coverage under this option began or after coverage terminated.
EXPERIMENTAL/INVESTIGATIONAL:
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.
GOVERNMENT AGENCY/LAWS/PLANS:
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 primary payer whether or not the Member has enrolled Medicare Part B.
Court-ordered services, or those required by court order as a condition of parole or probation (unless Medically Necessary and approved by the Plan).
MEDICATIONS:
Nonprescription drugs, medications or supplies (except insulin).
MEDICALLY NECESSARY:
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 guidelines.
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.
MISCELLANEOUS:
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.

MISCELLANEOUS (cont'd):
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.
SPECIAL CHARGES/SERVICES:
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.
SURGERY:
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.

THERAPIES:
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.
VISION CARE:
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.
WEIGHT REDUCTION PROGRAMS:
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 Administer 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 even within 60 days of that event and within the original 18-month period.

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

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

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

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**. (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**.

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 of 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**.

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.

AEP Benefits Center
1-888-237-2363

Updates to the 2016 Benefit Plan Summary Plan Descriptions (2020 Release – Active Employees, Retirees and Surviving Dependents)

To: AEP System Benefit Plan Participants and Covered Family Members

Please note: *Every effort has been made to ensure this information is accurate. However, the plans are governed by legal documents and insurance contracts. If there is any difference between the information in this update and plan documents, the plan documents will rule.*

Summary Plan Descriptions (SPDs) for various benefit plans were issued in 2016. Updates to those SPDs have been issued to summarize changes made for 2017 and 2018. This document describes provisions of the SPDs that have been added or changed to those 2016 Summary Plan Descriptions listed below (including their updates) that affect AEP active employees, retirees and surviving dependents. Please keep this document with those Summary Plan Descriptions and updates. We have tried to include page references to the affected SPDs or update.

The 2016 Summary Plan Descriptions affected by the changes described in this notice are as follows:

- **American Electric Power (AEP) System Comprehensive Medical Plan – HSA Plan Options – Summary Plan Description for Active Employees, Retirees and Surviving Dependents Under Age 65 – Issued 2016**
- **American Electric Power (AEP) System Comprehensive Medical Plan – HRA Plan Option – Summary Plan Description for Active Employees, Retirees and Surviving Dependents Under Age 65 – Issued 2016**
- **American Electric Power (AEP) Comprehensive Medical Plan - Summary Plan Description for Retirees & Surviving Dependents Age 65 and Older - Issued 2016**

1. Change to the description of eligible dependents

- AEP Comprehensive Medical Plan – HSA SPD (page 9)
- AEP Comprehensive Medical Plan – HRA SPD (page 8)
- AEP Comprehensive Medical Plan – Over 65 Retirees and Survivors (page 3)

Because the tax law has not offered individuals the opportunity to take a personal exemption deduction for their dependent children since 2018, we have changed the way the AEP Comprehensive Medical Plan describes children who may be covered by a member by reason of the employee's acting as the child's guardian. Effective since January 1, 2018, an employee's or retiree's eligible dependent children include those who are the employee's or retiree's dependent for federal income tax purposes, provided that neither natural parent of the child lives with the child *and* the employee or retiree is acting as the child's guardian.

Effective January 1, 2020, employees and retirees are permitted to cover their same-sex or different-sex partner and eligible dependent children. To be considered eligible for enrollment, the employee or retiree and their domestic partner must satisfy **all** of the following requirements:

- Must share the same permanent residence
- Must be each other's sole domestic partner and intend to remain so indefinitely

- Must have resided in the same household for at least 12 months
- Must both be at least eighteen (18) year and mentally competent to consent to a contract
- Must not be currently married to or legally separated from anyone else nor had another domestic partner within 12 months prior to designating each other as domestic partners
- Must not be in the relationship solely for the purpose of obtaining benefits coverage
- Must be financially interdependent as documented by three (3) of the following:
    - Joint ownership or lease of real property
    - Joint ownership of a motor vehicle
    - Joint bank account or credit account
    - Designation as the primary beneficiary for life insurance, retirement benefit or will
    - Assigned durable property power of attorney or healthcare power of attorney
    - Driver's license listing a common address
- Must have an approved Affidavit of Domestic Partnership on file with the AEP Benefits Center.

Note: Upon the termination of a marriage or domestic partnership, it is your responsibility to inform the AEP Benefits Center regarding the change in eligibility for your former spouse/ domestic partner. Failure to do so within 60 days after the date the marriage/domestic partnership ends will not prevent their loss of coverage retroactively, but will result in their loss of eligibility to elect COBRA continuation coverage.

2. 30 visits per incidence limit on Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)

- AEP Comprehensive Medical Plan – HSA SPD (pages 38 and 60)
- AEP Comprehensive Medical Plan – HRA SPD (page 38)

The AEP Comprehensive Medical Plan has provided coverage 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. Beginning January 1, 2019, the AEP medical plan limits visits for occupational therapy, physical therapy and speech therapy to 30 visits, per incidence. In addition, see item #6 below regarding expanded access to services related to diagnosis and treatment of developmental delays and learning disabilities effective January 1, 2019.

3. Certain pharmacy prescribed medications that are classified as "specialty" will be required to use the specialty mail-order pharmacy, Accredo, and manufacturer provided assistance will not be applied to the Plan deductible or out of pocket maximum

- AEP Comprehensive Medical Plan – HSA SPD (page 89)
- AEP Comprehensive Medical Plan – HRA SPD (page 69)

Starting January 1, 2019, members prescribed certain medications that are classified as "specialty" are required to use the specialty mail-order pharmacy, Accredo, the first time the medication is dispensed. Accredo specialty pharmacy serves patients with complex and chronic health

conditions, including cancer, hepatitis C, HIV, bleeding disorders and multiple sclerosis. Treatment for these conditions can be difficult, and this change ensures that well-trained clinicians specific to these conditions are able to support the member as well as connect them with payment-assistance programs, if available. Additional benefits such as nutritional counseling, social worker support, coordination of care and training on proper medication administration are available through Accredo. As a part of this program, to the extent that manufacturer-funded patient assistance is provided for these specialty drugs, the member will not be given credit for those amounts as out-of-pocket expenses and therefore will not be applied to their Plan's applicable deductible and out-of-pocket maximums. Contact Express Scripts at 1-800-841-3045 for more details.

4. Implement additional Formulary Exclusions

- AEP Comprehensive Medical Plan – HSA SPD (page 91)
- AEP Comprehensive Medical Plan – HRA SPD (page 69)

The AEP Comprehensive Medical Plan does exclude from coverage certain drugs for which appropriate clinical alternatives are available at substantially lower costs. Effective January 1, 2019, the following medications were explicitly added to the exclusion list: Rayos, Duexis, Jublia, Doxepin HCL, Fortamet, Santyl, Vimovo, and Kerydin. The drugs listed by the Plan as limited or excluded could change from time to time. Please continue to call the Express Scripts Member Services at the number listed on the back of your Identification Card to inquire about the limitations and exclusions then applicable.

5. Requirement for Accreditation of Out-of-Network Residential Treatment Centers (RTC), Partial Hospitalization (PHP) and Intensive Outpatient Therapy (IOP) relating to Behavioral Health

- AEP Comprehensive Medical Plan – HSA SPD (page 93)
- AEP Comprehensive Medical Plan – HRA SPD (page 71)

The 2016 SPDs for the AEP Comprehensive Medical Plan describe the requirement that out-of-network Residential Treatment Centers (RTC), and facilities that provide Partial Hospitalization (PHP) and Intensive Outpatient Therapy (IOP) must be duly licensed to be considered able to provide covered services. Effective January 1, 2019, out-of-network Residential Treatment Centers, and out-of-network facilities that provide Partial Hospitalization or Intensive Outpatient Therapy Services will not be covered unless the RTC, PHP, or IOP facility is both licensed and accredited.

6. Access to expanded services related to diagnosis and treatment of developmental delays and learning disabilities effective January 1, 2019

- AEP Comprehensive Medical Plan – HSA SPD (pages 80 and 98)
- AEP Comprehensive Medical Plan – HRA SPD (page 76)
- Update - 2018 Release – Item 5 (description of Coverage for Autism and Developmental Delays)

The 2016 SPDs describe the following among the limitations and exclusions under the AEP Comprehensive Medical Plan: 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. In addition to the expansion of services described in the 2018 release related to the 2016 SPDs, effective January 1, 2019, plan participants have access to office visits, labs, x-rays, and outpatient services related to the diagnosis and treatment of developmental delays and learning disabilities, including physical, occupational and speech therapy.

7. Changes to the AEP Benefits Center mailing address and web address

- AEP Comprehensive Medical Plan – HSA SPD (page 17)
- AEP Comprehensive Medical Plan – HRA SPD (page 17)
- AEP Comprehensive Medical Plan – Over 65 Retiree & Survivors SPD (page 48)

The AEP Benefits Center is available to assist you with questions regarding your eligibility, enrollment and participation in the Plan. Effective 07/01/2019, you may access the newly redesigned AEP Benefits Center website at **www.aepbenefits.com** or by mail at the following address:

AEP Benefits Center
Box 310552
Des Moines, IA 50331-0552

8. Change to HSA Basic Plan Deductible limits

- AEP Comprehensive Medical Plan – HSA SPD (pages 5, 19)
- AEP Comprehensive Medical Plan – HRA SPD (page 4)

Effective January 1, 2020, the annual in-network, embedded deductibles* for the HSA Basic Plan are as follows:

- Participant Only: $2,800
- Participant + Spouse/Domestic Partner: $5,600
- Participant + 1 Child: $5, 600
- Participant + Children: $8,400
- Family: $8,400

9. Changes to list of Participating AEP System Companies

- AEP Comprehensive Medical Plan – HSA SPD (page 8)
- AEP Comprehensive Medical Plan – HRA SPD (page 8)
- AEP Comprehensive Medical Plan – Over 65 Retiree & Survivors SPD (page 4)

Eligibility to participate in the American Electric Power System Comprehensive Medical Plan depends, in part, on employment with a Participating AEP System Company. AEP Energy, Inc. was added to the list of Participating AEP System Companies effective as of January 1, 2020. Also, AEP Texas Central Company and AEP Texas North Company were merged and became part of AEP Texas, Inc. effective December 31, 2016. Inclusion of any company in the list of Participating AEP System Companies may change for various reasons, including an amendment to the plan, or disposition of AEP's interest in the company. 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.

10. Applied Behavior Analysis treatment for autism no longer excluded effective January 1, 2017

- AEP Comprehensive Medical Plan – HRA SPD (page 77)
- AEP Comprehensive Medical Plan – HSA SPD (page 98)

The AEP Comprehensive Medical Plan no longer excludes coverage for medically necessary claims incurred on or after January 1, 2017, for Applied Behavior Analysis (ABA) for the treatment of autism. The medical plan will continue to exclude other services, treatment, educational testing or training related to learning disabilities or developmental delays, although speech therapy is allowed for developmental delays.

Participants will be required to obtain precertification in order to receive benefits for covered ABA treatment. If precertification is not obtained, claims for these benefits will be denied. However, claims may be reopened and any services found to be medically necessary may be covered.

11. FirstCare HMO Plan no longer offered effective January 1, 2017

- AEP Comprehensive Medical Plan - HRA SPD (pages 1, 5 – 6 & 10)
- AEP Comprehensive Medical Plan - HSA SPD (pages 1, 6 & 10)

The FirstCare HMO medical plan that had been available to employees in some areas of Texas was eliminated effective December 31, 2016.

12. Revised annual limitation on chiropractic visits and massage therapy effective January 1, 2017

- AEP Comprehensive Medical Plan - HRA Option (page 38)
- AEP Comprehensive Medical Plan – HSA SPD (pages 38 & 60)

Effective January 1, 2017, the annual limitation of 15 visits for Chiropractic care is replaced with a 15 Visit Maximum on spinal manipulations and massage therapy. Massage therapy continues to be covered when performed by a licensed provider.

13. Qualified Health Expense (QHE) form no longer required for Health Reimbursement Account (HRA) Plan participant behavioral health claims effective January 1, 2017

- AEP Comprehensive Medical Plan - HRA SPD (page 46)

Prior to January 1, 2017, Anthem may have required you to file 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 Qualified Health Expense (QHE) form to get reimbursed from your HRA. The QHE form is no longer required for covered claims incurred on or after January 1, 2017, for behavioral health benefits (i.e., mental health/substance abuse services).

14. Anthem became the administrator of the Employee Assistance Program (EAP) services and behavioral health benefits effective January 1, 2018

- AEP Comprehensive Medical Plan – HRA SPD (primarily pages 70 - 75)
- AEP Comprehensive Medical Plan – HSA SPD (primarily pages 91 - 97)

Effective January 1, 2018, Anthem has replaced Magellan Healthcare Inc. as the company responsible for administration of the Employee Assistance Program (EAP) and of the behavioral health benefits offered under the Medical Plan. Please consider all references in the Medical Plan SPDs to Magellan as replaced by Anthem. Your access to the EAP and the benefits offered under the Medical Plan for behavioral health are the same as those described in the SPDs except as follows:

Precertification
Please refer to the guidance regarding "Health Care Management – Precertification" staring on page 47 of the HRA SPD and page 69 of the HSA SPD. That discussion is supplemented by the section entitled "Precertification" in the Behavioral Health Benefits area of the SPDs (see page 71 of the HRA SPD and page 93 of the HSA SPD). The list of the services specified there should be replaced with the following as examples for purposes of treatment of covered Behavioral Health/Substance Abuse services:

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Residential Care
- Partial Hospitalization (PHP)
- Intensive Outpatient Therapy (IOP)
- ABA- Applied Behavioral Analysis

If precertification is not obtained, claims for these benefits will be denied. However, claims may be reopened and any services found to be medically necessary may be covered.

Call Anthem at the number specified on your AEP medical ID card for "Pre Certification" to precertify behavioral health services.

Coverage for Autism and Developmental Delays

The Medical Plan continues to provide coverage for attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD), including intellectual disability and developmental delays; however, the plan has excluded the use of certain therapies for treatment of these conditions. Therefore, although the plan provides coverage for Physical Therapy, Occupational Therapy and Speech Therapy services when used for treatment of a congenital defect, condition, sickness or injury, only Speech Therapy services are covered for developmental delays.

That said, beginning January 1, 2018, the plan began providing coverage for Physical Therapy and Occupational Therapy in addition to Speech Therapy services when used for treatment of Autism. Coverage for Physical Therapy and Occupational Therapy continues to be excluded for other developmental delays.

15. LiveHealth Online (LHO) replaced Teladoc as telehealth provider effective January 1, 2018

- AEP Comprehensive Medical Plan - HRA SPD (page 37)
- AEP Comprehensive Medical Plan - HSA SPD (pages 37 & 59)

Prior to January 1, 2018, telehealth services were available only through Teladoc. Effective beginning January 1, 2018, LiveHealth Online (LHO) has replaced Teladoc as AEP's sole telehealth provider. Teladoc is no longer a covered telehealth provider under the AEP medical plans. You may contact LiveHealth Online by calling 1-888-LiveHealth (1-888-548-3432). You may register or log in on its website at www.livehealthonline.com.

16. Prescription drug Exclusive Home Delivery program expanded effective January 1, 2018

- AEP Comprehensive Medical Plan - HRA SPD (page 67)
- AEP Comprehensive Medical Plan - HSA SPD (page 89)

Prior to January 1, 2018, participants were subject to limits on prescriptions filled at a retail pharmacy. There was an Exclusive Home Delivery program that limited the filling of prescriptions for maintenance medications to up to three times at a participating retail pharmacy. After the third fill, participants were required to fill their maintenance medications through Express Scripts Pharmacy mail order. If a participant had continued to fill these prescriptions at a retail pharmacy, they would have paid the entire cost of the medication and that cost was not reimbursed from their HRA balance, if applicable, or applied toward their deductible or annual out-of-pocket maximum.

Effective for prescriptions filled on or after January 1, 2018, prescriptions for such maintenance medications can be filled either through the Express Scripts Pharmacy or at a CVS pharmacy (including CVS pharmacies within a Target store).

17. Certain generic statins added to preventive drug program effective January 1, 2018

- AEP Comprehensive Medical Plan - HRA SPD (page 67)
- AEP Comprehensive Medical Plan - HSA SPD (page 89)

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 otherwise described in the SPD will apply.

Effective January 1, 2018, the list of preventive medication was expanded to include some generic low to moderate-dose statins for the treatment of high cholesterol for plan members ages 40–75. Please note that not all members and statins qualify to receive their prescription at no cost. Members should contact Express Scripts directly to determine if the statin they are taking is included as preventive and available at no cost.

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

18. Subrogation not applicable to Critical Illness or Accident Insurance coverage

- AEP Comprehensive Medical Plan - HRA SPD (page 94)
- AEP Comprehensive Medical Plan - HSA SPD (page 116)

The Medical Plan currently includes a provision reserving the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The Company has made arrangements for employees to be able to purchase Group Critical Illness Insurance coverage and Accident Insurance coverage through Securian Life Insurance Company. To ensure that the Medical Plan remains clear on this point, please understand that its provisions for Subrogation and Reimbursement do not extend to payments that may be issued pursuant the Critical Illness Insurance or Accident Insurance issued under a group policy for employees of the AEP Participating System Companies and their dependents.

AEP AMERICAN® ELECTRIC POWER

POWERING you

American Electric Power (AEP) System Comprehensive Medical Plan

HSA Plan Options

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 HSA Plan options 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 HRA Plan option 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.

What's Here:

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.

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

*** 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 Pus 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.

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

*** 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 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.

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

*** Embedded deductible –** a covered individual within a family can satisfy the amount shown as the Participant Only annual deductible, and Coinsurance will be applied to additional Covered Expenses incurred by that individual. Remaining family members' claims will be used 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 (HRA Plan Option) for additional information regarding the HRA plan option.

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**.

FirstCare HMO Plan Option Summary	
Plan features (in-network)	**You pay**
Annual medical deductible	No deductible
Annual medical out-of-pocket maximum (includes medical coinsurance and copays; does not include prescription drugs)	$3,000 participant/$6,000 family
Office visit – primary care provider	$20 copay
Office visit – specialist	$30 copay
Coinsurance	15%
Annual preventive maximum	No limit
Emergency room	15% coinsurance
Urgent care	$50 copay
Routine lab/X-rays	No copay
Chiropractic care	$30 copay; medical director authorization required
Annual prescription deductible	Retail: $50 individual/$150 family; Mail: $0
Annual prescription out-of-pocket maximum	$1,000 individual /$3,000 family includes annual prescription deductible)
Generic prescription benefit	Retail: $10 copay; Mail: $20 copay
Brand-name prescription benefit	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**. 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**) or by mail at the following address:

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

HSA Plans 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 Savings Account (HSA) Plan!

The Health Savings Account (HSA) plans provide an innovative approach to health benefits for eligible Employees of Participating AEP System Companies (generically, the "company" or your "Employer").

With the HSA plans, 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 is paid. Bottom line, the plans are designed to help you — and your family — take control of your health care dollars and decisions.

The HSA Plan – In Brief

The HSA Plan options may offer you an opportunity to set up and fund a Health Savings Account (HSA). If you meet the eligibility requirements imposed by the federal income tax code, you can contribute pre-tax dollars to you HSA. Others may also contribute dollars to your account. You can use the dollars to help meet your annual Deductible responsibility as well as other out-of-pocket expenses.

If you want to learn more about the eligibility requirements to have pre-tax contributions made to an HSA, you may read IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

The HSA Plan options help you stay healthy by encouraging you to use Preventive Care — 100% coverage for nationally recommended services using Network Providers. 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.

The HSA Plan options also offer you Traditional Health Coverage to protect you and your enrolled dependents to the extent your Out-of-Pocket Costs for Covered Services exceed your annual Deductible. Once Traditional Health Coverage is effective, the Plan will reimburse a percentage of the cost for Covered Services. You will be responsible for covering the remainder of the expense of Covered Services (called your Coinsurance responsibility), up to an annual Out-of-Pocket Maximum. After this amount has been met, you will receive coverage for Covered Services for the remainder of the Plan year as specified elsewhere in this SPD.

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

Financial Tools

Each HSA Plan option offers online financial tools to help you keep track of your health care dollars. Plus you can track your claims for Covered Services. You can review what you've spent on health care, view your HSA balance, or look up the status of a particular claim any time of the day.

To best control your Out-Of-Pocket expense, obtain Covered Services from a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use an Out-of-Network Provider, you are responsible for any balance due between the Out-of-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Deductibles, and non-covered charges.

Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

HSA Plus Plan

The HSA plan options may give you the opportunity to build your available health care dollars over time in a personal health savings account. AEP may impose limitations on the ability of certain individuals to enroll in the HSA Pus 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.

The HSA Plus plan option includes an annual company contribution to your HSA.

HSA Contribution	
Individual	$500
Employee + Spouse/Domestic Partner	$750
Employee + Child(ren)	$750
Family	$1,000

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

You also may be able to contribute to your HSA. The federal income tax code imposes limitations on whether contributions made an individual's health savings account (HSA) will be eligible for favorable tax treatment. If you qualify for favorable tax treatment of your HSA, then so long as you don't use the full amount of your HSA, it remains available to you tax-free for eligible expenses now and in the future.

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 of Company contributions 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 of Company contributions equal to a portion of the difference between the levels allocation. If your participation in the HSA Plus plan ends for any reason, amounts already properly contributed to your HSA remain yours.

The Traditional Health Coverage provisions of the HSA Plus Plan option do not kick in until the applicable annual Deductible has been met.

Your Annual Deductible is:

	In-Network	Out-of-Network
Individual	$2,000	$3,000
Employee + Spouse/Domestic Partner	$3,000	$4,500
Employee + Child(ren)	$3,000	$4,500
Family	$4,000	$6,000

Note: The Deductible applies to all Covered Services you incur in a Benefit Period except Network Preventive Care Services. 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 HSA account, the Plan offers additional health coverage to protect you and your covered family members in case you incur health care expenses that exceed your annual Deductible. This coverage begins once you have 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:

	Network	Out-of-Network
Individual	$4,000	$6,000
Employee + Spouse/Domestic Partner	$6,000	$9,000
Employee + Child(ren)	$6,000	$9,000
Family	$8,000	$12,000

Note: The Out-of-Pocket Maximum includes all Deductibles and/or Coinsurance you incur in a Benefit Period. 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.

The HSA Plus Plan has an embedded Out-of-Pocket Maximum, which means:

- An individual within the family will never pay more than their individual Out-of-Pocket Maximum; and
- If you also cover Dependents (other family members) under this Plan, the Out-of-Pocket costs for your and their Covered Services will be applied towards the remaining Out-of-Pocket Maximum for your coverage level. Once the Out-of-Pocket Maximum applicable for your coverage level is met, it is considered met for all covered 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 (HSA Plus Plan)

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

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Acupuncture	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
ADD/ADHD • Attention Deficit Disorders includes Intellectual Disability, Developmental Delays and Learning Disabilities.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Allergy Care		
Testing and Treatment – Physician or Specialist Physician	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Biofeedback	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Blood Processing and Storage	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Consultation, Second Opinion • Includes Family Planning.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Dental & Oral Surgery/TMJ Services		
Accidental Injury • Covered for treatment of an injury to sound and natural teeth. • Only if treatment is completed within 12 months of the accident. • Care must commence within 90 days of accident.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Oral Surgery - Subject to Medical Necessity – excludes appliances and orthodontic treatment. • Dental Anesthesia is covered only if related to a payable oral surgery. • DOES NOT include removal of impacted teeth.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
TMJ - Subject to Medical Necessity • Covered for medical treatment (surgical and non-surgical). • Excludes appliances and orthodontic treatment.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Diabetes Maintenance		
Diabetes Education/Diabetic Nutritional Counseling Outpatient Institutional • Nutritional Counseling for Diabetes. • May be covered at 100% under certain circumstances - refer to Preventive Care Benefits. • Covered for medical conditions that require a special diet. • Includes gestational. • Diabetic Supply - Covered only for glucometer or insulin infusion pump.	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	
Diagnostic Physician's Services		
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. • Covered at the In Network benefit level.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Dialysis/Hemodialysis Therapy	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Emergency Room, Urgent Care, and Ambulance Services		
Emergency room for an Emergency Medical Condition • 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). • Quick Care Options. • All other services.	Deductible then 15% Coinsurance	Covered at the In Network benefit level (See note below)
Use of the emergency room for non-Emergency Medical Conditions • Applies to non-emergency Medical Condition diagnoses (as defined by Prudent Layperson). • Quick Care Options • All other services.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Urgent Care clinic visit • All other services	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Ambulance Services (when Medically Necessary) • Land/Air (Air Ambulance will suspend for Medical Necessity).	Deductible then 15% Coinsurance	Covered at the In Network benefit level at Billed Charges. (See note below)
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: 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
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Eye Care		
Office visit – medical eye care exams (treatment of disease or Injury to the eye)		
• Physician / Specialist Physician Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Treatment other than office visit	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Glasses/Contacts after Cataract Surgery – Limited to one (1) occurrence: includes initial frames, lenses or contacts following Cataract surgery.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Hearing Care		
Office visit – Audiometric exam/hearing evaluation test		
• Physician / Specialist Physician Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Treatment other than office visit	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Cochlear Implants	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Hearing devices/hearing aids, including exams and hearing aid accessories. • No coverage for hearing loss due to age.	Not Covered	Not Covered
High Diagnostic Imaging		
• Includes MRI/MRA/CAT/PET/SPECT. • Hospital Based Provider services rendered by non-par providers are covered at the In-Network benefit level.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Home Health Care Services • Includes Private Duty Nursing and Home Infusion therapy (Services do NOT count toward the Home Health visit maximum.)	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)	
Hospice Care Services • Respite Care is Not Covered. • Bereavement Counseling is Not Covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Hospital Inpatient Services – Precertification Required		
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
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
Note: Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits at Billed Charges when providing Inpatient services**.**		
Infusion Therapy	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Maternity Care (Dependent Daughters are covered) & Other Reproductive Services		
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
Note: 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 • Includes Therapeutic and Elective Abortion. • Dependent Daughters are covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Outpatient Professional/Office Professional Visit • Includes Therapeutic and Elective Abortion. • Dependent Daughters are covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Infertility Services • Treatment for underlying medical conditions are covered as medical. • Covered for services to diagnose infertility only.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
• Treatment of infertility is not covered (except artificial insemination). Artificial Insemination is limited to 6 attempts per lifetime.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Invitro Fertilization - Includes in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, and reversal of voluntary sterilization.) are Not covered.	Not Covered	Not Covered
Sterilization Services that do not qualify as "Preventive Care" benefits (Precertification required for Inpatient procedures)	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.		
• Vasectomy Reversals are Not Covered.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Contraceptives –that do not qualify as "Preventive Care" benefits • Spermicide, vaginal ring, hormone patch Depo - Estradiol Cypionate • Covered for birth control as well as medical conditions.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Medical Supplies and Equipment		
Medical Supplies	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Durable Medical Equipment (DME) • (Purchase & Rental)	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Orthotics • Foot (Foot Orthotics based on Medical Necessity) and shoe	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Prosthetic Appliances (external) • Wigs/Toupees limited to one per Benefit Period, subject to Medical Necessity.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Nutritional Counseling for Non-Diabetes • May be considered Preventive Care Benefits under certain circumstances. • Eating Disorders are covered. • Covered for medical conditions that require a special diet.	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	
Nutritional Counseling for Eating Disorders	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Outpatient Hospital/Facility Services		
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
Physician Services (Home and Office Visits)		
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
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
Prescription Drugs (other than Preventive Care)		
Generic	Deductible then 15% Coinsurance	Deductible then 15% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Brand-name	Deductible then 15% Coinsurance	Deductible then 15% Coinsurance
Preventive Services (regardless of Provider or setting where Preventive care is provided)	Covered at 100%	Deductible then 30% Coinsurance
Contraceptives - qualify as "Preventive Care" benefit • 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). • Covered based on the diagnosis restriction within the "Preventive Care" benefits.	Covered at 100%	Deductible then 30% Coinsurance
Other Preventive Services		
Routine eye exams	Not Covered	Not Covered
Routine hearing exams • Limited to one per calendar year.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Routine Foot Care • Foot Orthotics may be covered as DME.	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Note: Preventive Care treatment generally applied to Covered Services only when claim submitted with a "well" diagnosis.		
Retail Health Clinics	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Skilled Nursing Facility	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
• Maximum days	120 days per calendar year combined Network and Out-of-Network.	
Surgical Services	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Bariatric Surgery	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Blue Distinction Bariatric Services Benefit: 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.		
Designated BD Bariatric COE: For the Covered Bariatric Procedure, you will pay 5% of the Maximum Allowable Amount for Bariatric Surgery facility.		
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.		
Out of Network Bariatric provider: you will pay 30% of the Maximum Allowable Amount for a Bariatric procedure performed at an Out-of-Network facility.		
Transportation and Lodging – Distance the patient must live from the surgical facility to use this benefit: 50 Miles. **Lodging allowance:** $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.		
Participation in Anthem BD Bariatric Specialty Care Management Program is required for benefits to be considered.		

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Blue Distinction Centers+/Blue Distinction Centers Transplant Surgery Benefit			
Designated BDC+ Provider for Transplant Surgery Procedures	**Designated BDC Provider for Transplant Surgery procedures**	**PAR (Network) Transplant Provider (non-BDC+/BD Provider)**	**Non-PAR (Out-of-Network) Transplant Provider**
Benefit Limits for Covered Transplant Procedure:			
For the Covered **Transplant** Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **Transplant** Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC** 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 **Transplant** Procedure, you will pay 15% of the Maximum Allowable Amount when using a **PAR**, 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 **Transplant** Procedure, you will pay 30% of the Maximum Allowable Amount when using a **non-PAR** 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).
Deductibles			
Applicable Deductibles apply	Applicable Deductibles apply	Applicable Deductibles apply.	Applicable Deductibles apply.

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

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Benefit Limits for Covered Cardiac Procedure:			
For the Covered Cardiac Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **BDC** 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 **PAR**, 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 **non-PAR**, 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).
Deductibles			
Normal Deductibles apply.	Normal Deductibles apply.	Normal Deductibles apply.	Out-of-Network Deductibles will apply.

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

Benefits	Network		Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Benefit Limits for Covered Orthopedic Procedure:			
For the Covered Orthopedic Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **BDC** 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 **PAR**, 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 **non-PAR**, 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).
Deductibles			
Normal Deductibles apply.	Normal Deductibles apply.	Normal Deductibles apply.	Out-of-Network Deductibles will apply.

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Travel Reimbursement			
Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. **Lodging allowance:** $50 per day for single occupancy/$100 per day for double occupancy. Meals are not covered. Reimbursed at 100% as long as orthopedic procedure is covered and performed at BDC facility. Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion. Facility must be 50 miles from member's residence.	Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. **Lodging allowance:** $50 per day for single occupancy/$100 per day for double occupancy. Meals are not covered. Reimbursed at 100% as long as orthopedic procedure is covered and performed at BDC facility. Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion. Facility must be 50 miles from member's residence.	Not Covered	Not Covered
Telehealth Visits			
• Includes Teladoc. • All other providers are NOT Covered. Please contact Customer Service for additional information.		Deductible then 15% Coinsurance	Not Covered

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Therapy Services (Outpatient)		
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	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
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.		
Chiropractic Care	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
– Maximum per calendar year	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.	
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
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Transgender Surgery	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
Transplants			
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. **The Center of Excellence requirements do not apply to** Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** 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.)			

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
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 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.
Covered Transplant Procedure during the Transplant Benefit Period	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, **you are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.**			
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)	Deductible then 5% Coinsurance	Deductible then 15% Coinsurance	Deductible then 30% Coinsurance
Includes unrelated donor search up to $30,000 per transplant.			

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	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.
Eligible Travel and Lodging – • 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. • Transportation for two companions if the patient is a minor child. • Travel is reimbursed for patient and companion.	Covered at 100%	Covered at 100%	Not Covered
All Other Covered Transplant Services	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

HSA Basic Plan

The HSA plan options approach gives you the opportunity to build your available health care dollars over time in a personal health savings account (HSA). If you enroll in the HSA Basic Plan option, you may be able to contribute to your HSA. The federal income tax code imposes limitations on whether contributions you make to your HSA will be eligible for favorable tax treatment. If you qualify for favorable tax treatment of your HSA, then so long as you don't use the full amount of your HSA, it remains available to you tax-free for eligible expenses now and in the future.

The Traditional Health Coverage provisions of the HSA Basic Plan option do not kick in until the applicable annual Deductible has been met.

Your Annual Deductible is:

	In-Network	Out-of-Network
Individual	$2,700	$4,000
Employee + Spouse/Domestic Partner	$5,400	$8,000
Employee + Child	$5,400	$8,000
Employee + Children	$8,100	$12,000
Family	$8,100	$12,000

Note: The Deductible applies to all Covered Services you incur in a Benefit Period except Network Preventive Care Services. The Network Deductible and Out-of-Network Deductible are not separate and do accumulate toward each other.

Your Plan has an embedded Deductible which means:

- A covered individual within a family can satisfy the amount shown as the Participant Only 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.

Traditional Health Coverage

The Plan offers additional health coverage to protect you and your covered family members in case you incur health care expenses that exceed your annual Deductible. This coverage begins once you have 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 90% 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 10% 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:

	In-Network	Out-of-Network
Individual	$4,000	$8,000
Employee + Spouse/Domestic Partner	$8,000	$16,000
Employee + Child	$8,000	$16,000
Employee + Children	$12,000	$24,000
Family	$12,000	$24,000

Note: The Out-of-Pocket Maximum includes all Deductibles and/or Coinsurance you incur in a Benefit Period. 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.

The HSA Basic Plan has an embedded Out-of-Pocket Maximum, which means:

- An individual within the family will never pay more than their individual Out-of-Pocket Maximum; and

- If you also cover Dependents (other family members) under this Plan, the Out-of-Pocket costs for your and their Covered Services will be applied towards the remaining Out-of-Pocket Maximum applicable for your coverage level. Once the Out-of-Pocket Maximum applicable for your coverage level is met, it is considered met for all covered 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 (HSA Basic Plan)

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

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Acupuncture	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
ADD/ADHD • Attention Deficit Disorders includes Intellectual Disability, Developmental Delays and Learning Disabilities.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Allergy Care		
Testing and Treatment – Physician or Specialist Physician	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Biofeedback	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Blood Processing and Storage	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Consultation, Second Opinion • Includes Family Planning.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Dental & Oral Surgery/TMJ Services		
Accidental Injury • Covered for treatment of an injury to sound and natural teeth. • Only if treatment is completed within 12 months of the accident. • Care must commence within 90 days of accident.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Oral Surgery - Subject to Medical Necessity – excludes appliances and orthodontic treatment. • Dental Anesthesia is covered only if related to a payable oral surgery. • DOES NOT include removal of impacted teeth.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
TMJ - Subject to Medical Necessity • Covered for medical treatment (surgical and non-surgical). • Excludes appliances and orthodontic treatment.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Diabetes Maintenance		
Diabetes Education/Diabetic Nutritional Counseling Outpatient Institutional • Nutritional Counseling for Diabetes. • May be covered at 100% under certain circumstances - refer to Preventive Care Benefits. • Covered for medical conditions that require a special diet. • Includes gestational. • Diabetic Supply - Covered only for glucometer or insulin infusion pump.	Deductible then 10% 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	
Diagnostic Physician's Services		
Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:		
Physician / Specialist Physician Coinsurance	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Diagnostic X-ray and Lab – office or independent lab. • Covered at the In Network benefit level.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Dialysis/Hemodialysis Therapy	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Emergency Room, Urgent Care, and Ambulance Services		
Emergency room for an Emergency Medical Condition • 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). • Quick Care Options. • All other services.	Deductible then 10% Coinsurance	Covered at the In Network benefit level (See note below)
Use of the emergency room for non-Emergency Medical Conditions • Applies to non-emergency Medical Condition diagnoses (as defined by Prudent Layperson). • Quick Care Options • All other services.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Urgent Care clinic visit • All other services.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Ambulance Services (when Medically Necessary) • Land/Air (Air Ambulance will suspend for Medical Necessity).	Deductible then 10% Coinsurance	Covered at the In Network benefit level at Billed Charges. (See note below)
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: 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
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Eye Care		
Office visit – medical eye care exams (treatment of disease or Injury to the eye)		
• Physician / Specialist Physician Coinsurance	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Treatment other than office visit	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Glasses/Contacts after Cataract Surgery – Limited to one (1) occurrence: includes initial frames, lenses or contacts following Cataract surgery.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Hearing Care		
Office visit – Audiometric exam/hearing evaluation test		
• Physician / Specialist Physician Coinsurance	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Treatment other than office visit	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Cochlear Implants	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Hearing devices/hearing aids, including exams and hearing aid accessories. • No coverage for hearing loss due to age.	Not Covered	Not Covered
High Diagnostic Imaging		
• Includes MRI/MRA/CAT/PET/SPECT. • Hospital Based Provider services rendered by non-par providers are covered at the In-Network benefit level.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Home Health Care Services • Includes Private Duty Nursing and Home Infusion therapy (Services do NOT count toward the Home Health visit maximum.)	Deductible then 10% 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)	
Hospice Care Services • Respite Care is Not Covered. • Bereavement Counseling is Not Covered.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Hospital Inpatient Services – Precertification Required		
Room and board (Semiprivate or ICU/CCU)	Deductible then 10% 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 10% Coinsurance	Deductible then 30% Coinsurance
Pre-Admission testing	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Physician Services:		
• Surgeon	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Anesthesiologist	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Radiologist	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Pathologist	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Note: Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits at Billed Charges when providing Inpatient services**.**		
Infusion Therapy	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Maternity Care (Dependent Daughters are covered) & Other Reproductive Services		
Physician's office: Global care (includes pre-and post-natal delivery)		
Primary Care Physician (includes obstetrician and gynecologist) Coinsurance	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Specialist Physician Coinsurance	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Midwife (Precertification required)	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Physician Hospital/Birthing Center Services (Precertification required)		
Physician's services	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Newborn nursery services (well baby care)	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Circumcision	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Note: 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 • Includes Therapeutic and Elective Abortion. • Dependent Daughters are covered.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Outpatient Professional/Office Professional Visit • Includes Therapeutic and Elective Abortion. • Dependent Daughters are covered.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Infertility Services • Treatment for underlying medical conditions are covered as medical. • Covered for services to diagnose infertility only.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
• Treatment of infertility is not covered (except artificial insemination). Artificial Insemination is limited to 6 attempts per lifetime.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Invitro Fertilization - Includes in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, and reversal of voluntary sterilization.) are Not covered.	Not Covered	Not Covered
Sterilization Services that do not qualify as "Preventive Care" benefits (Precertification required for Inpatient procedures)	Deductible then 10% 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.		
• Vasectomy Reversals are Not Covered.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Contraceptives –that do not qualify as "Preventive Care" benefits • Spermicide, vaginal ring, hormone patch Depo - Estradiol Cypionate • Covered for birth control as well as medical conditions.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Medical Supplies and Equipment		
Medical Supplies	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Durable Medical Equipment (DME) • (Purchase & Rental)	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Orthotics • Foot (Foot Orthotics based on Medical Necessity) and shoe	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Prosthetic Appliances (external) • Wigs/Toupees limited to one per Benefit Period, subject to Medical Necessity.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Nutritional Counseling for Non-Diabetes • May be considered Preventive Care Benefits under certain circumstances. • Eating Disorders are covered. • Covered for medical conditions that require a special diet.	Deductible then 10% 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	
Nutritional Counseling for Eating Disorders	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Outpatient Hospital/Facility Services		
Outpatient facility	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Lab and x-ray services	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Physician Services (Home and Office Visits)		
Primary Care Physician	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Specialist Physician	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Office Surgery	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Online Visits from LiveHealth Online Provider	Not Covered	Not Covered
Prescription Injectables/Prescription Drugs Dispensed in the Physician's Office	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Prescription Drugs (other than Preventive Care)		
Generic	Deductible then 10% Coinsurance	Deductible then 10% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Brand-name	Deductible then 10% Coinsurance	Deductible then 10% Coinsurance
Preventive Services (regardless of Provider or setting where Preventive care is provided)	Covered at 100%	Deductible then 30% Coinsurance
Contraceptives - qualify as "Preventive Care" benefit • 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). • Covered based on the diagnosis restriction within the "Preventive Care" benefits.	Covered at 100%	Deductible then 30% Coinsurance
Other Preventive Services		
Routine eye exams	Not Covered	Not Covered
Routine hearing exams • Limited to one per calendar year.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Routine Foot Care • Foot Orthotics may be covered as DME.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Note: Preventive Care treatment generally applied to Covered Services only when claim submitted with a "well" diagnosis.		
Retail Health Clinics	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Skilled Nursing Facility	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
• Maximum days	120 days per calendar year combined Network and Out-of-Network.	
Surgical Services	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Bariatric Surgery	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Blue Distinction Bariatric Services Benefit: 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.		
Designated BD Bariatric COE: For the Covered Bariatric Procedure, you will pay 5% of the Maximum Allowable Amount for Bariatric Surgery facility.		
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.		
Out of Network Bariatric provider: you will pay 30% of the Maximum Allowable Amount for a Bariatric procedure performed at an Out-of-Network facility.		
Transportation and Lodging – Distance the patient must live from the surgical facility to use this benefit: 50 Miles. **Lodging allowance:** $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.		
Participation in Anthem BD Bariatric Specialty Care Management Program is required for benefits to be considered.		

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Blue Distinction Centers+/Blue Distinction Centers Transplant Surgery Benefit			
Designated BDC+ Provider for Transplant Surgery Procedures	**Designated BDC Provider for Transplant Surgery procedures**	**PAR (Network) Transplant Provider (non-BDC+/BD Provider)**	**Non-PAR (Out-of-Network) Transplant Provider**
Benefit Limits for Covered Transplant Procedure:			
For the Covered **Transplant** Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **Transplant** Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC** 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 **Transplant** Procedure, you will pay 10% of the Maximum Allowable Amount when using a **PAR**, 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 **Transplant** Procedure, you will pay 30% of the Maximum Allowable Amount when using a **non-PAR** 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).
Deductibles			
Applicable Deductibles apply	Applicable Deductibles apply	Applicable Deductibles apply.	Applicable Deductibles apply.

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Live Donor Searches			
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 90% 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.
Bone Marrow Donor Search			
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
Organ Transplants (institutional)			
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 90% of Maximum Allowed Amount	Donor expenses are covered at 70% of Maximum Allowed Amount
Organ Transplants (professional)			
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 90% of Maximum Allowed Amount	Donor expenses are covered at 70% of Maximum Allowed Amount

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

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Benefit Limits for Covered Cardiac Procedure:			
For the Covered Cardiac Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **BDC** 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 10% of the Maximum Allowable Amount when using a **PAR**, 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 **non-PAR**, 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).
Deductibles			
Normal Deductibles apply.	Normal Deductibles apply.	Normal Deductibles apply.	Out-of-Network Deductibles will apply.

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

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Benefit Limits for Covered Orthopedic Procedure:			
For the Covered Orthopedic Procedure, you will pay 5% of the Maximum Allowable Amount when using a designated **BDC+** 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 **BDC** 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 10% of the Maximum Allowable Amount when using a **PAR**, 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 **non-PAR**, 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).
Deductibles			
Normal Deductibles apply.	Normal Deductibles apply.	Normal Deductibles apply.	Out-of-Network Deductibles will apply.

Benefits		Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.			
Travel Reimbursement			
Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. **Lodging allowance:** $50 per day for single occupancy/$100 per day for double occupancy. Meals are not covered. Reimbursed at 100% as long as orthopedic procedure is covered and performed at BDC facility. Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion. Facility must be 50 miles from member's residence.	Covered, as approved by the Medical Claims Administrator, for applicable transportation and lodging expenses. Prior approval is required. **Lodging allowance:** $50 per day for single occupancy/$100 per day for double occupancy. Meals are not covered. Reimbursed at 100% as long as orthopedic procedure is covered and performed at BDC facility. Travel includes: Transportation for two companions if the patient is a minor child. Travel is reimbursed for patient and companion. Facility must be 50 miles from member's residence.	Not Covered	Not Covered
Telehealth Visits			
• Includes Teladoc. • All other providers are NOT Covered. Please contact Customer Service for additional information.		Deductible then 10% Coinsurance	Not Covered

Benefits	Network	Out-of-Network
Note: Unless otherwise noted, In Network and Out-of-Network services are subject to the applicable Deductible and Coinsurance.		
Therapy Services (Outpatient)		
Physician – Coinsurance, per visit	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Specialist Physician or other – Coinsurance per visit	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Physical Therapy Occupational Therapy Speech Therapy	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
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.		
Chiropractic Care	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
– Maximum per calendar year	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.	
Cardiac Rehabilitation	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Radiation Therapy	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Chemotherapy	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Respiratory Therapy	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Vision Therapy	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Transgender Surgery	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
Transplants			
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. **The Center of Excellence requirements do not apply to** Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** 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.)			

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
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 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.
Covered Transplant Procedure during the Transplant Benefit Period	Deductible then 5% Coinsurance	Deductible then 10% 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, **you are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.**			
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)	Deductible then 5% Coinsurance	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
Includes unrelated donor search up to $30,000 per transplant.			
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	Deductible then 5% Coinsurance, as approved, up to a $30,000 benefit limit	Deductible then 10% 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.

Benefits	Center of Excellence	Network Transplant Provider	Out-of-Network Transplant Provider
Eligible Travel and Lodging –	Covered at 100%	Covered at 100%	Not Covered
• 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. • Transportation for two companions if the patient is a minor child. • Travel is reimbursed for patient and companion.			
All Other Covered Transplant Services	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

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 - SCPs), 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.
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 the "Health Care Management – Precertification" section 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** or **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**), select "Locate a Pharmacy" from the "Manage Prescriptions" menu and search by ZIP code or city and state.
- 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 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**;

Magellan: **www.magellanhealth.com**; and

Express Scripts: **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 $3,000 – 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.

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** or **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 HSA Plan options 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**, 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.

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**. 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**. 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

HSA 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 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 applied to your annual deductible or 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 HSA Plans:

- 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 HSA Plans provide 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**.

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**, 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 HSA Plans:

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.

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**. Please refer to the description of the "Employee Assistance Program" section that immediately follows for more details.

* 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.

**********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.

ACT OF WAR/MILITARY DUTY:
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.
CUSTODIAL/CONVALESCENT CARE:
Services for Custodial Care.
Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
DENTAL SERVICES:
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.
ELIGIBILITY:
Charges for treatment received before coverage under this option began or after coverage terminated.
EXPERIMENTAL/INVESTIGATIONAL:
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.

GOVERNMENT AGENCY/LAWS/PLANS:
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 primary payer whether or not the Member has enrolled Medicare Part B.
Court-ordered services, or those required by court order as a condition of parole or probation (unless Medically Necessary and approved by the Plan).
MEDICATIONS:
Nonprescription drugs, medications or supplies (except insulin).
MEDICALLY NECESSARY:
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 guidelines.
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.
MISCELLANEOUS:
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.
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.

MISCELLANEOUS (cont'd):
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.
SPECIAL CHARGES/SERVICES:
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.
SURGERY:
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.
THERAPIES:
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.
VISION CARE:
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.
WEIGHT REDUCTION PROGRAMS:
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 Administer 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

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 even within 60 days of that event and within the original 18-month period.

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

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

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

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**. (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**.

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 of 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**.

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 HSA Plan options (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.

AEP Benefits Center
1-888-237-2363

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_28 Provide detailed descriptions of all early retirement plans or other staff reduction programs the utility has offered or intends to offer its employees during the test period. Include all cost-benefit analyses associated with these programs.

RESPONSE

During the test period, no early retirement plans or other staff reduction programs were offered or in place.

Witness: Andrew R. Carlin

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_29 Provide a complete description of the utility's other post-employment benefit package(s) provided to its employees.

RESPONSE

Please refer to KPCO_R_KPSC_2_29_Attachment1 for the requested information.

Witness: Andrew R. Carlin

RETIRING FROM AEP

A GUIDE TO YOUR BENEFITS

Retirees age 55 or older with 10 or more years of credited service

AMERICAN ELECTRIC POWER

WELCOME TO RETIREMENT

CONGRATULATIONS!

Your hard-earned retirement is here. Retirement can be one of the most fulfilling and rewarding chapters of your life — especially if you're prepared for it.

As you leave AEP, you'll have many important decisions to make about your health and retirement benefits. This guide will help you prepare for retirement and learn about your AEP retiree benefits.

Contact the AEP Benefits Center to discuss your benefit options with an AEP Retiree Counselor by calling 1-888-237-2363, Monday-Friday, 9 a.m. – 6 p.m. EST.

IS THIS THE RIGHT GUIDE FOR YOU?

This benefits guide contains the right information for your situation if you are BOTH of the following:

AGE 55 AND UP

AND

10+ YRS CREDITED AEP Service

TABLE OF CONTENTS

FIND IT FAST!

IMPORTANT

This guide covers the benefits of retirees who are age 55 or older and who have ten or more years of credited service with AEP as of their last day of employment.

If you are under age 55 with ten years of credited service as of your last day of employment, please refer to the guide "Leaving AEP: A guide for ending employment."

If you were a part-time employee, please note that the following plans or programs referenced in this guide are not applicable: life insurance, dependent life insurance, accidental death & dismemberment (AD&D) insurance, the long-term disability (LTD) plan, personal days off, educational assistance, adoption assistance, the educational awards program, and SIRVA Mortgage Services.

This guide is not intended to be a plan document, Summary Plan Description, or required notice with respect to any of the plans mentioned. AEP reserves the right to modify, amend, suspend, or terminate the plans at any time. Refer to the applicable plan document if you have any questions relating to a specific plan or benefit.

RETIREMENT STEPS CHECKLIST

Use the following checklists to help you stay organized and take the necessary steps before/after you retire from AEP.

THINKING ABOUT RETIREMENT

☐ DISCUSS YOUR RETIREMENT DATE WITH YOUR MANAGER

- Discuss your retirement plans with your manager, including your last day and any vacation or personal days off you intend to take before the end of your employment.
- Your manager must submit your termination transaction in the AEP system. It's important that the date that you and your manager discuss together is the date that is entered into the system.

☐ CONTACT THE AEP BENEFITS CENTER

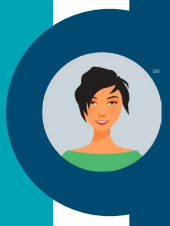
The best time to contact the AEP Benefits center is 60-90 before your anticipated retirement date. Discuss your plans for retiring and benefit options with an AEP Retiree Counselor by calling 1-888-237-2363 Monday-Friday, 9 a.m. – 6 p.m. EST.

☐ CONFIRM YOUR PERSONAL CONTACT INFORMATION

Verify your address, email, and phone numbers before and after your employment with AEP ends. While you are still employed with AEP, check HR Now and ensure all of your information is up-to-date. This is the contact information that will be used for any emails, phone calls or information being mailed to you prior to your last day of employment. After your last day with AEP, any updates to your personal information should be updated at www.aepbenefits.com or by calling the AEP Benefits Center.

☐ CONSIDER AYCO FINANCIAL COUNSELING

Ayco provides confidential financial counseling and retirement planning, to AEP employees, at no cost. You can contact an Ayco financial coach at 1-866-217-8693 Monday-Thursday, 9 a.m.-8 p.m. ET, and Friday, 9 a.m.-5 p.m. ET. You can also visit the digital platform to learn more at www.ayco.com/login/aep.



SOFIA

Chat with Sofia℠, your online personal benefits assistant. She's available 24/7 to answer many of your benefits questions, whether you are using the mobile app or the website. Access Sofia once you login to www.aepbenefits.com and use the Chat link on the top of the site.

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HEALTH & WELFARE BENEFITS

☐ DETERMINE YOUR OPTIONS

Discuss your medical, dental, vision, and life insurance plan options and associated costs with an AEP Retiree Counselor. Your active employee coverage ends on the last day of the month in which you end your employment with AEP. Your coverage as an AEP retiree begins the following day, assuming you meet all eligibility requirements.

☐ ENROLL IN MEDICARE PART B (IF APPLICABLE)

If you and/or your spouse are eligible for Medicare at the time of your termination date, whether due to age or disability, you MUST contact Medicare to enroll into Medicare Parts A & B. If you don't do this prior to your retirement effective date, your medical coverage through AEP will be impacted and potentially terminated. You should contact Medicare at least 30 days before your last day of employment in order to ensure timely enrollment in Part B.

☐ CONSIDER YOUR HEALTH SAVINGS ACCOUNT (HSA)

If you contributed to an HSA or received employer-deposited HSA funds, contact HealthEquity to discuss your options. Refer to the "Health Savings Account" section for additional information.

☐ CONTINUE VOLUNTARY COVERAGE

If you were enrolled as an active employee in any voluntary benefits such as life insurance, long-term care, legal plan, auto/home insurance, or pet insurance, decide if you want to continue coverage (see pages 24-26).

AEP RETIREMENT PLAN (PENSION)

☐ ESTIMATE YOUR PENSION BENEFIT

Consider your pension payment options and estimate your pension amount at any time using different retirement dates and assumptions. Visit www.aepbenefits.com. After logging in, click on the AEP Pension Plan link and then select "Plans" and then "Retirement Plan (Pension)." From there the "Estimate your pension" link can be found on the right side of the page under "Take Action."

☐ REQUEST YOUR DISTRIBUTION PACKAGE

Once you've decided on your retirement date and if applicable, your pension benefit commencement date, you must request a distribution package. This information will include all of your options under the AEP Retirement Plan, using the last day worked and commencement date that you specify. You can request a distribution kit by following the same instructions as requesting an estimate except select "Request a distribution package." You should receive your package via U.S. Mail in about 7-10 business days.

☐ COMPLETE AND RETURN YOUR RETIREMENT PLAN FORMS

Once you select the option that best fits your financial needs, review the instructions on what sections of the forms must be completed and any documentation that must be submitted with your completed paperwork. You may also choose to defer your pension benefit to some later date (but not beyond your reaching age 70½). If you wish to defer your benefits until a later date, no action is needed. Once you are ready to commence your benefit, follow the steps to request a distribution package at least 60 days before you'd like to commence.

☐ UPDATE/REVIEW YOUR PENSION BENEFICIARY INFORMATION (IF APPLICABLE)

If you are electing to defer your AEP Retirement Plan (Pension) benefit, it's important to ensure that you have a beneficiary on file. You can review your pension beneficiary information by going to www.aepbenefits.com and selecting the "AEP Pension Plan" link. Then select "Plans" and "AEP Retirement (Pension)." Select the "Beneficiaries" tab and review/update as needed.

AEP RETIREMENT SAVINGS 401(k) PLAN

☐ LEARN ABOUT YOUR OPTIONS

Visit www.aep401k.com or call Empower at 1-877-237-4015 to learn about your options for your 401(k) plan account, including distributions, rollovers to IRAs, or repayment of any outstanding loans. Depending on your account balance, you may also choose to leave your retirement savings plan account in place until a later date (though you must begin taking required minimum distributions beginning at age 72).

☐ UPDATE/REVIEW YOUR 401(k) BENEFICIARY

Contact Empower Retirement at 1-877-237-4015 or visit www.aep401k.com.

OTHER THINGS TO CONSIDER

☐ AEP WILL INFORM YOU ABOUT APPLICABLE VACATION PAYOUTS

You will not be paid out for any unused personal days. See the "Unused Time Off" section on page 26 for additional information.

☐ FINALIZE ACCOUNTS AND RETURN COMPANY PROPERTY

Be prepared to make arrangements to pay off any applicable pay advances, settle any expense accounts, and return company property.

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☐ EXECUTIVE BENEFIT PLAN PARTICIPANTS

If you participate in any executive benefit plans, please direct your questions to:

- Supplemental Retirement Savings Plan and Incentive Compensation Deferral Plan – visit www.aep401k.com or call 1-877-237-4015.
- Long-term Incentive Plan(s) – visit www.netbenefits.fidelity.com or call 1-800-544-9354.
- Supplemental Excess Retirement Plan (SERP) – contact the AEP Benefits Center at 1-888-237-2363 or visit www.aepbenefits.com. After logging in, click on the AEP Pension Plan link and then select "Plans" and then "SERP Non-Qual Pension." From there the "Estimate your pension" link can be found on the right side of the page under "Take Action."

You can speak with an AEP Retiree Counselor by phone Monday through Friday from 9 a.m to 6 p.m. EST. AEP Retiree Counselors can help walk you through the retirement process, answer many of your questions about retirement benefits and help you with site navigation, support and password resets.

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AEP RETIREMENT PLAN (PENSION)

The following summarizes the AEP Retirement Plan (Pension) benefits available to all AEP vested employees. For plan-specific details such as formulas or early retirement factors, please refer to the AEP Retirement Plan (Pension) Summary Plan Description.

WHO IS ELIGIBLE?

If you are a member of the AEP Retirement Plan (Pension) with three or more years of credited vesting service, you are vested in your pension benefit.

AEP RETIREMENT PLAN (PENSION) GRANDFATHERED PARTICIPANTS

If you were continuously employed with an AEP company since January 1, 2001, and you were either a participant in the AEP Retirement Plan (Pension) or in the waiting period, you are eligible for grandfathering provisions.

DISABLED AEP RETIREMENT PLAN (PENSION) PARTICIPANTS

If you became disabled while an active employee with an AEP company, you received annual interest credits and company credits through August 31, 2013. After September 1, 2013, disabled pension plan participants no longer received company credits under the plan; however, they continued to receive interest credits.

If you choose to begin your pension benefit payment or receive retiree coverage under any of the AEP Health & Welfare plans, you terminate your right to receive any additional payments under the AEP Long-Term Disability (LTD) Plan.

CENTRAL AND SOUTHWEST CORPORATION CASH BALANCE RETIREMENT PLAN PARTICIPANTS

The Central and Southwest Corporation Cash Balance Retirement Plan (CSW Pension) was incorporated into the American Electric Power System Retirement Plan effective December 31, 2008, when the CSW Pension Plan was merged into the AEP Retirement Plan (Pension). This summary will refer to the CSW Pension Plan as if it continued to be a separate plan.

The CSW Pension Plan generally provides the same cash balance benefit formula that is provided under the AEP Retirement Plan, but it also includes special provisions for calculating the benefits payable to employees who have been continuously employed with the Company since July 1, 1997, either because they were then at least age 50 with at least 10 years of service (a Grandfathered CSW Plan Participant) or not (Protected Prior CSW Pension Plan Participants). Please refer to the CSW Pension Plan - Summary Plan Description for Active Employees for additional details.

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WHEN WILL MY PENSION PAYMENTS BEGIN?

The earliest your pension benefits can begin is the first of the month following the date you ended employment. No benefits are paid out until that date or after, depending on when you choose to commence your benefit.

Your first payment will be paid as soon as possible upon receipt of appropriately completed paperwork and the required documentation associated with the payment option you selected.

If you choose a monthly annuity, you will receive subsequent payments on the first of the month. Annuity checks will be dated the first of the month. Direct deposits will be effective the first of the month.

WATCH YOUR MAILBOX FOR YOUR PENSION PLAN DISTRIBUTION PACKAGE

If you are vested in the AEP Pension Plan and you have not already requested a distribution package you will receive one automatically **45 days** after your last day of employment. Your distribution package will include your pension calculation and the paperwork you'll need to make a pension benefit payment election. If you would like to defer payment until a later date, you can disregard the distribution package and request one at a later date when you are ready to commence your benefit.

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AEP RETIREMENT SAVINGS 401(k) PLAN

Your 401(k) plan can be a valuable part of your retirement portfolio. Be sure to review your options below to ensure you get the most out of the assets you've worked so hard to build.

401(k) PLAN ACCOUNT BALANCE OPTIONS

Your options will depend on your account balance, as outlined below. **NOTE: After your employment ends, there is a 30-day hold period before you can take a distribution.**

IF YOUR ACCOUNT BALANCE IS $1,000 OR LESS

Your money may not remain in the 401(k) plan. You may:

- **Directly roll over your money to an individual retirement account (IRA) or another qualified plan to preserve its tax-deferred status.** You must initiate a rollover within 90 days following the end of the month in which your employment ended by visiting www.aep401k.com or by calling 1-877-237-4015.
- **"Cash out" your account by taking no action within 90 days.** If you do not initiate a direct rollover within 90 days, approximately four months after your employment ends, you will receive a check for the amount of your account balance minus 20% mandatory federal income tax withheld. You may also be subject to a 10% early withdrawal penalty if you're under age 59½. The check will be mailed to your address on record. By January 31 of the year following your distribution, you will receive a Form 1099-R stating the total distribution amount and its taxable and nontaxable portions. You will need to report the distribution on your income tax return.

IF YOUR ACCOUNT BALANCE IS BETWEEN $1,000 AND $5,000

Your money may not remain in the 401(k) plan. You may:

- Directly roll over your money to an IRA or another qualified plan to preserve its tax-deferred status. Rollovers must be elected within 90 days following the end of the month in which your employment ended by visiting www.aep401k.com or calling 1-877-237-4015.
- Allow your money to be automatically rolled into an IRA by taking no action within 90 days. If you do not elect a direct rollover within 90 days, your total account balance will be automatically rolled over to an IRA with the IRA provider selected by AEP. You will receive additional information if this process applies to your account.
- Apply for a distribution in the form of a lump-sum or partial payment (federal income tax will apply, and you may also be subject to a 10% early withdrawal penalty if you're under age 59½*). Visit www.aep401k.com or call 1-877-237-4015 to do so.

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IF YOUR ACCOUNT BALANCE IS MORE THAN $5,000

You may:

- Directly roll over your money to an IRA or another qualified plan to preserve its tax-deferred status. To do so, visit www.aep401k.com or call 1-877-237-4015.
- Leave your money in the 401(k) plan (note that you may no longer contribute to your account). If you choose to defer payment of your account balance, you can do so until April 1 of the year following the year in which you turn age 72, at which time required minimum distributions (RMDs) must begin as mandated by the IRS.
- Apply for a distribution in the form of a lump-sum or partial payment (federal income tax will apply, and you may also be subject to a 10% early withdrawal penalty if you're under age 59½*). Visit www.aep401k.com or call 1-877-237-4015 to do so.

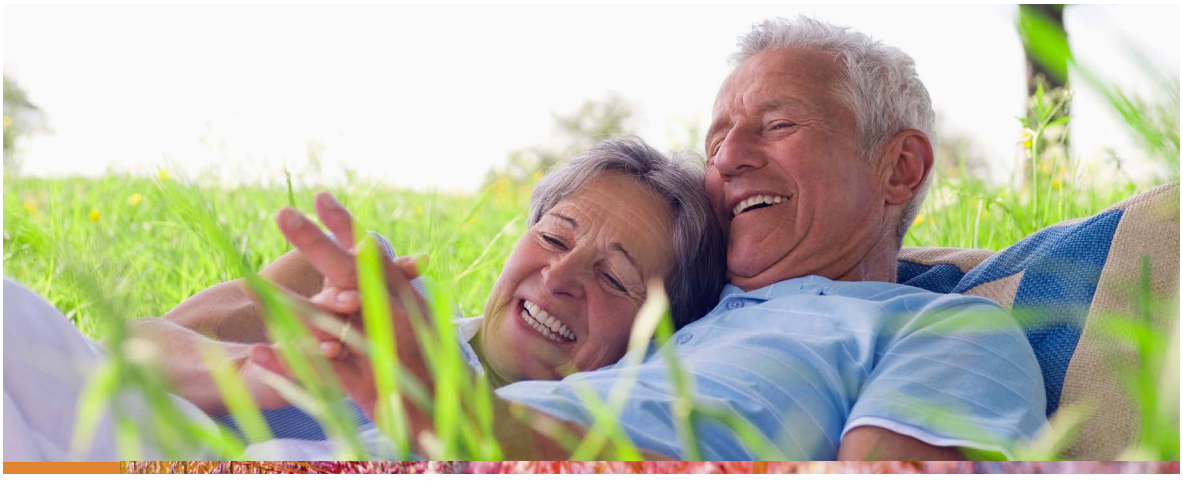
* The 10% early withdrawal penalty does not apply to payments made after you separate from service, if you will be at least age 55 in the year of your separation of employment.

IMPORTANT TAX INFORMATION

You may wish to consult with a tax or financial advisor before deciding how to handle your account balance in the 401(k) plan since your actions can have significant financial implications. Read the retirement savings plan's "Special Tax Notice with Roth Addendum" for detailed information about the tax rules associated with qualified plan distributions.

A NOTE ABOUT ROTH 401(k) BALANCES

All Roth 401(k) account balances will be considered separately when deciding whether that portion of your account meets the $1,000 or the $5,000 distribution threshold. This means that the Roth 401(k) portion of your balance may be subject to either the mandatory cash-out or the automatic rollover distribution rules while the non-Roth 401(k) portion of your account may not, or vice versa.



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AEP STOCK DISTRIBUTIONS

You may elect to have your applicable 401(k) plan balance in the AEP Stock Fund paid to you in-kind. To request an in-kind distribution of AEP stock, call 1-877-237-4015. If you request to roll over your distribution, you must provide the name of the institution, your account number, and Depository Trust Company (DTC) number for the receiving financial institution at the time of your distribution request (the DTC is the clearinghouse for electronic security transfers).

There are special rules regarding payments from the 401(k) plan that include AEP stock that may affect your taxes and rollover decisions. Read the section regarding employer stock of the "Special Tax Notice with Roth Addendum" referenced on the previous page for a more detailed explanation of these rules and how they can affect your distribution choices.

OUTSTANDING 401(k) PLAN LOANS

If you have an outstanding loan, read this section carefully.

How to pay off your loan balance(s):

1. **Recalculate your loan to a monthly payment**
   You can continue to make your scheduled payments via electronic deduction from your bank account, or you may send paper checks. Call 1-877-237-4015 and talk to an Empower representative to review your options.
2. **You may pay off your loan(s) in full**
   To obtain your loan payoff amount(s), visit www.aep401k.com or call 1-877-237-4015. If you choose to pay off your outstanding loan balance(s):
   - Your payment must be made with a cashier's check, certified check, or money order — personal checks will not be accepted. It should be made payable to "Trustee of the AEP System Retirement Savings Plan."
   - Place the words "FBO" [insert your name and Social Security number] on the "Memo" line of the check. "FBO" means "for benefit of."
   - Mail your payment to:

     Empower Retirement
     PO Box 419784
     Kansas City, MO 64141-6784

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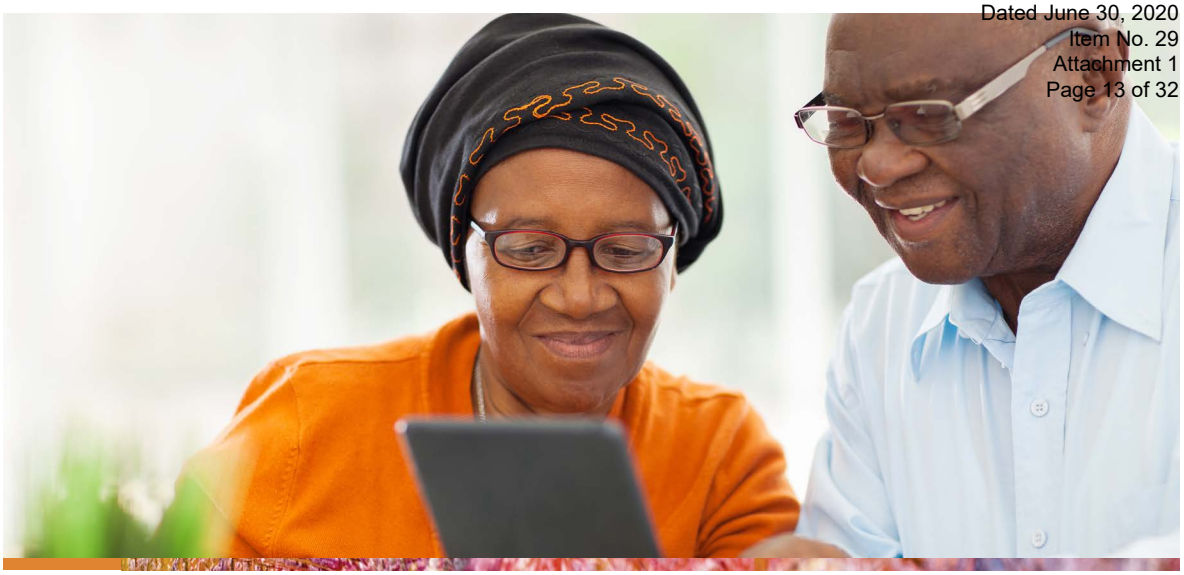

IMPORTANT CONSIDERATIONS ABOUT YOUR OUTSTANDING LOAN BALANCE(S)

- Full payment must be received before you request a distribution from your account. If you do not pay off your loan before you request a distribution, it is considered defaulted, and you will owe federal income tax on the outstanding balance as well as a 10% early withdrawal penalty if you are under age 59½.*
- Once you request a lump-sum distribution from your 401(k) plan account, you no longer qualify for loan repayment. Your outstanding loan balance(s) will be offset against your account balance prior to the lump-sum distribution.
- If you choose to defer payment of your 401(k) plan account balance and do not sign up for electronic deduction from your bank account for your loan payments, your loan will be considered due in 90 days. Likewise, if you choose to defer payment of your retirement savings account balance and do not submit payment(s), your loan will be considered due in 90 days.
- If you do not make any loan payments after your employment ends, you will receive default notices for your outstanding loan balance(s) until the loan(s) payments are brought current or an actual loan default occurs.

* The 10% early withdrawal penalty does not apply to payments made after you separate from service if you will be at least age 55 in the year of your separation of employment.

CONTACT EMPOWER RETIREMENT

To contact an Empower Retirement representative, call 1-877-237-4015 between 8 a.m. and 9 p.m. EST Monday through Friday and Saturdays between 9 a.m. and 5:30 p.m. EST. The TDD number for participants with a hearing impairment is 1-800-345-1833.

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RETIREE BENEFITS CONTINUATION

AEP currently offers retiree Health & Welfare benefits, including medical, dental, vision, and life insurance.

WHO IS ELIGIBLE?	RETIRING UNDER AGE 65	RETIRING AGE 65 OR OLDER
Medical coverage		
You are eligible for retiree medical benefits if you are at least age 55 and have at least 10 years of service as of your termination date AND were hired or rehired prior to January 1, 2014 (note there are some exceptions for rehired retirees who previously met the retiree medical eligibility requirements).	Your election as an active employee will automatically carryover, covering the same eligible dependents. If you don't want AEP retiree medical coverage at retirement, you MUST take action to opt out. You may not change your medical plan due to retirement, but you may add or drop dependents from your coverage within 31 days of your retirement date. You may also drop medical coverage at retirement and pick up at a later date during annual enrollment or within 31 days of a qualifying event.	If you are enrolled in an AEP medical plan as an active employee, you will be defaulted into the Aetna Medicare Standard Plan, covering the same eligible dependents, unless you select a different plan or opt out. If you don't want AEP retiree medical coverage at retirement, you MUST take action to opt out. Enrollment in any AEP retiree medical plan for participants age 65 or older requires enrollment in Medicare Parts A and B and no participation in any other Medicare supplement plan outside of AEP. This includes any over age 65 covered spouses and/or dependents as well.
Dental & Vision coverage		
You are eligible for retiree dental and vision benefits if you are at least age 55 and have at least 10 years of service as of your termination date.	Your elections for dental and vision coverage will automatically carry over into retirement, covering the same eligible dependents. If you do not wish to continue retiree dental or vision, you MUST take action to opt out. If you were not enrolled in dental coverage as an active employee, you must elect it within 31 days of the date your employment ends, or you will lose your eligibility permanently, and you will not be able to re-enroll at a later date.	
Life insurance		
You are eligible for retiree life insurance if you are at least age 55 and have at least 10 years of service as of your termination date AND were hired or rehired prior to January 1, 2011.	As an eligible retiree, you will receive a flat $30,000 in life insurance, at no cost to you. Active employee coverage ends on the last day of the month in which your employment with AEP ends; however, if you die within 31 days of your last day of work, the plan will provide the full death benefit you would have received under the terms of the policy. NOTE: Grandfathering provisions may apply to those who were at least age 50 with at least 10 years of service as of December 31, 2000.	

TIP

Visit www.aepbenefits.com for more information on specific plan coverage for your under-age-65 spouse.

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RETIREE MEDICAL COVERAGE

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

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

Your age + years of service are calculated by adding age and full years of service as of your employment-termination date. There is no rounding or credit for partial age or years of service.

Note: The contribution % rates apply to the retiree only coverage tier. If you cover any dependent(s), the actual % will be slightly higher.

Speak to an AEP Retiree Counselor to confirm the specific contribution rate for your medical plan, coverage tier and number of points for age + years of service.

HEALTH INSURANCE MARKETPLACE COVERAGE

There may be other coverage options for you and your family. Now that the key parts of the health care law have taken effect, you can buy coverage through the health insurance marketplace. In the marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductible, and out-of-pocket costs will be before you decide to enroll. To find out more, visit www.healthcare.gov.

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MEDICARE

You, or any of your Medicare eligible dependents, (whether due to age or disability) must enroll in Medicare Parts A and B upon your retirement. If you or your dependents fail to enroll in Medicare Parts A and B, you will not be eligible to receive retiree medical and prescription drug coverage through AEP, and your coverage will be terminated.

YOU MUST TAKE ACTION

Important: You must elect Medicare Part B. Visit www.medicare.gov for further information about Medicare B, to get enrollment instructions, and find your nearest Medicare office.

If you or your covered dependents currently have Medicare Part A, your retirement from AEP is considered a qualifying event that allows you or your Medicare-eligible dependents to enroll in Medicare Part B coverage without incurring a late enrollment penalty. Please contact Medicare within 30-60 days of your retirement date at Medicare.gov or by calling them at 1-800-MEDICARE to enroll in Medicare Part B or you could incur penalties or be denied enrollment into the AEP Medicare Advantage plans or have reduced coverage. Contact the AEP Benefits Center to provide them with your and/or your dependent(s) Medicare Beneficiary Identifier. This information is required to process your enrollment into the AEP retiree medical plans.

CANCERBRIDGE – PERSONALIZED CANCER GUIDANCE

As a retiree, you will continue to have access to CancerBridge, an information-based cancer navigation service that provides you with personalized access to cancer experts who can answer your questions about cancer and cancer treatments.

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UNDER AGE 65

The paragraphs below detail the benefits provisions that apply to AEP employees who retire before reaching age 65.

HOW DO I ELECT COVERAGE?

If you were enrolled in AEP medical coverage as an active employee, you will be auto-enrolled in the same coverage upon your retirement, covering the same eligible dependents. To review or change your retiree medical enrollment, contact an AEP Retiree Counselor after your employment termination date, or login to www.aepbenefits.com. Please note that although you can add and/or remove dependents as part of your retirement elections, you can't change medical plans. You can only change medical plans during annual enrollment each year or within 31 days of a qualifying event. If you don't want AEP retiree medical coverage you MUST take action to opt out.

WHAT IF I DON'T ELECT COVERAGE?

If you choose to opt out of retiree medical coverage when you retire, your coverage, and any of your covered dependents' coverage, will end at the end of the month in which your employment with AEP ends. You will have the opportunity to enroll in AEP retiree medical coverage during annual enrollment each year as well as within 31 days of a qualifying life event. Your spouse and/or dependent children cannot be enrolled in an AEP medical plan without you also being enrolled.

WHEN DOES MY COVERAGE SWITCH?

Active employee coverage ends on the last day of the month in which your employment with AEP ends. The plan pays for eligible medical and prescription claims incurred through that date, as long as those claims are filed within one year from the date of service. Your coverage as an AEP retiree begins the first of the month following your employment end date.

If you were not enrolled in benefits as an active employee, you may elect AEP retiree medical coverage at retirement.

NEW ID CARDS

You will receive a new Anthem medical plan ID card a few weeks after your enrollment in an AEP retiree medical plan. This will serve as your medical and prescription drug ID card.

If you are under age 65 and your spouse is age 65 or older, your spouse will need to elect Medicare Parts A and B, and Medicare will be the primary payer of your spouse's claims. Please see the section titled "Medicare" on page 30 for additional details.

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AGE 65 OR OVER

The paragraphs below detail the benefits provisions that apply to AEP employees who retire after reaching age 65.

HOW DO I ELECT COVERAGE?

If you are age 65 or older when you retire and enrolled in an AEP medical plan, you will be defaulted into the Aetna Group Medicare Standard Plan option covering the same eligible dependents. This election will remain in effect unless you elect the Aetna Group Medicare Select Plan option during enrollment or choose to waive medical coverage. Please note that automatic enrollment into the Aetna Medicare Standard Plan assumes that you and your spouse, if age 65 or older, have enrolled into Medicare Part B as of the first of the month following your last day of employment and you have not elected any other Medicare supplement plan.

TAKE ACTION

You must contact the AEP Benefits Center to provide your Medicare Beneficiary Identifier (MBI) and that of your applicable age-65-or-older spouse. This information is required for your enrollment into the age-65-or-older Medicare Advantage plans through AEP or your enrollment may be delayed or denied, which may cause an interruption in coverage, as well as possible termination of your AEP coverage.

Also, you MUST be enrolled in Medicare Parts A and B in order to be enrolled in the AEP Medicare Advantage plans. Without enrollment into Medicare Parts A and B, AEP will not be able to enroll you into the age-65-or-older Medicare Advantage plans through AEP. This would be true for your age-65-or-older spouse as well, if applicable.

TIP

If you are age 65 or older, but your eligible dependent is under age 65, you both will be covered by an age-65-or-older medical option; however, your under-age-65 dependent will have different benefits than you.

WHAT IF I DON'T ELECT COVERAGE?

If you choose to opt out of retiree medical coverage when you retire, your coverage, and any of your covered dependents' coverage, will end at the end of the month in which your employment with AEP ends. You will have the opportunity to enroll in AEP retiree medical coverage during annual enrollment each year as well as within 31 days of a qualifying life event. Your spouse and/or dependent children cannot be enrolled in an AEP medical plan without you also being enrolled.

WHAT ABOUT PRESCRIPTION DRUG COVERAGE?

If you are an AEP retiree age 65 or older covered by an AEP medical plan—or if you are an AEP retiree age 65 or older with a spouse age 65 or older and you are both covered by an AEP medical plan—your prescription drug coverage will change to a group-based, company-sponsored Medicare Part D plan administered by Express Scripts Medicare. AEP will enroll you in this coverage if you elect one of the AEP age-65-or-older medical plan options. You cannot have AEP prescription drug coverage without being enrolled in an AEP medical plan.

If you enroll in a Medicare Part D plan on your own outside of AEP, you will lose your AEP-provided medical and prescription coverage.

WHEN DOES MY COVERAGE SWITCH?

Active employee coverage ends on the last day of the month in which your employment with AEP ends. The plan pays for eligible medical and prescription claims incurred through that date, as long as those claims are filed within one year from the date of service. Your coverage as an AEP retiree begins the first of the month following your employment end date.

Upon retirement, since you are age 65 or older, you must provide all of the required information outlined in this guide, including your Medicare Beneficiary Identifier.

If you were not enrolled in benefits as an active employee, you may elect AEP retiree medical coverage at retirement.

MEMBER ID CARDS

You and any covered dependents will receive new medical plan ID cards from Aetna a few weeks after your enrollment into the retiree medical plan. This card will serve as your medical plan card ONLY. You and any covered dependents will also receive a prescription drug ID card from Express Scripts. You will have TWO separate cards - one for medical and one for prescription drugs.

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DENTAL COVERAGE

HOW DO I ELECT COVERAGE?

If you were enrolled in AEP dental coverage as an active employee, you will be automatically enrolled into the same coverage upon your retirement, covering the same eligible dependents.

If you were not enrolled in dental coverage as an active employee, you have a one-time opportunity to elect retiree dental coverage. If you do elect retiree dental coverage and later cancel it, you will not be able to elect it again in the future.

WHAT IF I DON'T ELECT COVERAGE?

If you do not elect retiree dental coverage at retirement or choose to opt out of dental coverage at that time, you will not be eligible to elect retiree dental coverage at a later date.*

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

WHEN DOES MY COVERAGE SWITCH?

Active employee coverage ends on the last day of the month in which your employment with AEP ends. The plan pays for eligible dental expenses incurred through that date, as long as those claims are filed within one year from the date of service. Your dental coverage as an AEP retiree begins the first of the month following your employment end date.

MEMBER ID CARDS

The same group number and member ID you had as an active employee will continue to apply to you and any of your covered dependents after you retire. You will not receive a new dental ID card.

VISION COVERAGE

HOW DO I ELECT COVERAGE?

If you were enrolled in AEP vision coverage as an active employee, you will be automatically enrolled into the same coverage upon your retirement, covering the same eligible dependents. To review or change your vision election, contact an AEP Retiree Counselor after your employment termination date, or login to www.aepbenefits.com.

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WHAT IF I DON'T I ELECT COVERAGE?

If you choose to opt out of retiree vision coverage when you retire, your coverage and any of your covered dependents' coverage, will end at the end of the month in which your employment with AEP ends. You will have the opportunity to enroll in AEP retiree vision coverage during annual enrollment each year as well as within 31 days of a qualifying life event. Your spouse and/or dependent children cannot be enrolled in an AEP vision plan without you also being enrolled.

WHEN DOES MY COVERAGE SWITCH?

Active employee coverage ends on the last day of the month in which your employment with AEP ends. The plan pays for eligible vision claims incurred through that date, as long as those claims are filed within one year from the date of service. Your vision coverage as an AEP retiree begins the first of the month following your employment end date.

MEMBER ID CARDS

The same group number and member ID you had as an active employee will continue to apply to you and any of your covered dependents after you retire. You will not receive a new vision ID card.

CONTINUATION OF COVERAGE UNDER COBRA

The AEP Benefits Center is required by law to notify you of your rights and coverage under COBRA. You will receive information and may continue your medical, dental and vision coverage under COBRA after your employment ends. AEP Retiree Counselors will discuss this and other coverage options with you.

PAYING FOR COVERAGE

- If you elect payment of your AEP System Retirement Plan (Pension) benefit as a monthly annuity, your retiree Health & Welfare benefit premiums will be deducted from your monthly pension benefit check, if possible. However, for the first two to three months of premiums, invoices will be sent to you until your monthly annuity has been set up.
- If you elect a lump-sum payment or choose to defer your AEP System Retirement Plan (Pension) benefit, you will receive a monthly invoice for your retiree Health & Welfare benefit premiums.
- Be sure to review your first monthly invoice as well as your pension annuity check (if applicable) for your retiree deductions. If there is a discrepancy, contact the AEP Benefits Center as soon as possible.
- Failure to remit premium payments in a timely manner will result in loss of coverage. You may not have an opportunity to re-enroll in that coverage, or if you do, the coverage may not be effective until the following plan year.

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HEALTH SAVINGS ACCOUNT (HSA)

The HSA is non-forfeitable and portable, meaning you take it with you when you leave AEP; however, your pre-tax contributions to the HSA stop after the pay period in which your employment with AEP ends.

You may continue to make after-tax deposits to your HSA, up to the applicable limit, provided you remain eligible (for example, you are enrolled in and covered exclusively by a qualifying high-deductible health plan). You may:

- Keep your HSA open with HealthEquity and continue to withdraw funds as you see fit, including payment for current and future eligible expenses as defined by the IRS. Please note that monthly administrative fees may apply.
- Close your HSA and receive any remaining funds, which may be subject to tax penalties and an account closure fee.
- Transfer your HSA balance to a new administrator with no tax implications.

FLEXIBLE SPENDING ACCOUNTS (FSA)

AEP offers tax-advantaged spending accounts to help pay for out-of-pocket medical, dental, vision, and dependent care expenses. The paragraphs below detail these plans.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

Coverage ends on the last day of the month in which your employment with AEP ends. You may claim expenses incurred prior to your coverage end date up to the full annual election amount.

If you have an HCFSA debit card, it will be deactivated on your last day of employment. Eligible claim expenses incurred on or before the date you end employment and prior to your coverage end date, up to the full annual election amount, may be submitted for reimbursement by completing a claim form and supplying the documentation of the eligible expense. Any HCFSA balance for which claims have not been received by the vendor by March 31 of next year may be forfeited.

Continuation of HCFSA participation under COBRA

You can continue to participate in the HCFSA through COBRA for the remainder of the calendar year in which your employment ends if you have not been reimbursed more than you have contributed up to your last day of employment. If you have contributions left in your account, COBRA allows you to continue contributions on an after-tax basis until the end of the current plan year. If you elect COBRA, you will be able to submit claims incurred after your coverage end date through the end of the current plan year.

Continuation of HCFSA participation under COBRA (continued)

A notification letter and election form will be mailed to your home to explain your rights and the options available to you. You may submit claims incurred during the remainder of the plan year by completing an online claim or requesting a paper claim form and submitting the proper documentation for the eligible expense. The debit card option is not available through COBRA continuation.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

Coverage ended on the last day of the month in which your employment with AEP ended. You cannot contribute to the spending account after the pay period in which you ended your employment; however, you may continue to file claims for reimbursement of eligible expenses incurred during the remainder of the plan year, up to the total of the balance in the account. Any balance for which claims have not been received by the vendor by March 31 of the following year will be forfeited.

RETIREE REIMBURSEMENT ACCOUNT (RRA)

If you were enrolled in the Anthem HRA Plan as an active employee immediately prior to retiring, and you were age 65 or older when you retired from AEP, you may be eligible for an RRA.

If you have unused Health Reimbursement Account (HRA) dollars 90 days after your Anthem HRA Plan coverage ends, any funds remaining in your HRA will be automatically converted to an RRA administered by Aetna. You will receive a welcome letter from Aetna with more details. You can also refer to your Summary Plan Description, available on www.aepbenefits.com or by calling the AEP Benefits Center at 1-888-237-2363.

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LIFE INSURANCE

Active employee coverage ends on the last day of the month in which your employment with AEP ends; however, if you die within 31 days of ending your employment, the plan will provide a death benefit in the amount of the insurance you would have been eligible to convert under the terms of the policy.

As an eligible retiree, you will automatically receive life insurance coverage of $30,000 by AEP at no cost to you, provided you were hired or rehired prior to April 1, 2011. You may continue any life insurance coverage you had as an active employee over the company-provided retiree life insurance coverage into retirement through approved portability/conversion.

When you end employment, you may be eligible to continue your group term life and accidental death & dismemberment (AD&D) insurance under the portability provision (port) or to convert your group term life to an individual life insurance policy. You may also be eligible to port your dependents' life insurance in effect on your portability date. You did not have to be actively at work on the last day of employment with AEP to be eligible for portability. Portability allows you to continue coverage by paying the applicable premiums directly to the insurance company.

The life insurance provider's portability rates are not the same as the rates active employees pay for coverage that is available under the AEP Life and Accidental Insurance Plan. In general, portability rates are higher than the AEP life insurance plan rates.

You may also be eligible to convert your life insurance coverage. Under the conversion option, you can purchase any individual life policy then customarily issued by Minnesota Life for purposes of conversion up to the amount of the life coverage lost under the AEP group plan. Rates are significantly higher than group rates. Premiums are paid directly to the insurance carrier.

DEPENDENT LIFE INSURANCE

Coverage ends on the last day of the month in which your AEP employment ends. If you are eligible and elect to port your life insurance coverage, you may also elect to port any covered spouse's and/or covered dependent child(ren)'s insurance that are in effect on your portability date.

If you port some or all of your life insurance coverage (minimum portable amount is $10,000):

- You may port your spouse's dependent (spousal) life insurance and AD&D insurance coverage up to the amount that he or she had in effect on your portability date, not to exceed $500,000.
- You may port $10,000 of dependent (child) life insurance coverage.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Coverage ends on the last day of the month in which your employment with AEP ends. Basic, supplemental, and dependent AD&D insurance coverage may be ported if you or your covered dependent(s) are eligible for and elect to port your life insurance.

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SUPPLEMENTAL COVERAGES

LONG-TERM DISABILITY (LTD) PLAN

Coverage ends when your employment with AEP ends.

GROUP LEGAL PLAN

Coverage ends on the last day of the month in which your employment ends; however, within 30 days you may choose to port and continue the Group Legal Plan for 12 months. You will receive a bill for 12 months of service which you must pay up front. This is a one-time option and cannot be renewed. For more information, contact MetLife at www.MetLife.com/mybenefits or 1-800-438-6388.

AUTO & HOME GROUP INSURANCE

You may continue participating in auto and home insurance on a direct-bill basis; however, the AEP group discounts may be lost. For more information, contact MetLife at www.MetLife.com/mybenefits or 1-800-438-6388 within 30 days of your employment ending.

PET INSURANCE

You may continue participating in veterinary pet insurance, but on a direct-bill basis. For more information, contact MetLife at www.MetLife.com/mybenefits or 1-800-438-6388 within 30 days of ending employment.

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UNUSED TIME OFF

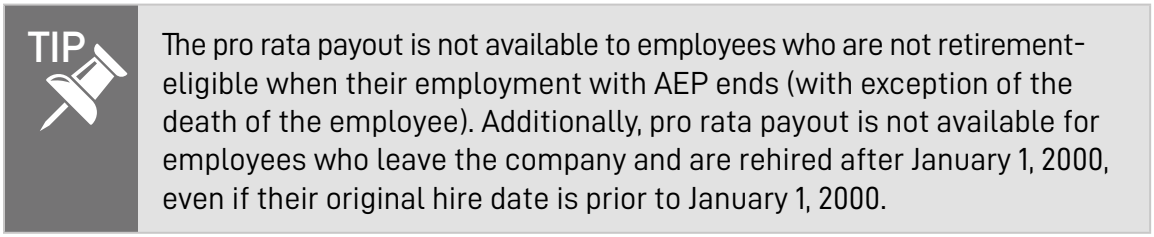
Unused current year's vacation, including vacation days deferred from the previous year, if any, will be paid in your final paycheck via direct deposit or mailed to your mailing address on file if you did not elect direct deposit.

If you elected to purchase vacation through the Vacation Purchase Program and you do not use all of your purchased vacation by the time your employment ends, you will be refunded the amount deducted from your pay for vacation that was purchased but not taken.

If you purchase and take vacation, then terminate employment without fully paying for the vacation, the amount owed to the company will be deducted from your final pay, except as prohibited by state law.

PRO RATA VACATION PAYOUT (FOR EMPLOYEES HIRED PRIOR TO JANUARY 1, 2000)

Employees hired prior to January 1, 2000, are eligible for a pro rata vacation payout at retirement or death, which compensates for vacation-eligible service accumulated during the year of hire. If eligible, you will receive one-twelfth of your vacation allowance for each month in which you worked at least eight hours, including the month of retirement if your last day worked is on or after the 15th of the month. This payout is in addition to payout of the current year's vacation allowance.



PERSONAL DAYS OFF

You will not be paid for any applicable personal days off that you did not use before ending employment.

EDUCATIONAL ASSISTANCE

If you received educational assistance in the 12 months immediately preceding your last date of employment, you must repay that amount.

ADOPTION ASSISTANCE

You will qualify for reimbursement as outlined within the plan if the adoption decree date is on or before your last day of employment with AEP. This is a taxable benefit.

SERVICE AWARDS

You are not eligible to receive a service award once your employment ends.

WELLNESS PLAN INCENTIVE

An employee, or employee's spouse or domestic partner, who meets one or more wellness plan incentive requirements and voluntarily terminates for any reason other than retirement, is not eligible to receive any incentive payout.

An employee, or employee's spouse or domestic partner, who meets one or more wellness plan incentive requirements and whose employment is either involuntarily severed or due to retirement, is eligible to receive an incentive payout for any rewards completed prior to the end of the month in which their employment terminates.

Payouts for a wellness plan year are generally made during the month of March of the following year. Any eligible incentive payments will be paid out in the form of a physical check and mailed to your address on file.

AEP EDUCATIONAL AWARD PROGRAM

Your dependents who currently receive AEP Educational Award scholarship grant will remain eligible after your employment ends as long as he or she continues to meet program guidelines.

AYCO FINANCIAL COUNSELING

Ayco financial counseling and retirement planning is available to AEP employees through the end of the month in which their employment ends.

SIRVA MORTGAGE SERVICES

After your retirement, you can no longer request financing through SIRVA Mortgage Lending Services; however, your retirement does not affect any existing SIRVA mortgages you got prior to your retirement.

FINAL PAYMENTS AND MISCELLANEOUS

EXPENSE ACCOUNTS

You should request reimbursement for eligible expense account items prior to your last day of employment.

COMPANY EQUIPMENT

Prior to or on your last day of employment, you should return your company ID, access badges, secured access ID (for remote computer access), and corporate credit cards to the Human Resources Department. Company equipment, including cell phone, laptop/laptop printer/corresponding manuals, tools, etc., should be returned to your department.

FINAL PAYCHECK, INSURANCE CONTRIBUTIONS AND TIME REPORTING

Your final pay, which will include earnings through the date you end employment and any applicable vacation payout, will be direct-deposited in your banking account(s) or mailed to your mailing address on file with AEP if you did not elect direct deposit.

If you received a pay advance in April 2001 when the company transitioned from a semi-monthly to a biweekly pay cycle, the advanced amount will be deducted from your final pay.

Any remaining insurance deductions will be taken from the final paycheck when sufficient funds exist. If sufficient funds do not exist in your final pay, you will be billed for all applicable remaining insurance deductions.

DIRECT DEPOSIT

If you are on direct deposit, the direct deposit will be canceled after all final payments have occurred. Checks issued later for any other type of payment will not be direct deposited, but will be mailed to your mailing address on file with AEP.

INCENTIVE COMPENSATION PROGRAM (ICP)

You may be eligible for an ICP award if your employment with AEP ends during the plan year. Please refer to award eligibility in the Incentive Plan Summary or discuss with your manager.

CHARITABLE CONTRIBUTIONS

Charitable contributions will be deducted from your final paycheck unless it is the third paycheck of the month or there are insufficient funds in your final paycheck to cover them.

PARKING FEES

Any deductions or refunds for parking fees will be reflected in your final pay.

COURT ORDERS, GARNISHMENTS AND/OR IRS WITHHOLDING

HR Operations Payroll will notify the applicable court of your separation from the company in accordance with the applicable court order — usually within ten days of your leaving.

W-2 TAX FORM

HR Operations Payroll will issue your Form(s) W-2 for wages earned while on the AEP payroll. The Form(s) will be sent to your mailing address on file with AEP prior to January 31 of the following year. Therefore, you are encouraged to notify the AEP Benefits Center of any changes to your mailing address. You should also provide a daytime phone number to assist the company if there is a need to contact you.

SOCIAL SECURITY

You can obtain get information about Social Security benefits by calling 1-800-772-1213, going to your local office of the Social Security Administration or visiting www.ssa.gov.

VISIT THE AEP RETIREE WEBSITE

Stay informed with AEP's retiree website at www.AEPRetirees.com. You'll find articles on a variety of topics such as the energy industry, retiree benefits, human interest stories on fellow retirees, obituary listings, historical photographs, important announcements, and much more.

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MEDICARE

Most Americans age 65 or older are eligible for Medicare, the health program currently offered by the US government. Visit www.medicare.gov for more information.

If you remain eligible for AEP medical benefits, you will receive a notice advising you of the need to select a new medical plan for age-65-or-older participants about two months prior to your Medicare eligibility. You will receive more information before you turn age 65.

Once you're eligible for Medicare, you must enroll in Medicare Part A and Medicare Part B. **If you do not enroll in both Parts A and B, you will not be eligible to receive retiree medical and prescription drug coverage through AEP and your coverage will be terminated.** Therefore, it is important that you and any Medicare-eligible dependents enroll in Medicare Part B as soon as you are eligible. If you become eligible for Medicare prior to turning age 65, please contact the AEP Benefits Center as soon as possible at 1-888-237-2363.

PERSONAL CONTACT INFORMATION CHANGES

Should any of your personal contact information change after leaving AEP, contact the AEP Benefits Center at 1-888-237-2363, or log in at www.aepbenefits.com, click Change My Benefits to the right under Quick Links, and select Update Personal Information under the Life Events drop down menu. Keeping your personal information updated will ensure that AEP can continue to send you information relating to any benefits that you may continue to be eligible for as an AEP retiree.

PROVIDER CONTACTS

Please contact the individual company/provider listed here to learn more about a specific benefit plan.

Benefit	Provider	Phone number	Website
AEP Retiree Counselors *(General benefit inquiries)*	AEP Benefits Center	1-888-237-2363, option 1 or 2	www.aepbenefits.com
AEP Retirement Savings 401(k) Plan	Empower Retirement	1-877-237-4015	www.AEP401k.com
AEP Stock	AEP Investor Relations	1-800-237-2667	www.AEP.com
AEP Retirement Plan (Pension)	AEP Benefits Center, Pension Support	1-888-237-2363, option 1 or 2	www.aepbenefits.com
Cancer Guidance	CancerBridge	1-855-366-7700	www.mycancerbridge.com
Dental Plan	Aetna	1-800-243-1809	www.aetna.com
Flexible Spending Accounts (FSAs) and Health Savings Account (HSA)	HealthEquity	1-877-713-7712	www.healthequity.com
Group Legal Plan Auto & Home Group Insurance Pet Insurance	MetLife	1-888-237-2363	www.metlife.com/mybenefits
Life Insurance	Minnesota Life	1-877-491-5268	www.lifebenefits.com
Medical *(participants 65 or older)*	Aetna	1-855-527-2452	www.aetna.com
Medical and Behavioral Health *(participants under 65)*	Anthem	1-877-585-9572	www.anthem.com
Mortgage Program	SIRVA	1-866-802-0721	www.AEP.myhomebenefits.com
Prescription Drug Plan	Express Scripts Express Scripts Medicare	1-800-841-3045 1-877-703-7344	www.express-scripts.com
Vision Plan	EyeMed	1-866-723-0513	www.eyemedvisioncare.com

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_30 Provide a complete description of the financial reporting and ratemaking treatment of the utility's pension costs.

RESPONSE

American Electric Power Co. (AEP) maintains a qualified, defined benefit pension plan (Qualified Plan), which covers substantially all nonunion and certain union employees, and unfunded, nonqualified supplemental plans (Nonqualified Plans) to provide benefits in excess of amounts permitted under the provisions of the tax law for participants in the Qualified Plan (collectively the Pension Plans). AEP engaged Willis Towers Watson US LLC (Willis Towers Watson) to value the AEP's Pension Plans as of January 1, 2020. A separate actuarial report is prepared for the Qualified Plan and Nonqualified Plans.
The primary purpose of the actuarial valuation is to determine the Net Periodic Benefit Cost/ (Income) and Projected Benefit Obligation, in accordance with FASB Accounting Standards Codification Topic 715 for the fiscal year beginning January 1, 2020. AEP's actuary, Willis Towers Watson, provides allocations of actuarial data individually for each of AEP's subsidiary companies, including Kentucky Power, based on the subsidiary company's specific employee demographics.
Please refer to KPCO_R_KPSC_2_30_Attachment1 for the 2020 actuarial valuation report for the Nonqualified Plans.
Please refer to KPCO_R_KPSC_2_30_Attachment2 for the 2020 Qualified Plan net periodic pension cost provided by Will Towers Watson. The 2020 actuarial valuation report for the Qualified Plan is not available. Willis Towers Watson is anticipating the 2020 actuarial valuation report for the Qualified Plan to be completed by September 30, 2020.
KPCO_R_KPSC_2_30_Attachment1 and KPCO_R_KPSC_2_30_Attachment2 were utilized in the Company's Pension operating expense adjustment included in Section V, Exhibit 2 W21 of Kentucky Power's application.

Witness: Heather M. Whitney

American Electric Power

Excess Benefit Plan

Actuarial Valuation Report
Benefit Cost for Fiscal Year Beginning January 1, 2020 under US GAAP

April 2020

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Purposes of valuation

American Electric Power Co. engaged Willis Towers Watson US LLC (Willis Towers Watson) to value the Company's pension plan.

As requested by American Electric Power Co. (the Company or AEP), this report documents the results of an actuarial valuation of the American Electric Power Excess Benefit Plan (the Plan) as of January 1, 2020.

The primary purpose of this valuation is to determine the Net Periodic Benefit Cost/(Income) (Benefit Cost), in accordance with FASB Accounting Standards Codification Topic 715 (ASC 715) for the fiscal year beginning January 1, 2020. It is anticipated that a separate report will be prepared for year-end financial reporting purposes.

Limitations

This valuation has been conducted for the purposes described above and may not be suitable for any other purpose. In particular, please note the following:

1. There may be certain events that have occurred since the valuation date that are not reflected in the current valuation. See Subsequent Events in the Basis for Valuation section below for more information.

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Section 1: Summary of key results

Benefit cost, plan assets & obligations

All monetary amounts shown in US Dollars

Fiscal Year Beginning		01/01/2020	01/01/2019
Benefit Cost/ (Income)	Net Periodic Benefit Cost/(Income)	6,292,020	5,943,903
	Benefit Cost/(Income) due to Special Events	0	0
	Total Benefit Cost/(Income)	6,292,020	5,943,903
Measurement Date		**01/01/2020**	**01/01/2019**
Plan Assets	Fair Value of Plan Assets (FVA)	0	0
	Market Related Value of Assets (MRVA)	N/A	N/A
	Actual Return on Fair Value of Plan Assets during Prior Year	N/A	N/A
Benefit Obligations	Accumulated Benefit Obligation (ABO)	(69,624,467)	(65,419,725)
	Projected Benefit Obligation (PBO)	(77,324,650)	(70,600,656)
Funded Ratios	Fair Value of Plan Assets to ABO	0.0%	0.0%
	Fair Value of Plan Assets to PBO	0.0%	0.0%
Accumulated Other Comprehensive (Income)/Loss (Pre-tax)	Net Prior Service Cost/(Credit)	211,094	0
	Net Loss/(Gain)	36,034,924	29,849,555
	Total Accumulated Other Comprehensive (Income)/Loss (pre-tax)	36,246,018	29,849,555
Assumptions	Discount rate	3.15%	4.20%
	Expected Long-Term Rate of Return on Plan Assets	N/A	N/A
	Rate of Compensation Increase	Rates vary by age from 3.0% to 11.5%	Rates vary by age from 3.5% to 12.0%
Participant Data	Census Date	01/01/2020	01/01/2019

Comments on results

The actuarial gains/(losses) due to demographic experience, including any assumption changes during the prior year were $(7,981,510).

Change in net periodic cost and funded position

The net periodic cost increased from $5,943,903 in fiscal 2019 to $6,292,020 in fiscal 2020 and the funded position declined from $(70,600,656) to $(77,324,650).

All monetary amounts shown in US Dollars

	Net Periodic Cost
Prior year	5.9
Change due to:	
■ Expected based on prior valuation and contributions during prior year	0.1
■ Unexpected noninvestment experience	0
■ Unexpected investment experience	0
■ Assumption changes	0.3
■ Plan amendments	0
■ Settlements, curtailments, certain termination benefits	0
■ Acquisitions	0
■ Method changes	0
■ Changes in estimation techniques	0
Current year	6.3

Significant reasons for these changes include the following:

- The discount rate decreased 105 basis points compared to the prior year which increased the net periodic cost and decreased the funded position.
- The termination, retirement, and salary increase rate assumptions were updated to reflect the results of an experience study conducted in 2019 for the experience period January 1, 2014 to December 31, 2018. These assumption changes increased the net periodic cost and decreased the funded position.
- The base mortality scale has been updated from RP-2014, factored to 2006, with white collar adjustment to Pri-2012 (using contingent survivor tables only after retiree death) with white collar adjustment, and the mortality improvement scale has been updated from a modified version of MP-2018 adjusted to reflect 75% of the long-term improvement rates to a modified version of MP-2019 adjusted to reflect 75% of the long-term improvement rates. These two mortality assumption changes each decreased the net periodic cost and increased the funded position.
- The lump sum mortality assumption was updated from the PPA 2019 optional combined mortality with static projection to commencement using MP-2018 as of December 31, 2018 to the PPA 2020 optional combined mortality with static projection to commencement using MP-2019 as of

December 31, 2019. These two lump sum mortality assumption changes decreased the net periodic cost and decreased the funded position.

- The lump sum conversion rate was changed from 3.90% to 3.00%, which decreased the net periodic cost and decreased the funded position.
- The Plan was amended to prospectively remove the cap on covered compensation for cash balance participants which increased the net periodic cost and decreased the funded position.

Basis for valuation

Appendix A summarizes the assumptions and methods used in the valuation. Appendix B summarizes our understanding of the principal provisions of the plan being valued. Both of these appendices include a summary of any changes since the prior valuation. Unless otherwise described below under Subsequent Events, assumptions were selected based on information known as of the measurement date.

Changes in benefits valued

The Plan was amended to remove the cap on covered compensation for cash balance participants for amounts paid after December 31, 2019.

Subsequent events

None.

Additional information

None.

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Actuarial certification

This valuation has been conducted in accordance with generally accepted actuarial principles and practices. However, please note the information discussed below regarding this valuation.

Reliances

In preparing the results presented in this report, we have relied upon information regarding plan provisions, participants, assets, and sponsor accounting policies and methods provided by AEP and other persons or organizations designated by AEP. See the Sources of Data and Other Information section of Appendix A for further details.

We have relied on all the data and information provided as complete and accurate. We have reviewed this information for overall reasonableness and consistency, but have neither audited nor independently verified this information. Based on discussions with and concurrence by the plan sponsor, assumptions or estimates may have been made if data were not available. We are not aware of any errors or omissions in the data that would have a significant effect on the results of our calculations.

The results presented in this report are directly dependent upon the accuracy and completeness of the underlying data and information. Any material inaccuracy in the data, assets, plan provisions or other information provided to us may have produced results that are not suitable for the purposes of this report and such inaccuracies, as corrected by AEP, may produce materially different results that could require that a revised report be issued.

Measurement of benefit obligations, plan assets and balance sheet adjustments

Census date/measurement date

The measurement date is January 1, 2020. The benefit obligations were measured as of January 1, 2020 and are based on participant data as of the census date, January 1, 2020.

Plan assets and balance sheet adjustments

Willis Towers Watson used information supplied by AEP regarding amounts recognized in accumulated other comprehensive income as of December 31, 2019. The data was reviewed for reasonableness and consistency, but no audit was performed.

Accumulated other comprehensive (income)/loss amounts shown in the report are shown prior to adjustment for tax effects. Any tax effects in AOCI should be determined in consultation with AEP's tax advisors and independent accountants.

Assumptions and methods under U.S. GAAP

As required by U.S. GAAP, the actuarial assumptions and methods employed in the development of the pension cost and other financial reporting have been selected by AEP. Willis Towers Watson has concurred with these assumptions and methods. U.S. GAAP requires that each significant assumption "individually represent the best estimate of a particular future event."

The results shown in this report have been developed based on actuarial assumptions that, to the extent evaluated by Willis Towers Watson, we consider to be reasonable. Other actuarial assumptions could also be considered to be reasonable. Thus, reasonable results differing from those presented in this report could have been developed by selecting different reasonable assumptions.

A summary of the assumptions, methods and sources of data and other information used is provided in Appendix A. Note that any subsequent changes in methods or assumptions for the January 1, 2020 measurement date will change the results shown in this report.

Nature of actuarial calculations

The results shown in this report are estimates based on data that may be imperfect and on assumptions about future events that cannot be predicted with any certainty. The effects of certain plan provisions may be approximated, or determined to be insignificant and therefore not valued. Reasonable efforts were made in preparing this valuation to confirm that items that are significant in the context of the actuarial liabilities or costs are treated appropriately, and are not excluded or included inappropriately. Any rounding (or lack thereof) used for displaying numbers in this report is not intended to imply a degree of precision, which is not a characteristic of actuarial calculations.

If overall future plan experience produces higher benefit payments or lower investment returns than assumed, the relative level of plan costs reported in this valuation will likely increase in future valuations (and vice versa). Future actuarial measurements may differ significantly from the current measurements presented in this report due to many factors, including: plan experience differing from that anticipated by the economic or demographic assumptions, changes in economic or demographic assumptions, increases or decreases expected as part of the natural operation of the methodology used for the measurements (such as the end of an amortization period), and changes in plan provisions or applicable law. Due to the limited scope of our assignment, we did not perform an analysis of the potential range of such future measurements.

See Basis for Valuation in Section 1 above for a discussion of any material events that have occurred after the valuation date that are not reflected in this valuation.

Limitations on use

This report is provided subject to the terms set out herein and in our Master Consulting Services Agreement letter dated July 29, 2004 and any accompanying or referenced terms and conditions.

The information contained in this report was prepared for the internal use of AEP and its independent accountants in connection with our actuarial valuation of the pension plan as described in Purposes of Valuation above. It is not intended for and may not be used for other purposes, and we accept no responsibility or liability in this regard. AEP may distribute this actuarial valuation report to the appropriate authorities who have the legal right to require AEP to provide them this report, in which case AEP will use best efforts to notify Willis Towers Watson in advance of this distribution. Further distribution to, or use by, other parties of all or part of this report is expressly prohibited without Willis Towers Watson's prior written consent. Willis Towers Watson accepts no responsibility for any consequences arising from any other party relying on this report or any advice relating to its contents.

Professional qualifications

The undersigned are members of the Society of Actuaries and meet the "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States" relating to pension plans. Our objectivity is not impaired by any relationship between the plan sponsor and our employer, Willis Towers Watson US LLC.

Joseph A. Perko, FSA, EA, MAA
Director, Retirement – Valuation Actuary
20-06491
April 30, 2020

Brian A. Hartman, FSA, EA
Director, Retirement – Valuation Actuary
20-07613
April 30, 2020

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Section 2: Accounting exhibits

2.1 Balance sheet asset/(liability)

All monetary amounts shown in US Dollars

Measurement Date		01/01/2020	01/01/2019
A	**Development of Balance Sheet Asset/(Liability)[1]**		
1	Projected benefit obligation (PBO) [2]	(77,324,650)	(70,600,656)
2	Fair value of plan assets (FVA)	0	0
3	Net balance sheet asset/(liability)	(77,324,650)	(70,600,656)
B	**Current and Noncurrent Classification[3]**		
1	Noncurrent asset	0	0
2	Current liability	(6,041,950)	(6,214,629)
3	Noncurrent liability	(71,282,700)	(64,512,562)
4	Net balance sheet asset/(liability)	(77,324,650)	(70,600,656)
C	**Accumulated Benefit Obligation (ABO)**	(69,624,467)	(65,419,725)
D	**Accumulated Other Comprehensive (Income)/Loss**		
1	Net prior service cost/(credit)	211,094	0
2	Net loss/(gain)	36,034,924	29,849,555
3	Accumulated other comprehensive (income)/loss[4]	36,246,018	29,849,555
E	**Assumptions and Dates**		
1	Discount rate	3.15%	4.20%
2	Rate of compensation increase	Rates vary by age from 3.0% to 11.5%	Rates vary by age from 3.5% to 12.0%
3	Cash balance interest crediting rate	4.00%	4.00%
4	Census date	01/01/2020	01/01/2019

1 Whether any amounts in this table that differ from those disclosed at year-end must be disclosed in subsequent interim financial statements should be determined.
2 East PBO = $43,387,068, West PBO = $33,937,582 as of January 1, 2020.
3 The current liability (for each underfunded plan) was measured as the discounted value of benefits expected to be paid over the next 12 months in excess of the fair value of the plan's assets at the measurement date.
4 Amount shown is pre-tax and should be adjusted by plan sponsor for tax effects.

2.2 Changes in plan obligations and assets

All monetary amounts shown in US Dollars

Period Beginning		01/01/2020	01/01/2019
A	**Change in Projected Benefit Obligation (PBO)**		
1	PBO at beginning of prior fiscal year	70,600,656	79,011,173
2	Employer service cost	1,258,828	1,261,678
3	Interest cost	2,888,934	2,621,447
4	Actuarial loss/(gain)	7,981,510	(1,016,222)
5	Plan participants' contributions	0	0
6	Benefits paid from plan assets	0	0
7	Benefits paid from Company assets	(5,616,372)	(11,277,420)
8	Administrative expenses paid [1]	0	0
9	Plan amendments	211,094	0
10	Acquisitions/(divestitures)	0	0
11	Curtailments	0	0
12	Settlements	0	0
13	Special/contractual termination benefits	0	0
14	PBO at beginning of current fiscal year	77,324,650	70,600,656

[1] Only if future expenses are accrued in PBO through a load on service cost.

2.3 Summary of net balances

All monetary amounts shown in US Dollars

A Summary of Net Prior Service Cost/(Credit)

Measurement Date Established	Original Amount	Net Amount at 01/01/2020	Remaining Amortization Period	Amortization Amount in 2020	Effect of Curtailments	Other Events
12/31/2019	211,094	211,094	11.70383	(18,036)	0	0
Total		211,094		(18,036)	0	0

All monetary amounts shown in US Dollars

B Summary of Net Loss/(Gain) (see Appendix A for a description of amortization method) [1]

	Net Amount at 01/01/2020 [2]	Amortization Amount in 2020	Effect of Curtailments	Effect of Settlements	Other Events (Identify)
	36,034,924	(2,380,286)	0	0	0

[1] See Appendix A for description of amortization method.
[2] Before any immediate recognition on the same date.

2.4 Summary and comparison of benefit cost and cash flows

All monetary amounts shown in US Dollars

Fiscal Year Ending		12/31/2020	12/31/2019
A	**Total Benefit Cost**		
1	Employer service cost	1,506,418	1,258,828
2	Interest cost	2,387,280	2,888,934
3	Expected return on plan assets	0	0
4	Subtotal	3,893,698	4,147,762
5	Net prior service cost/(credit) amortization	18,036	0
6	Net loss/(gain) amortization	2,380,286	1,796,141
7	Subtotal	2,398,322	1,796,141
8	Net periodic benefit cost/(income)	6,292,020	5,943,903
9	Curtailments	0	0
10	Settlements	0	0
11	Special/contractual termination benefits	0	0
12	Total benefit cost	6,292,020	5,943,903
B	**Assumptions** [1]		
1	Discount rate	3.15%	4.20%
2	Expected long-term rate of return on plan assets	N/A	N/A
3	Rate of compensation increase	Rates vary by age from 3.0% to 11.5%	Rates vary by age from 3.5% to 12.0%
4	Cash balance interest crediting rate	4.00%	4.00%
5	Census date	01/01/2020	01/01/2019
C	**Fair Value of Assets at Beginning of Year**	0	0
D	**Cash Flows**	**Expected**	**Actual**
1	Employer contributions	0	0
2	Plan participants' contributions [2]	0	0
3	Benefits paid from Company assets	6,136,373	5,616,372
4	Benefits paid from plan assets	0	0
E	**Amortization Period**	11.89036	12.68803

[1] These assumptions were used to calculated Net Periodic Benefit Cost/(Income) as of the beginning of the year. Rates are expressed on an annual basis where applicable. For assumptions used for interim measurement periods, if any, refer to Appendix A.
[2] Over the fiscal year.

Section 3: Participant data

3.1 Summary of participant data

All monetary amounts shown in US Dollars

Census Date	01/01/2020	01/01/2019
A Participating Employees		
1 Number	16,655	16,673
2 Expected plan compensation for year beginning on the valuation date	1,849,490,167	1,801,861,437
3 Average expected plan compensation	111,047	107,974
4 Average age	47.1	47.5
5 Average credited service	16.6	17.3
6 Average future working life	11.890	12.688
B Participants with Deferred Benefits		
1 Number (non-cash balance)	1	0
2 Total annual pension (non-cash balance)	209	0
3 Average annual pension (non-cash balance)	209	0
4 Number of cash balance	4	4
5 Total cash balance	727,127	518,229
6 Average cash balance	181,782	129,557
7 Average age	61.6	60.7
C Participants Receiving Benefits		
1 Number	74	79
2 Total annual pension	4,571,500	5,018,652
3 Average annual pension	61,777	63,527
4 Average age	78.2	77.4

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Appendix A: Statement of actuarial assumptions, methods and data sources

Plan Sponsor

American Electric Power Co.

Statement of Assumptions

The assumptions disclosed in this Appendix are for the fiscal year 2020 benefit cost.

Assumptions and methods for pension cost purposes

Actuarial Assumptions and Methods – Pension Cost		
Economic Assumptions		
Discount rate		3.15%
Annual rates of increase		
■ Compensation:		
Representative rates	*Age*	*Rate*
	< 25	11.50%
	25 – 29	8.50%
	30 – 34	7.00%
	35 – 39	6.00%
	40 – 44	5.00%
	45 – 49	4.50%
	50 – 54	4.00%
	55 – 59	3.75%
	60 – 64	3.50%
	65 – 69	3.25%
	70+	3.00%
Weighted average		5.00%
■ Cash balance crediting rate		4.00%
■ Lump sum/annuity conversion rate		3.00%
■ Future Social Security wage bases		4.00%
■ Statutory limits on compensation		2.50%

Demographic Assumptions

Inclusion Date	The valuation date coincident with or next following the date on which the employee becomes a participant.
New or rehired employees	It was assumed there will be no new or rehired employees.
Mortality	Base mortality rates are derived from Pri-2012 (using contingent survivor tables only after retiree death).
■ Healthy	The Pri-2012 Private Retirement Plans mortality tables with sex-distinct rates for employees, retirees, and contingent survivors, with white collar adjustment, and a fully generational mortality improvement projection using a modified version of Scale MP-2019 projecting from the base year of 2012. The modified projection scale reflects long-term rates of mortality improvement equal to 75% of the corresponding rates of Scale MP-2019.
■ Disabled	The Pri-2012 Private Retirement Plans disabled mortality tables with separate rates for males and females and a fully generational mortality improvement projection using a modified version of Scale MP-2019 projecting from the base year of 2012. The modified projection scale reflects long-term rates of mortality improvement equal to 75% of the corresponding rates of Scale MP-2019.
■ Lump sum/annuity conversion	PPA 2020 optional combined mortality with static projection to commencement using MP-2019.
Termination	Rates varying by age and service

Percentage leaving during the year	
Attained vested service	Rate
< 3	7.00%
3 – 4	6.00%
5 – 9	5.00%
10 – 14	4.00%
15 – 19	2.50%
20 +	1.50%

Disability — Rates apply to employees not eligible to retire and vary by age and sex as indicated by the following sample values:

Percentage becoming disabled during the year		
Age	Male	Female
20	0.060%	0.090%
30	0.060%	0.090%
40	0.074%	0.110%
50	0.178%	0.267%
60	0.690%	1.035%

Retirement — Rates varying by age; average retirement age 63:

Percentage retiring during the year	
Age	Rate
55 – 58	4.00%
59	6.00%
60	7.50%
61	9.00%
62 – 64	16.00%
65 – 67	25.00%
68 – 69	20.00%
70+	100.00%

Benefit commencement date:

- Preretirement death benefit — The later of the death of the active participant or the date the participant would have attained age 55.
- Deferred vested benefit — The later of age 55 or termination of employment.
- Disability benefit — Upon disablement.
- Retirement benefit — Upon termination of employment.

Form of payment — 100% lump sum for all retirement eligible participants. Married and unmarried participants are both assumed to elect a lump sum.

Percent married — 80% of male participants; 70% of female participants.

Spouse ages — Wives are assumed to be three years younger than husbands.

Valuation pay

2020 base salary pay (Grandfathered) – not estimated due to freeze of final average pay accruals at December 31, 2010.

2020 expanded pay (Cash Balance) – sum of the following updated one year according to the salary increase assumption:

(i) 2020 base salary
(ii) a 15% increase for overtime eligible employees and a target bonus percent increase for incentive-eligible employees

Timing of benefit payments — Annuity payments are payable monthly at the beginning of the month and lump sum payments are payable on date of decrement.

Methods – Pension Cost and Funded Position

Service cost and projected benefit obligation — Projected unit credit

Benefits not valued — All benefits described in the Plan Provisions sections of this report were valued. Willis Towers Watson has reviewed the plan provisions with AEP and is not aware of any significant benefits required to be valued that were not.

Sources of Data and Other Information

Willis Towers Watson used participant and asset data as of January 1, 2020, supplied by Morneau Shepell, the third party administrator for AEP. Data were reviewed for reasonableness and consistency, but no audit was performed. Based on discussions with the plan sponsor, assumptions or estimates were made when data were not available, and the data was adjusted to reflect any significant events that occurred between the date the data was collected and the measurement date. To the extent that data was not provided, estimates were made based on prior year information.

The Company also provided the amounts recognized in accumulated other comprehensive income as of the end of the December 31, 2019 fiscal year and amounts recognized in other comprehensive income during the December 31, 2019 fiscal year.

Assumptions Rationale - Significant Economic Assumptions

Discount rate	As required by U.S. GAAP, the discount rate was chosen by the plan sponsor based on market information on the measurement date.
Cash balance interest crediting rate	The plan credits interest to cash balance accounts using the 30-year Treasury rate for the September of the preceding year with a minimum rate of 4.00%. The assumption is based on the plan sponsor's long-term expectations of yields on U.S. Treasuries. We believe that the selected assumption does not significantly conflict with what would be reasonable based on market conditions at the measurement date.
Conversion rate for lump sums and annuities	The plan uses IRC 417(e)(3) as its basis to convert between lump sums and annuities. Because the 417(e)(3) interest rates are based on corporate bond yields, the assumption is based on the plan sponsor's long-term expectations of yields on high-quality corporate bonds. We believe that the selected assumption does not significantly conflict with what would be reasonable based on market conditions at the measurement date.
Rates of increase in compensation	Rates of increase in compensation were based on an experience study conducted in 2019, with annual consideration of whether any conditions have changed that would be expected to produce different results in the future.

Assumptions Rationale - Significant Demographic Assumptions

Mortality	Assumptions were selected by the plan sponsor and, as required by U.S. GAAP, represent a best estimate of future experience.
Termination	Termination rates are based on an experience study conducted in 2019, with annual consideration of whether any conditions have changed that would be expected to produce different results in the future. Assumed termination rates differ by service because of observed differences in termination rates as employees attain additional years of service.
Retirement	Retirement rates are based on an experience study conducted in 2019, with annual consideration of whether any conditions have changed that would be expected to produce different results in the future.
Form of payment	Rates at which retirees elect lump sums versus annuities are based on an experience study conducted in 2019, with annual consideration of whether any conditions have changed that would be expected to produce different results in the future.

Source of Prescribed Methods

Accounting methods	The methods used for accounting purposes as described in Appendix A, are "prescribed methods set by another party", as defined in the actuarial standards of practice (ASOPs). As required by U.S. GAAP, these methods were selected by the plan sponsor.

Changes in Assumptions and Methods

Change in assumptions since prior valuation	The discount rate decreased from 4.20% to 3.15%. The lump sum conversion rate assumption decreased from 3.90% to 3.00%. The base mortality scale has been updated from RP-2014, factored to 2006 with white collar adjustment, to Pri-2012 (using contingent survivor tables only after retiree death) with white collar adjustment. The mortality improvement scale has been updated from a modified version of MP-2018 adjusted to reflect 75% of the long-term improvement rates to a modified version of MP-2019 adjusted to reflect 75% of the long-term improvement rates. The termination, retirement, and salary increase rate assumptions were updated to reflect the results of an experience study conducted in 2019 for the experience period January 1, 2014 to December 31, 2018. The lump sum mortality assumption was updated from the PPA 2019 optional combined mortality with static projection to commencement using MP-2018 as of December 31, 2018 to the PPA 2020 optional combined mortality with static projection to commencement using MP-2019 as of December 31, 2019.
Change in methods since prior valuation	None.

Appendix B: Summary of principal plan provisions

The Excess Benefit Plan provides a benefit determined in accordance with the provisions of the American Electric Power System's Retirement Plan (a qualified defined benefit plan), without recognition of the statutory maximums on benefits and pay, less the benefit payable from the qualified plan. MICP awards are also included in the definition of pay for the former East Plan grandfathered benefit for executives with base pay in excess of the IRS limit. Certain executives have contracts providing additional benefits. Certain former Central and South West company executives are eligible for a final average pay cash balance benefit (pension equity – type formula) if it produces a larger benefit. The schedule of contribution percentages for this formula is identical to the cash balance formula.

Prior to 2004, all executives had their cash balance pay limited to $1,000,000. In addition, pay was limited for executives in an uncapped incentive plan to two times base pay for both the final average pay formula and the cash balance formula. Base pay rate is determined at the earlier of year-end or date of termination.

Effective January 1, 2004, pay for all executives is limited to the greater of two times base pay or $1 million for the cash balance formula only. The executives in the uncapped incentive plan continue to have two times pay limit apply to the former East Plan final average pay formula.

Effective December 31, 2010, accruals under the east grandfathered final average pay formula were discontinued.

Effective December 31, 2013, accruals for participants in long-term disability were discontinued.

Effective January 1, 2020, pay earned after December 31, 2019 for all executives is no longer limited to the greater of two times base pay or $1 million for the cash balance formula.

Effective January 1, 2020, pay earned after December 31, 2019 for executives in the uncapped incentive plan is no longer limited to two times the pay limit.

Effective January 1, 2020, certain former Central and South West company executives are eligible for a final average cash balance benefit in the form of a ten-year deferred instalment option of their cash balance account.

Future Plan Changes

Willis Towers Watson is not aware of any future plan changes that are required to be reflected.

Changes in Benefits Valued Since Prior Year

Effective January 1, 2020, pay earned after December 31, 2019 for all executives is no longer limited to the greater of two times base pay or $1 million for the cash balance formula.

Effective January 1, 2020, pay earned after December 31, 2019 for executives in the uncapped incentive plan is no longer limited to two times the pay limit.

Effective January 1, 2020, certain former Central and South West company executives are eligible for a final average cash balance benefit in the form of a ten-year deferred instalment option of their cash balance account.

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Appendix C: Results by business unit

AMERICAN ELECTRIC POWER
NONQUALIFIED RETIREMENT PLAN
2020 NET PERIODIC PENSION COST

Location	Projected Benefit Obligation	Market-Related Value of Assets	Service Cost	"Other" Cost: Interest Cost	"Other" Cost: Expected Return on Assets	"Other" Cost: Amortizations PSC	"Other" Cost: Amortizations (G)/L	Total "Other" Cost	Net Periodic Pension Cost
140 Appalachian Power Co - Distribution	$419,022	$0	$36,145	$14,290	$0	$0	$12,899	$27,189	$63,334
215 Appalachian Power Co - Generation	14,148	0	692	368	0	0	436	804	1,496
150 Appalachian Power Co - Transmission	0	0	0	0	0	0	0	0	0
Appalachian Power Co. - FERC	**$433,170**	**$0**	**$36,837**	**$14,658**	**$0**	**$0**	**$13,335**	**$27,993**	**$64,830**
225 Cedar Coal Co	0	0	0	0	0	0	0	0	0
Appalachian Power Co. - SEC	**$433,170**	**$0**	**$36,837**	**$14,658**	**$0**	**$0**	**$13,335**	**$27,993**	**$64,830**
211 AEP Texas Central Company - Distribution	2,590,187	0	24,668	78,600	0	0	79,734	158,334	183,002
147 AEP Texas Central Company - Generation	0	0	0	0	0	0	0	0	0
169 AEP Texas Central Company - Transmission	1,181	0	105	41	0	0	36	77	182
AEP Texas Central Co.	**$2,591,368**	**$0**	**$24,773**	**$78,641**	**$0**	**$0**	**$79,770**	**$158,411**	**$183,184**
119 AEP Texas North Company - Distribution	759,838	0	96	22,500	0	0	23,390	45,890	45,986
166 AEP Texas North Company - Generation	619,560	0	0	18,683	0	0	19,072	37,755	37,755
192 AEP Texas North Company - Transmission	34	0	7	1	0	0	1	2	9
AEP Texas North Co.	**$1,379,432**	**$0**	**$103**	**$41,184**	**$0**	**$0**	**$42,463**	**$83,647**	**$83,750**
AEP Texas	**$3,970,800**	**$0**	**$24,876**	**$119,825**	**$0**	**$0**	**$122,233**	**$242,058**	**$266,934**
170 Indiana Michigan Power Co - Distribution	390,185	0	31,788	13,234	0	0	12,011	25,245	57,033
132 Indiana Michigan Power Co - Generation	43,158	0	7,749	1,604	0	0	1,329	2,933	10,682
190 Indiana Michigan Power Co - Nuclear	975,667	0	82,953	33,219	0	0	30,034	63,253	146,206
120 Indiana Michigan Power Co - Transmission	92,754	0	0	2,750	0	0	2,855	5,605	5,605
280 Ind Mich River Transp Lakin	0	0	0	0	0	0	0	0	0
Indiana Michigan Power Co. - SEC	**$1,501,764**	**$0**	**$122,490**	**$50,807**	**$0**	**$0**	**$46,229**	**$97,036**	**$219,526**
110 Kentucky Power Co - Distribution	64,471	0	2,880	2,108	0	0	1,985	4,093	6,973
117 Kentucky Power Co - Generation	0	0	0	0	0	0	0	0	0
180 Kentucky Power Co - Transmission	0	0	0	0	0	0	0	0	0
600 Kentucky Power Co. - Kammer Actives	0	0	0	0	0	0	0	0	0
701 Kentucky Power Co. - Mitchell Actives	5,066	0	513	176	0	0	156	332	845
702 Kentucky Power Co. - Mitchell Inactives	0	0	0	0	0	0	0	0	0
Kentucky Power Co.	**$69,537**	**$0**	**$3,393**	**$2,284**	**$0**	**$0**	**$2,141**	**$4,425**	**$7,818**
250 Ohio Power Co - Distribution	441,822	0	28,300	14,767	0	0	13,601	28,368	56,668
160 Ohio Power Co - Transmission	0	0	0	0	0	0	0	0	0
Ohio Power Co.	**$441,822**	**$0**	**$28,300**	**$14,767**	**$0**	**$0**	**$13,601**	**$28,368**	**$56,668**
167 Public Service Co of Oklahoma - Distribution	1,472,680	0	20,221	45,462	0	0	45,334	90,796	111,017
198 Public Service Co of Oklahoma - Generation	436,752	0	2,912	13,420	0	0	13,445	26,865	29,777
114 Public Service Co of Oklahoma - Transmission	1,193	0	219	44	0	0	37	81	300
Public Service Co. of Oklahoma	**$1,910,625**	**$0**	**$23,352**	**$58,926**	**$0**	**$0**	**$58,816**	**$117,742**	**$141,094**
159 Southwestern Electric Power Co - Distribution	203,523	0	9,945	6,492	0	0	6,265	12,757	22,702
168 Southwestern Electric Power Co - Generation	1,181,957	0	1,242	36,059	0	0	36,384	72,443	73,685
161 Southwestern Electric Power Co - Texas - Distribution	1,352	0	404	55	0	0	42	97	501
111 Southwestern Electric Power Co - Texas - Transmission	0	0	0	0	0	0	0	0	0
194 Southwestern Electric Power Co - Transmission	98	0	22	4	0	0	3	7	29
Southwestern Electric Power Co.	**$1,386,930**	**$0**	**$11,613**	**$42,610**	**$0**	**$0**	**$42,694**	**$85,304**	**$96,917**
230 Kingsport Power Co - Distribution	0	0	0	0	0	0	0	0	0
260 Kingsport Power Co - Transmission	0	0	0	0	0	0	0	0	0
Kingsport Power Co.	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
210 Wheeling Power Co - Distribution	0	0	0	0	0	0	0	0	0
200 Wheeling Power Co - Transmission	0	0	0	0	0	0	0	0	0
Wheeling Power Co.	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
103 American Electric Power Service Corporation	61,132,881	0	1,041,643	1,876,337	0	18,036	1,881,853	3,776,226	4,817,869
293 Elmwood	0	0	0	0	0	0	0	0	0
292 AEP River Operations LLC	0	0	0	0	0	0	0	0	0
American Electric Power Service Corp	**$61,132,881**	**$0**	**$1,041,643**	**$1,876,337**	**$0**	**$18,036**	**$1,881,853**	**$3,776,226**	**$4,817,869**
270 Cook Coal Terminal	109	0	9	4	0	0	3	7	16
AEP Generating Company	**$109**	**$0**	**$9**	**$4**	**$0**	**$0**	**$3**	**$7**	**$16**
104 Cardinal Operating Company	0	0	0	0	0	0	0	0	0
181 Ohio Power Co - Generation	830,766	0	2,772	25,293	0	0	25,573	50,866	53,638
AEP Generation Resources - FERC	**$830,766**	**$0**	**$2,772**	**$25,293**	**$0**	**$0**	**$25,573**	**$50,866**	**$53,638**
290 Conesville Coal Preparation Company	0	0	0	0	0	0	0	0	0
AEP Generation Resources - SEC	**$830,766**	**$0**	**$2,772**	**$25,293**	**$0**	**$0**	**$25,573**	**$50,866**	**$53,638**
171 CSW Energy, Inc.	0	0	0	0	0	0	0	0	0
175 AEP Energy Partners	5,549,925	0	205,638	178,571	0	0	170,843	349,414	555,052
419 Onsite Partners	96,320	0	5,495	3,198	0	0	2,965	6,163	11,658
AEP Energy Supply	**$6,477,011**	**$0**	**$213,905**	**$207,062**	**$0**	**$0**	**$199,381**	**$406,443**	**$620,348**
143 AEP Pro Serv, Inc.	0	0	0	0	0	0	0	0	0
AEP Pro Serv, Inc.	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
245 Dolet Hills	1	0	0	0	0	0	0	0	0
Dolet Hills	**$1**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total	**$77,324,650**	**$0**	**$1,506,418**	**$2,387,280**	**$0**	**$18,036**	**$2,380,286**	**$4,785,602**	**$6,292,020**
Total without Dolet Hills	$77,324,649	$0	$1,506,418	$2,387,280	$0	$18,036	$2,380,286	$4,785,602	$6,292,020

AMERICAN ELECTRIC POWER
QUALIFIED PENSION PLAN
ACTUAL 2020 NET PERIODIC PENSION COST

		SERVICE (Operating)	NON-SERVICE (Non-Operating)					GRAND TOTAL
	Location	*Service Cost*	*Interest Cost*	*Expected Return on Assets*	*Prior Service Cost Amortization*	*Gain/Loss Amortization*	*Non-Service Total*	*Net Periodic Pension Cost*
140	Appalachian Power Co - Distribution	$6,278,752	$10,832,051	($17,505,482)	$0	$5,973,310	($700,121)	$5,578,631
215	Appalachian Power Co - Generation	4,160,192	8,510,457	(14,916,888)	0	4,717,094	($1,689,337)	2,470,855
150	Appalachian Power Co - Transmission	0	854,385	(922,328)	0	481,529	$413,586	413,586
	Appalachian Power Co. - FERC	**$10,438,944**	**$20,196,893**	**($33,344,698)**	**$0**	**$11,171,933**	**($1,975,872)**	**$8,463,072**
225	Cedar Coal Co	0	73,243	(264,836)	0	41,568	(150,025)	(150,025)
	Appalachian Power Co. - SEC	**$10,438,944**	**$20,270,136**	**($33,609,534)**	**$0**	**$11,213,501**	**($2,125,897)**	**$8,313,047**
211	AEP Texas Central Company - Distribution	$6,440,496	$9,474,043	($15,188,388)	$0	$5,266,999	($447,346)	$5,993,150
147	AEP Texas Central Company - Generation	0	70,497	(731,680)	0	40,570	(620,613)	(620,613)
169	AEP Texas Central Company - Transmission	1,129,132	1,122,497	(1,541,131)	0	616,540	197,906	1,327,038
	AEP Texas Central Co.	**$7,569,628**	**$10,667,037**	**($17,461,199)**	**$0**	**$5,924,109**	**($870,053)**	**$6,699,575**
119	AEP Texas North Company - Distribution	$1,825,961	$2,263,611	($3,286,505)	$0	$1,248,372	225,478	$2,051,439
166	AEP Texas North Company - Generation	0	471,616	(1,373,334)	0	267,229	(634,489)	(634,489)
192	AEP Texas North Company - Transmission	634,351	432,753	(657,423)	0	234,139	9,469	643,820
	AEP Texas North Co.	**$2,460,312**	**$3,167,980**	**($5,317,262)**	**$0**	**$1,749,740**	**($399,542)**	**$2,060,770**
	AEP Texas	**$10,029,940**	**$13,835,017**	**($22,778,461)**	**$0**	**$7,673,849**	**($1,269,595)**	**$8,760,345**
170	Indiana Michigan Power Co - Distribution	$3,568,120	$5,236,686	($9,214,342)	$0	$2,879,266	($1,098,390)	$2,469,730
132	Indiana Michigan Power Co - Generation	1,578,605	3,117,633	(6,069,212)	0	1,721,856	(1,229,723)	348,882
190	Indiana Michigan Power Co - Nuclear	8,331,914	8,816,468	(14,006,741)	0	4,786,026	(404,247)	7,927,667
120	Indiana Michigan Power Co - Transmission	923,790	1,262,550	(1,871,346)	0	689,759	80,963	1,004,753
280	Ind Mich River Transp Lakin	908,347	1,160,732	(2,072,376)	0	639,191	(272,453)	635,894
	Indiana Michigan Power Co. - SEC	**$15,310,776**	**$19,594,069**	**($33,234,017)**	**$0**	**$10,716,098**	**($2,923,850)**	**$12,386,926**
110	Kentucky Power Co - Distribution	$1,535,362	$2,671,271	($3,683,962)	$0	$1,475,635	$462,944	$1,998,306
117	Kentucky Power Co - Generation	181,228	925,003	(1,659,490)	0	513,970	(220,517)	(39,289)
180	Kentucky Power Co - Transmission	0	93,614	(49,703)	0	52,548	96,459	96,459
600	Kentucky Power Co. - Kammer Actives	0	106,336	(312,759)	0	61,648	(144,775)	(144,775)
701	Kentucky Power Co. - Mitchell Actives	1,398,561	935,430	(1,481,518)	0	491,954	(54,134)	1,344,427
702	Kentucky Power Co. - Mitchell Inactives	0	1,236,777	(2,703,583)	0	694,764	(772,042)	(772,042)
	Kentucky Power Co.	**$3,115,151**	**$5,968,431**	**($9,891,015)**	**$0**	**$3,290,519**	**($632,065)**	**$2,483,086**
250	Ohio Power Co - Distribution	$9,613,793	$14,200,722	($24,287,387)	$0	$7,813,304	($2,273,361)	$7,340,432
160	Ohio Power Co - Transmission	12,649	1,208,517	(1,993,097)	0	683,565	(101,015)	(88,366)
	Ohio Power Co.	**$9,626,442**	**$15,409,239**	**($26,280,484)**	**$0**	**$8,496,869**	**($2,374,376)**	**$7,252,066**
167	Public Service Co of Oklahoma - Distribution	$4,178,296	$5,194,591	($8,963,901)	$0	$2,852,045	($917,265)	$3,261,031
198	Public Service Co of Oklahoma - Generation	2,382,553	2,651,129	(4,534,526)	0	1,460,589	(422,808)	1,959,745
114	Public Service Co of Oklahoma - Transmission	717,661	638,014	(1,072,126)	0	342,860	(91,252)	626,409
	Public Service Co. of Oklahoma	**$7,278,510**	**$8,483,734**	**($14,570,553)**	**$0**	**$4,655,494**	**($1,431,325)**	**$5,847,185**
159	Southwestern Electric Power Co - Distribution	$3,400,330	$3,738,314	($5,774,878)	$0	$2,056,389	$19,825	$3,420,155
168	Southwestern Electric Power Co - Generation	4,317,273	4,235,145	(6,163,713)	0	2,322,305	393,737	4,711,010
161	Southwestern Electric Power Co - Texas - Distribution	1,443,804	1,653,595	(2,753,108)	0	910,344	(189,169)	1,254,635
111	Southwestern Electric Power Co - Texas - Transmission	0	0	0	0	0	0	0
194	Southwestern Electric Power Co - Transmission	720,594	548,221	(947,547)	0	292,293	(107,033)	613,561
	Southwestern Electric Power Co.	**$9,882,001**	**$10,175,275**	**($15,639,246)**	**$0**	**$5,581,331**	**$117,360**	**$9,999,361**
230	Kingsport Power Co - Distribution	$303,475	$484,182	($762,550)	$0	$264,890	($13,478)	$289,997
260	Kingsport Power Co - Transmission	0	63,863	(69,383)	0	36,202	30,682	30,682
	Kingsport Power Co.	**$303,475**	**$548,045**	**($831,933)**	**$0**	**$301,092**	**$17,204**	**$320,679**
210	Wheeling Power Co - Distribution	$335,947	$475,040	($869,548)	$0	$260,336	($134,172)	$201,775
200	Wheeling Power Co - Transmission	0	10,807	(40,036)	0	6,357	(22,872)	(22,872)
	Wheeling Power Co.	**$335,947**	**$485,847**	**($909,584)**	**$0**	**$266,693**	**($157,044)**	**$178,903**
103	American Electric Power Service Corporation	$41,666,673	$59,819,815	($78,387,680)	$0	$32,975,637	$14,407,772	$56,074,445
293	Elmwood	0	39,800	(325,044)	0	23,023	(262,221)	($262,221)
292	AEP River Operations LLC	0	418,062	(2,847,680)	0	243,309	(2,186,309)	(2,186,309)
	American Electric Power Service Corp	**$41,666,673**	**$60,277,677**	**($81,560,404)**	**$0**	**$33,241,969**	**$11,959,242**	**$53,625,915**
270	Cook Coal Terminal	$138,653	$108,788	($246,339)	$0	$58,101	($79,450)	$59,203
	AEP Generating Company	**$138,653**	**$108,788**	**($246,339)**	**$0**	**$58,101**	**($79,450)**	**$59,203**
104	Cardinal Operating Company	$2,737	$2,125,684	($5,233,503)	$0	$1,191,498	($1,916,321)	($1,913,584)
181	Ohio Power Co - Generation	607,134	7,456,434	(19,142,976)	0	4,196,245	(7,490,297)	(6,883,163)
	AEP Generation Resources - FERC	**$609,871**	**$9,582,118**	**($24,376,479)**	**$0**	**$5,387,743**	**($9,406,618)**	**($8,796,747)**
290	Conesville Coal Preparation Company	0	86,513	(243,553)	0	49,037	(108,003)	(108,003)
	AEP Generation Resources - SEC	**$609,871**	**$9,668,631**	**($24,620,032)**	**$0**	**$5,436,780**	**($9,514,621)**	**($8,904,750)**
171	CSW Energy, Inc.	0	89,612	(142,111)	0	50,307	(2,192)	(2,192)
175	AEP Energy Partners	1,528,325	520,871	(500,479)	0	258,164	278,556	1,806,881
419	Onsite Partners	168,056	43,107	(20,078)	0	20,576	43,605	211,661
	AEP Energy Supply	**$2,306,252**	**$10,322,221**	**($25,282,700)**	**$0**	**$5,765,827**	**($9,194,652)**	**($6,888,400)**
143	AEP Pro Serv, Inc.	$0	$37,261	($52,902)	$0	$20,597	$4,956	$4,956
	AEP Pro Serv, Inc.	**$0**	**$37,261**	**($52,902)**	**$0**	**$20,597**	**$4,956**	**$4,956**
245	Dolet Hills	1,104,255	233,518	(190,277)	0	110,166	153,407	1,257,662
	Dolet Hills	**$1,104,255**	**$233,518**	**($190,277)**	**$0**	**$110,166**	**$153,407**	**$1,257,662**
	Total	**$111,537,019**	**$165,749,258**	**($265,077,449)**	**$0**	**$91,392,106**	**($7,936,085)**	**$103,600,934**
	Total without Dolet Hills	**$110,432,764**	**$165,515,740**	**($264,887,172)**	**$0**	**$91,281,940**	**($8,089,492)**	**$102,343,272**

Key Assumptions as of January 1, 2020:

Discount rate	3.25%
Valuation data	1/1/2020
Mortality base table	Pri-2012 (using contingent survivor tables after retiree death for annuitants), without collar or quartile adjustment
Mortality projection scale	MP-2019 adjusted with long-term rate multiplied by 0.75
Expected return on assets	5.75%
Interest crediting rate	4.00%

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DATA REQUEST

KPSC 2_31 Regarding the utility's employee compensation policy:
a. Provide the utility's written compensation policy as approved by the Board of Directors.
b. Provide a narrative description of the compensation policy, including the reasons for establishing the policy and the utility's objectives for the policy.
c. Explain whether the compensation policy was developed with the assistance of an outside consultant. If the compensation policy was developed or reviewed by a consultant, provide any study or report provided by the consultant.
d. Explain when the utility's compensation policy was last reviewed or given consideration by the Board of Directors.

RESPONSE

a. AEP does not have a written policy covering all compensation for all employees that has been approved by the board of directors. AEP has a policy governing incentive compensation that has been approved by the Board of Directors. Please refer to KPCO_R_KPSC_2_31_Attachment1 for the policy.
b. Please see answer to subpart (a) above. The reason and objectives for adoption of the policy were to provide a framework and establish limits for AEP's incentive compensation programs, consistent with corporate governance.
The incentive compensation policy was developed to govern incentive compensation which is one of the responsibilities and duties listed in the charter of the HR Committee of the Board of Directors.
c. AEP's Incentive Compensation Guiding Principles and Policies were not developed with the assistance of an outside consultant. They are reviewed annually by the HR Committee and its outside compensation consultant in the normal course of business but the compensation consultant has not been asked to provide a study, report or opinion with respect to this policy.
d. This policy was last reviewed by the HR Committee of the Board of Directors in April 2020.

Witness: Kimberly K. Kaiser

AEP Incentive Compensation
Guiding Principles and Policies
Revised as of April 2020

Compensation Governance - American Electric Power Company, Inc. (AEP) and the Human Resources Committee of AEP's Board of Directors (HR Committee) has established the following incentive compensation standards for the Company and its subsidiaries. These standards are reviewed at least annually and adjusted as needed.

Approvals and Exceptions- The approval of the CEO and, as necessary or appropriate, the HR Committee is required for any substantial exceptions to these standards. The approval of the Director of Compensation, Managing Director Total Rewards, SVP Chief HR Officer or EVP & Chief Administrative Officer is required for all other exceptions to these standards. The Chairman of the HR Committee is responsible for determining which exceptions require full HR Committee review and approval in accordance with the HR Committee Charter as part of the agenda setting process for the HR Committee. The EVP & Chief Administrative Officer is responsible for reviewing exceptions to these standards that may require HR Committee approval with the Chairman of the HR Committee so that the Chairman of the HR Committee has sufficient information to set its agenda.

All compensation commitments and payments that exceed $100,000 and that are granted outside a previously approved plan or program require notification to the HR Committee Chairman. Examples of such commitments and payments include signing bonuses, retention awards and buy-outs of prior employer compensation and benefits. All compensation commitments and payments that exceed $200,000 and that are granted outside a previously approved plan or program require the approval of the HR Committee Chairman or, at the HR Committee Chairman's discretion, the full HR Committee.

Incentive Award Opportunity - Standard target and maximum annual incentive award opportunity levels have been established by the HR Committee as shown in the tables below. These standard target and maximum award levels are periodically reviewed and adjusted as needed to reflect market competitive compensation levels; AEP's compensation strategy and desired compensation mix; and AEP's financial situation, among other factors.

All individual incentive compensation awards in excess of the maximum award opportunity (defined below) require the approval of an executive council member unless the HR Committee has previously approved higher maximum award opportunities for the plan or executive in question. The maximum award levels do not necessarily represent potential or possible outcomes of any plan or performance measure.

SP20 Grade Structure		
Salary Plan	**Grade**	**Target %***
SP20	1	5%
	2	5%
	3	5%
	4	6%
	5	8%
	6	9%
	7	10%
	8	10%
	9	15%
	10	20%
	11	25%
	12	30%
	13	35%
	14	40%
	15	45%
	16	50%
	17	55%
	18	60%
	19	80%
	20 (CEO)	135%
* As a percent of eligible earnings.		

Performance Measure Design - Performance metrics shall be established at levels that foster the sustained achievement of business objectives that balance the interests of all stakeholders, including shareholders, customers, employees and the communities we serve. As general guidelines, performance metrics should:

- Provide stretch but achievable goals
- Be aligned with the Company's business plan so that target awards are provided only when performance is at or better than the business plan or budget, if applicable
- Allow for adjustment to reflect changing business needs
- Generally have a probability of below threshold or above maximum performance that is no greater than ~10%-15% for any single performance measure and no higher than ~5%-10% for all performance measures combined, in a normal year using external comparisons whenever possible.

A 2.0 cap shall apply to all performance objectives unless the value-sharing proposition of any uncapped performance objective is reviewed and approved by the CEO and, as necessary or appropriate, the HR Committee.

Performance Measures – Funding of all annual incentive plans will be based on AEP's Operating Earnings per Share and other measures established by the HR Committee.

All annual incentive plans shall include a discretionary Operating Unit Performance Factor, which the Plan Compensation Committee (defined below) may use to adjust the overall score to the extent that it determines that such score is not indicative of the group's overall performance or economic situation.

Annual incentive awards for all employees classified in the SP20 salary plan shall be discretionarily determined based on management's assessment of each participant's performance for the plan year and other appropriate and legal business considerations.

Generally, at least 25% of the total target award for each incentive plan or group should be based on quantitative financial objectives.

Board Policy on Recouping Incentive Compensation - All incentive compensation plans shall incorporate the following Board Policy on Recouping Incentive Compensation.

This policy applies to all executive officers of the Company as well as all other employees of the Company or any of its subsidiaries at salary grade 15 or equivalent and higher, regulated operating company presidents and officer direct reports to the Company's Chief Executive Officer (collectively, the "Covered Employees").

This policy relates to incentive compensation paid or payable to such Covered Employees, whether under this Plan, the Company's Long Term Incentive Plan or otherwise.

The Board of Directors believes, subject to the exercise of its discretion based on the facts and circumstances of a particular case, that incentive compensation provided by the Company should be reimbursed to the Company if, in the Board's determination:

- Such incentive compensation was received by a Covered Employee where the payment or the award was predicated upon the achievement of financial or other results that were subsequently materially restated or corrected, and
- Incentive compensation would have been materially lower had the achievement been calculated on such restated or corrected financial or other results.

Therefore, this Plan, hereby, requires Cover Employees to reimburse the Company, if and to the extent that, in the Board's view, such reimbursement is warranted by the facts and circumstances of the particular case or if the applicable legal requirements impose more stringent requirements on the Company to obtain reimbursement of such compensation. The Company also may retain any deferred compensation credited to a Covered Employee, including earnings thereon, if, when and to the extent that it otherwise would become payable.

This right to reimbursement is in addition to, and not in substitution for, any and all other rights the Company might have to pursue reimbursement or such other remedies against a Covered Employee in the course of employment by the Company or otherwise based on applicable legal considerations, all of which are expressly retained by AEP.

Incentive Plan Design Standards - All AEP incentive plans shall be documented in writing and shall include the signature of a member of the Executive Council showing the plan's approval, unless the plan has been approved by the HR Committee.

All annual incentive plans shall be administered by the HR Committee with respect to executives in the HR Committee Review Group and a Plan Compensation Committee that generally consists of AEP's CEO, CFO, General Counsel and Chief Administrative Officer with respect to all other participants. The applicable Committee shall have authority to modify or terminate the plan at any time for any reason the Committee deems appropriate, including the ability to adjust, modify, substitute, or eliminate performance measures and their weights at any time. This allows for the adjustment of performance measures and results that are inconsistent with or detrimental to the underlying performance or economics of a business unit or AEP as a whole. The applicable Committee shall also have the discretion to determine plan participation, add or delete participants, and adjust a participant's award payout.

Plan eligibility shall generally be limited to full-time and regular part-time active employees of the business unit or function.

Employment At Will - Participation in an incentive plan does not confer a right to continued employment.

Continued Participation - Participation in one or more years does not confer the right to participate or to receive an award in any subsequent year.

Standard Eligible Earnings Definition - Base and overtime earnings for the plan year (not base rate at year-end) are used to calculate annual incentive compensation opportunities. Base earnings generally include paid time off, such as vacation, PDOs, bereavement, sick leave, jury duty, etc.

Standard Termination of Employment Provisions – Employees who voluntarily resign prior to the award payment date are ineligible for an award.

Participants are ineligible for an award if they separate from service with AEP during the Plan Year as part of a voluntary or involuntary severance program or a layoff as defined under a collective bargaining agreement or the Supplemental Handbook and they are not rehired during the Plan Year. Severed employees are ineligible for an award even if, in connection with their severance, they are (a) placed on a Leave of Absence or (b) offered, but fail to meet the qualifications to be paid a severance benefit (e.g., if they would fail to timely sign and return, a Severance and Release of All Claims Agreement). In the event a severed employee is rehired during the Plan Year, such Participant is eligible for an award only to the extent of their earnings for the period after they were rehired.

Employees who are terminated for cause or resign in lieu of termination for cause at any time before the award payment date are ineligible for an award.

Participants remain **eligible** for an award if their employment with AEP is terminated during the Plan Year due to their death or retirement (age 55 with 10 years of service) and, effective January 1, 2018, they were employed by AEP through at least the first 3 months of the Plan Year. Because such awards are based on participant's eligible earnings for a Plan Year, which reflects the portion of the year in which they worked, they are effectively prorated.

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DATA REQUEST

KPSC 2_32 State whether the utility's expenses for wages, salaries, benefits, and other compensation included in the test period, and any adjustments to the test period, are compliant with the Board of Directors' compensation policy.

RESPONSE

As described in the Company's response to KPSC 2-31, the Board of Directors' compensation policy is limited in scope to incentive compensation. All wages, salaries, benefits, and other compensation included in the test period, as well as adjustments to the test period, are compliant with the Board of Directors Compensation policy as applicable.

Witness: Kimberly K. Kaiser

DATA REQUEST

KPSC 2_33 Provide, in the format provided in Schedule I, the following information for the utility's compensation and benefits for the test period and the three most recent calendar years preceding the test period. Provide information individually for each corporate officer and by category for Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees. Provide the amounts, in gross dollars, separately for total company operations and jurisdictional operations.

a. Regular salary or wages.
b. Overtime pay.
c. Excess vacation payout.
d. Standby/Dispatch pay.
e. Bonus and incentive pay.
f. Any other forms of incentives, including stock options or forms of deferred compensation.
g. Other amounts paid and reported on the employees' W-2 (specify).
h. Healthcare benefit cost.
   (1) Amount paid by the utility.
   (2) Amount paid by employee.
i. Dental benefits cost.
   (1) Amount paid by the utility.
   (2) Amount paid by employee.
j. Vision benefits cost.
   (1) Amount paid by the utility.
   (2) Amount paid by employee.
k. Life insurance cost.
   (1) Amount paid by the utility.
   (2) Amount paid by employee.
l. Accidental death and disability benefits.
   (1) Amount paid the utility.
   (2) Amount paid by employee.
m. Defined Benefit Retirement.
   (1) Amount paid by employer.
   (2) Amount paid by employee.
n. Defined Contribution – 401(k) or similar plan cost. Provide the amount paid by the utility.
o. Cost of any other benefit available to an employee (specify).

RESPONSE

Please refer to KPCO_R_KPSC_2_33_ConfidentialAttachment1 for the requested information.

Witness: Kimberly K. Kaiser

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DATA REQUEST

KPSC 2_34 For each item of benefits listed in Item 33 above where an employee is required to pay part of the cost, provide a detailed explanation as to how the employee contribution rate was determined.

RESPONSE

Employee contribution rate determination varies by benefit plan. For fully insured plans, the market drives the cost of the employee contributions. For self-insured plans, such as the Company's health benefit, AEP utilizes the services of outside third party experts to assist in determining those rates. The Company offers three consumer driven health plans; an HRA plan (Health Reimbursement Account) and two HSA (Health Savings Account) health plans to all employees. The employees have the option to choose one of the three plans best suited for their specific needs.
The methodology for deriving the rates for the self-insured health and dental plans for 2020 included the analysis of prior year incurred claims and enrollment projected forward to 2020 after adjusting for items such as trend, inflation and migration of employees between the three healthcare plans offered. Active employee contribution rates were then set equal to 24.6% of the projected plan cost for the HRA plan with dependents paying an additional 2%. For the other two health plans, the AEP subsidy was set approximately equal to the subsidy provided to the HRA plan; employee contributions were therefore set equal to the difference between total cost and the AEP subsidy. Dental contributions were set equal to 40% of total projected cost with dependents paying an additional 2%.

Contribution rates do not vary by employee classification.

Witness: Andrew R. Carlin

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DATA REQUEST

KPSC 2_35 Provide a listing of all healthcare plan categories, dental plan categories, and vision plan categories available to corporate officers individually and to groups defined as Corporate Officers, Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees (e.g., single, family). Include the associated employee contribution rates and employer contribution rates of the total premium cost for each category, and each plan's deductible(s) amounts.

RESPONSE

Please see response to KPSC 2-25.

Witness: Andrew R. Carlin

Kentucky Power Company
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DATA REQUEST

KPSC 2_36 Provide a listing of all life insurance plan categories available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees. Include the associated employee contribution rates and employer contribution rates of the total premium cost for each plan category.

RESPONSE

The Company provides full-time employees coverage under the AEP Life and Accident Plan two times their base annual pay in life insurance at no cost to the employee for those employees hired prior to January 1, 2020. Employees hired after December 31, 2019 are provided one times their base annual pay. The Company does not offer a separate life insurance plan for corporate officers. Please refer to KPCO_R_KPSC_2_36_ConfidentialAttachment1 and to KPCO_R_KPSC_2_36_PublicAttachment1 for the employer contribution rates of the total premium cost for each plan category. Most employees may purchase up to eight times their base pay in supplemental coverage. The total amount of combined coverage for salary grade 15 and above may not exceed $5 million.

Witness: Andrew R. Carlin

The employer contribution rates of the total premium cost for each plan category are as follows:

$[redacted] Rate/1000/Month for Active;

$[redacted] Rate/1000/Month for Executive.

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DATA REQUEST

KPSC 2_37 Provide a listing of all retirement plans available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees. Include the associated employee contribution rates, if any, and employer contribution rates of the total premium cost for each plan category.

RESPONSE

Please refer to KPCO_R_KPSC_2_37_Attachment1 for descriptions of the retirement plans available to all employees at AEP.

Witness: Andrew R. Carlin

Included below are descriptions for the retirement plans available to all employees at AEP.

AEP SYSTEM RETIREMENT SAVINGS PLAN (Qualified 401k Plan)

The AEP System Retirement Savings Plan (RSP) is a 401(k) savings plan that gives employees an opportunity to save through payroll deductions on a pre-tax and after-tax basis. Generally, employees can contribute from 1% to 50% of their eligible compensation on a pre-tax basis, after-tax basis, including Roth 401(k) after-tax, or in a combination of any of the contribution options, up to the limits established by the IRS. The Company adds 100% to their account for every dollar they contribute up to the first 1% and 70% for every dollar they contribute up to the next 5% each pay period. All contribution sources are eligible for the match, but the 6% limit is applied to the total amount contributed each pay period. Employees can invest in any combination of the 19 investment options available and/or the self-directed brokerage account to design their own diversified portfolio. Employees are immediately 100% vested in the value of their contributions and AEP contributions.

AEP SYSTEM RETIREMENT PLAN (Qualified Pension Plan)

Each of the AEP affiliates establishes a recordkeeping account for their employees to track growth of a participant's benefit over time. The plan provides a cash balance benefit. The account balance grows through two annual credits: an interest credit and an annual employer company credit which is a percentage of a participant's pay, based on age and service. Employees are eligible to participate after completing one year of service with AEP. Employees are automatically enrolled in the AEP System Retirement Plan once eligible.

Participants are 100% vested in their accrued benefit after three years of service.

Participants of the AEP System Retirement Plan who were employed by the Company on 12/31/2000 and participants of the Central and South West Retirement Plan who were age 50 or older with at least 10 years of service as of June 30, 1997, are grandfathered in each plan's prior pension formula. Grandfathered participants receive the higher benefit from the prior formulas provided by the plans or the newer cash balance formula.

The following plans are available generally to employees whose compensation exceeds IRS qualified plan limits.

SUPPLEMENTAL RETIREMENT SAVINGS PLAN (Non-Qualified 401k Excess Plan)

This plan allows eligible participants to save on a pre-tax basis and to continue to receive Company matching contributions beyond the limits imposed by the Internal Revenue Code on the AEP System Retirement Savings Plan. This plan is unfunded. Participants have an unsecured contractual commitment from the Company to pay the amounts due under the plans from the general assets of the Company.

- Participants can defer up to 50 percent of their base salary and annual incentive award in excess of the IRS' eligible compensation limit for qualified plans, which was $265,000 for 2016, up to $2,000,000.
- The Company match is the same as the qualified RSP.
- Participants may not withdraw any amount credited to their account until their termination of employment with AEP.
- Participants may direct the investment of their plan account among the core investment options that are available to all employees in AEP's qualified RSP and one additional option that provides interest at a rate set each December at 120 percent of the applicable federal long-term rate with monthly compounding. There were no above-market or preferential earnings with respect to the Supplemental Retirement Savings Plan.

AEP SUPPLEMENTAL BENEFIT PLAN

The AEP Supplemental Benefit Plan is a nonqualified defined benefit pension plan. It generally provides eligible participants with benefits that are in excess of those provided under the AEP Retirement Plan (without regard to the provisions now included as the result of the merger of the CSW Retirement Plan into the AEP Retirement Plan) as determined upon the participant's termination of employment. These excess benefits are calculated under the terms of the AEP Retirement Plan described above with the following modifications: (i) additional years of service or benefit credits are taken into account; (ii) annual incentive pay was taken into account for purposes of the frozen final average pay formula; and (iii) the limitations imposed by the Internal Revenue Code on annual compensation and annual benefits are disregarded. However, eligible pay taken into account under the cash balance formula is limited to the greater of $1 million or two times the participant's year-end base salary. Participants do not become vested in

their AEP Supplemental Plan benefit until they become vested in their AEP Retirement Plan benefit or upon a change in control.

CSW EXECUTIVE RETIREMENT PLAN

The CSW Executive Retirement Plan is a nonqualified defined benefit pension plan. It generally provides eligible participants with benefits that are in excess of those provided under the terms of the former CSW Retirement Plan (which was merged into the AEP Retirement Plan) as determined upon the participant's termination of employment. The excess benefits are calculated without regard to the limitations imposed by the Internal Revenue Code on annual compensation and annual benefits.

The following plans are only available for certain eligible employees.

Other Voluntary Deferred Compensation Plans

These plans allow eligible participants to defer receipt of a portion of their base salary, annual incentive compensation and performance unit awards. Such deferrals may better enable participants to achieve their retirement savings goals. The plans are unfunded and do not provide any employer contributions. Participants have an unsecured contractual commitment from the Company to pay the amounts due under the plans from the general assets of the Company.

Incentive Compensation Deferral Plan - This plan allows eligible employees to defer payment of up to 80 percent of vested performance units. AEP does not offer any matching contributions. Participants may direct the investment of their plan accounts among the core investment options that are available to all employees in AEP's qualified Retirement Savings Plan. There were no above-market or preferential earnings with respect to the Incentive Compensation Deferral Plan in 2016. Generally, participants may not withdraw any amount credited to their account until their termination of employment with AEP. However, participants may make one withdrawal of amounts attributable to their pre-2005 contributions prior to termination of employment. The withdrawal amount would be subject to a 10 percent withdrawal penalty. Participants may elect among the same payment options for the distributions of their account value as described above for the Supplemental Retirement Savings Plan.

Stock Ownership Requirement Plan - This plan assists executives in achieving their minimum stock ownership requirements. It does this primarily by tracking the executive's AEP Career Shares. AEP Career Shares are a form of deferred compensation, which are unfunded and unsecured general obligations of AEP. The rate of return on AEP Career Shares is equivalent to the total return on AEP stock with dividends reinvested. Participants may not withdraw any amount credited to their account until their termination of employment with AEP. Participants may elect among the same payment options for the distribution of the value of their AEP Career Shares as described above for the Supplemental Retirement Savings Plan.

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DATA REQUEST

KPSC 2_38 Provide an analysis of the utility's expenses for research and development activities for the test year and the three preceding calendar years. For the test year include the following:

a. Basis of fees paid to research organizations and the utility's portion of the total revenue of each organization. Where the contribution is monthly, provide the current rate and the effective date.
b. Details of the research activities conducted by each organization.
c. Details of services and other benefits provided to the utility by each organization during the test year and the preceding calendar year.
d. Total expenditures of each organization including the basic nature of costs incurred by the organization.
e. Details of the expected benefits to the company.

RESPONSE

a. Fees paid by AEP Service Corporation to research organizations are allocated to AEP subsidiaries (including Kentucky Power) based on various R&D projects' attribute allocators that are updated on a regular basis. None of the contributions are monthly.
b. c. & e. Please see KPCO_R_KPSC_2_38_Attachment1 for the 12-months ended March 31, 2020, as well as calendar years 2019, 2018 and 2017.
d. Recent annual R&D budgets for organizations for which Kentucky Power incurred R&D expenses during the test year ended March 31, 2020 include the following:
Electric Power Research Institute (EPRI) - $415.6 million
National Carbon Capture Center (NCCC) - $40.5 million
National Electric Energy Testing Research and Applications Center (NEETRAC) - $6 million
Power Systems Engineering Research Center (PSERC) - $1.7 million

Witness: Deryle B. Mattison

DATA REQUEST

KPSC 2_39 Provide a running total the following information concerning the cost of preparing this case:

a. A detailed schedule of expenses incurred to date for the following categories. For each category, the schedule should include the date of each transaction, check number or other document reference, the vendor, the hours worked, the rates per hour, amount, a description of the services performed, and the account number in which the expenditure was recorded. Provide copies of any invoices, contracts, or other documentation that support charges incurred in the preparation of this rate case. Indicate any costs incurred for this case that occurred during the test year.
   (1) Accounting;
   (2) Engineering;
   (3) Legal; and
   (4) Consultants; and Other Expenses (Identify separately).

b. An itemized estimate of the total cost to be incurred for this case. Expenses should be broken down into the same categories as identified in (a) above, with an estimate of the hours to be worked and the rates per hour. Include a detailed explanation of how the estimate was determined, along with all supporting workpapers and calculations.

Provide monthly updates of the actual costs incurred in conjunction with this rate case, reported in the manner requested in (a) above. Updates will be due when the utility files its monthly financial statements with the Commission, through the month of the public hearing.

RESPONSE

a-b. Please refer to KPCO_R_KPSC_2_39_Attachment1 for the summary of expenses and estimate. The estimates were prepared by outside counsel for Kentucky Power and Company Witness McKenzie. Please refer to KPCO_R_KPSC_2_39_Attachment2 for the non-privileged invoices or receipts incurred through June 30, 2020. It is the Company's policy not to retain receipts for transactions of $25.00 or less. Likewise, receipts are not available for personal auto mileage.

c. The Company will provide monthly updates of the actual costs incurred, in the manner requested in (a) above. Because this response includes expenses through June, the first supplemental response will be provided on or before August 31, 2020.

Witness: Brian K. West

FINANCIAL CONCEPTS AND APPLICATIONS, INC.
3907 RED RIVER
AUSTIN, TEXAS 78751

fincap2@texas.net
(512) 458-4644 Fax (512) 458-4768

May 31, 2020

Mr. Brian West
Director, Regulatory Services
American Electric Power Service Corporation
855 Central Avenue
Ashland, Kentucky 41101

DUE ON RECEIPT

Reference No.: 01988 -9
Taxpayer ID No.: 74-2058652

Consulting Services:	Research, Analysis, and Testimony Preparation in Connection with Rate of Return on Equity for Kentucky Power before the Kentucky Public Service Commission. For the Period: Through May 31, 2020		
Professional Time:	Adrien M. McKenzie		
	12.5 hours @ $ 400		$ 5,000
	Brent L. Heidebrecht		
	29.0 hours @ $ 275		7,975
Total			**$ 12,975**

Bruce H. Fairchild

FINANCIAL CONCEPTS AND APPLICATIONS, INC.
3907 RED RIVER
AUSTIN, TEXAS 78751

(512) 458-4644

fincap2@texas.net
Fax (512) 458-4768

June 30, 2020

Mr. Brian West
Director, Regulatory Services
American Electric Power Service Corporation
855 Central Avenue
Ashland, Kentucky 41101

DUE ON RECEIPT

Reference No.: 01988 -10
Taxpayer ID No.: 74-2058652

Consulting Services: Research, Analysis, and Testimony Preparation in Connection with Rate of Return on Equity for Kentucky Power before the Kentucky Public Service Commission.

For the Period:
June 1 through June 30, 2020

Professional Time:			
Adrien M. McKenzie			
20.5 hours @ $ 400		$	8,200
Brent L. Heidebrecht			
4.0 hours @ $ 275			1,100
Total		**$**	**9,300**

Bruce H. Fairchild

From: Panera Bread
To: Brian West
Subject: [EXTERNAL] Your Panera Order - 438936108
Date: Thursday, June 4, 2020 5:21:39 PM

Panera

Thanks for your order!

Order number:
438936108

Time Ready:
11:20 AM

Please click I'm Here when you arrive and we'll meet you with your food shortly.

Need help?

For quick answers to most questions, please visit: customer help

For assistance with your order, please call: 855-372-6372

Order Type

Take Out

Date: 06/05/2020

Time Ready: 11:20 AM

Cafe Address

500 Winchester Ave
Ashland, KY 41101
606-329-0439

Special Instructions: Blue Audi S6

I'm Here

Whole Caesar Salad with Chicken with French Baguette	$ 8.69
Bowl Broccoli Cheddar Soup with French Baguette	$ 6.19
Whole Cuban Sandwich with Chips	$ 9.79
Whole Spicy Thai Salad with Chicken with French Baguette	$ 9.79
Whole Strawberry Poppyseed Salad with Chicken with French Baguette	$ 10.59

Whole Napa Almond Chicken Salad Sandwich with Chips	$ 8.19
Whole Mediterranean Veggie with No Red Onions with Chips	$ 6.99
Whole Spicy Thai Salad with Chicken with French Baguette	$ 9.79
Whole Bacon Turkey Bravo Sandwich with Chips	$ 8.89
Chips	$ 0.99
Chips	$ 0.99
Chocolate Chipper Cookie 4-Pack	$ 6.19
Agave Lemonade - Half Gallon	$ 4.99

Subtotal	$ 92.07
Tax	$ 5.15
Tip	$ 10.00
Total	$ 107.22

Feel free to tip your bakery-cafe team for excellent service.
Never expected. Always appreciated.

Type	Amnt.	Balance
MAST 8364	$ 107.22	

MyPanera Number: 621210096841

Available Rewards: 1

(1) Free Pastry or Sweet Welcome Reward (Up To $3.85)
(Expires 08/03/20)

You'll get a MyPanera visit credit once your order is picked up or delivered

We bake our items fresh daily and will try our best to fulfill your order exactly as you specify. However, should an issue occur, we'll do our best to replace, substitute or work with you on arrival to adjust the order to your liking.

Your feedback is important to us. Let us know how we can help by contacting us here .

Need to cancel your order? Click here

From: Panera Bread
To: Brian West
Subject: [EXTERNAL] Your Panera Order - 440069309
Date: Tuesday, June 9, 2020 10:14:24 AM

Panera

Thanks for your order!

Order number:
440069309

Time Ready:
11:30 AM

Please click I'm Here when you arrive and we'll meet you with your food shortly.

Need help?

For quick answers to most questions, please visit: customer help

For assistance with your order, please call: 855-372-6372

Order Type

Take Out

Date: 06/10/2020

Time Ready: 11:30 AM

Cafe Address

500 Winchester Ave
Ashland, KY 41101
606-329-0439

Special Instructions: Blue Audi S6

I'm Here

Whole Spicy Thai Salad with Chicken $ 9.79

with French Baguette

You Pick Two $ 8.38

Cup Southwest Chicken Tortilla Soup
Special Instructions:

Half Heritage Ham & Swiss
Special Instructions:

with French Baguette

Whole Toasted Frontega Chicken $ 8.89

with No Red Onions
with Chips

Half Strawberry Poppyseed Salad with $ 7.49

Chicken

with French Baguette

Whole Strawberry Poppyseed Salad with Chicken	$ 10.59

with French Baguette

Half Green Goddess Cobb Salad with Chicken	$ 7.49

with Chips

Chips	$ 0.99
Chips	$ 0.99
Chips	$ 0.99
Chips	$ 0.99
Raspberry Almond Thumbprint Cookie	$ 1.99
Raspberry Almond Thumbprint Cookie	$ 1.99
Homestyle Chocolate Chunk Cookie	$ 3.39
Agave Lemonade - Half Gallon	$ 4.99
Chocolate Chipper Cookie 4-Pack	$ 6.19

Subtotal	$ 75.14
Discount	$ 3.39
Tax	$ 3.69
Tip	$ 10.00

Total $ 85.44

Feel free to tip your bakery-cafe team for excellent service.
Never expected. Always appreciated.

Type	Amnt.	Balance
MAST 8364	$ 85.44	

MyPanera Number: 621210096841

Available Rewards: 0
No rewards, no worries. Just be sure to show your MyPanera card (or tell us your phone number) each time you visit to keep the surprises coming.

Visits to Next Reward: 2
You'll get a MyPanera visit credit once your order is picked up or delivered

We bake our items fresh daily and will try our best to fulfill your order exactly as you specify. However, should an issue occur, we'll do our best to replace, substitute or work with you on arrival to adjust the order to your liking.

Your feedback is important to us. Let us know how we can help by contacting us here .

Need to cancel your order? Click here

From: Panera Bread
To: Brian West
Subject: [EXTERNAL] Your Panera Order - 442020836
Date: Tuesday, June 16, 2020 10:57:40 AM

Panera

Thanks for your order!

Order number:
442020836

Time Ready:
11:30 AM

Please click I'm Here when you arrive and we'll meet you with your food shortly.

Need help?

For quick answers to most questions, please visit: customer help

For assistance with your order, please call: 855-372-6372

Order Type

Take Out

Date: 06/17/2020

Time Ready: 11:30 AM

Cafe Address

500 Winchester Ave
Ashland, KY 41101
606-329-0439

Special Instructions: Blue Audi S6

I'm Here

Whole Mediterranean Veggie $ 6.99

with No Red Onions
with Chips

You Pick Two $ 8.38

Cup Southwest Chicken Tortilla Soup
Special Instructions:

Half Heritage Ham & Swiss
Special Instructions:

with French Baguette

Half Strawberry Poppyseed Salad with Chicken $ 7.49

with French Baguette

Cup Broccoli Cheddar Soup	$ 5.19
with French Baguette	
Whole Seasonal Greens Salad	$ 8.98
with Smoked Pulled Chicken with Poppyseed with No Balsamic Vinaigrette with French Baguette	
Agave Lemonade - Half Gallon	$ 4.99
Potato Chips, 4-Pack	$ 1.99
Potato Chips, 4-Pack	$ 1.99
Chocolate Chipper Cookie 4-Pack	$ 6.19
Chocolate Chipper Cookie	$ 2.29
Chocolate Chipper Cookie	$ 2.29

Subtotal	$ 56.77
Discount	$ 1.68
Tax	$ 2.66
Tip	$ 10.00
Total	$ 67.75

Feel free to tip your bakery-cafe team for excellent service.
Never expected. Always appreciated.

Type	Amnt.	Balance
MAST 8364	$ 67.75	

MyPanera Number: 621210096841

Available Rewards: 0
No rewards, no worries. Just be sure to show your MyPanera card (or tell us your phone number) each time you visit to keep the surprises coming.

Visits to Next Reward: 1
You'll get a MyPanera visit credit once your order is picked up or delivered

We bake our items fresh daily and will try our best to fulfill your order exactly as you specify. However, should an issue occur, we'll do our best to replace, substitute or work with you on arrival to adjust the order to your liking.

Your feedback is important to us. Let us know how we can help by contacting us here .

Need to cancel your order? Click here

(Up to $50.00 included)
First-Class Mail® 1 $3.20 $3.20
Large Envelope
(Domestic)
(PRESTONSBURG, KY 41653)
(Weight:0 Lb 12.00 Oz)
(Estimated Delivery Date)
(Monday 06/22/2020)
First-Class Mail® 1 $3.20 $3.20
Large Envelope
(Domestic)
(GRAYSON, KY 41143)
(Weight:0 Lb 12.00 Oz)
(Estimated Delivery Date)
(Monday 06/22/2020)
PM 2-Day 1 $8.25 $8.25
(Domestic)
(ASHLAND, KY 41101)
(Weight:1 Lb 1.90 Oz)
(Expected Delivery Day)
(Monday 06/22/2020)
(USPS Tracking #)
(9505 5105 4481 0171 5277 27)
Insurance $0.00
(Up to $50.00 included)

Total: $71.30

Credit Card Remitd $71.30
(Card Name:MasterCard)
(Account #:XXXXXXXXXXXX6915)
(Approval #:025227)
(Transaction #:498)
(AID:A0000000041010 Chip)
(AL:MASTERCARD)
(PIN:Not Required MASTERCARD)

****
Due to limited transportation
availability as a result of
nationwide COVID-19 impacts
package delivery times may be
extended. Priority Mail Express®
service will not change.
****

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Text your tracking number to 28777
(2USPS) to get the latest status.
Standard Message and Data rates may
apply. You may also visit www.usps.com
USPS Tracking or call 1-800-222-1811.

Save this receipt as evidence of
insurance. For information on filing
an insurance claim go to
https://www.usps.com/help/claims.htm

Preview your Mail
Track your Packages
Sign up for FREE @
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All sales final on stamps and postage.
Refunds for guaranteed services only.
Thank you for your business.

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POSTAL EXPERIENCE

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https://postalexperience.com/Pos

840-5400-0270-001-00047-76601-02

or scan this code with

Office DEPOT
OfficeMax

ASHLAND - (606) 325-3114
06/17/2020 2:05 PM

VPVT5P5P3Y35RB8R6

SALE	6246-1-3836-965689-20.5.2	
872955	PNCL,ZGRP,.7MM	4.89 S
612051	LABEL,1130,100	33.39 S
544743	PEN,RT,20PK,AS	11.99S
Instant Savings		-5.99
	You Pay	**6.00S**
680049	ENV,9X12,100BX	31.89 S
683262	EN,100BX,10X13	35.99 S
8106621	AY21,8X10,PLAN	40.99 S
	Subtotal:	153.15
	KY State Tax 6%	9.18
	Total:	162.33
	MasterCard 6915:	162.33

AUTH CODE 021126
TDS Chip Read
AID A0000000041010 MASTERCARD
TVR 0400088000
CVS No Signature Required

AMANDA CLARK 5756014287
Please create your online rewards account at officedepot.com/rewards. You must complete your account to claim your rewards and view your status.
Total Savings:
$5.99

****

WE WANT TO HEAR FROM YOU!
Visit survey.officedepot.com
and enter the survey code below:
75QE 48HH 7WCQ

****

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_40 Provide the following information for the most recent calendar year concerning the utility and any affiliated service corporation or corporate service division/unit:

a. A schedule detailing the costs charged, either directly or those allocated by the utility to the service company. Indicate the utility's accounts where these costs were originally recorded. For costs that are allocated, include a description of the allocation factors utilized.
b. A schedule detailing the costs charged, either directly or allocated, by the service company to the utility. Indicate the utility's accounts where these costs were recorded. For costs that are allocated, include a description of the allocation factors utilized.

RESPONSE

Please note that the responses below represent test year amounts. Per discussion with Staff this question was intended to be for the test year, not the most recent calendar year.
a. During the test year, Kentucky Power billed $804,702 to AEP Service Corporation for costs related to Kentucky Power buildings partially occupied by AEPSC employees. Kentucky Power recorded the original transactions in various accounts, including (but not limited to) depreciation, property tax and building maintenance. When the costs are billed, Kentucky Power records revenue in Account 4540 (Rent from Electric Property, Affiliated) and AEPSC records expense to Account 9310 (Rents – Real Property, Associated).
b. Please refer to Section II, Exhibits U for costs directly charged to and costs allocated by AEPSC to Kentucky Power for the requested information.

Witness: Brian K. West

DATA REQUEST

KPSC 2_41 Provide the following information for the most recent calendar year concerning all affiliate-related activities not identified in response to Item 40:

a. Provide the names of affiliates that provided some form of service to the utility and the type of service the utility received from each affiliate.
b. Provide the names of affiliates to whom the utility provided some form of service and the type of service the utility provided to each affiliate.
c. Identify the service agreement with each affiliate, state whether the service agreement has been previously filed with the Commission, and identify the proceeding in which it was filed. Provide each service agreement that has not been previously filed with the Commission.

RESPONSE

Please note that the response below represent test year amounts. Per discussion with Staff this question was intended to be for the test year, not the most recent calendar year.
a. Please refer to Section II, Exhibits V for costs directly charged to and costs allocated by Other Affiliates to Kentucky Power for the requested information.

Additional services to Kentucky Power included the following from these affiliates:
$4,619,533 from Indiana Michigan Power Company for Barging.
$3,800,927 from AEP Credit, Inc. for Customer Factoring.
$1,187,117 from Appalachian Power Company for Central Machine Shop.
$91,586 from United Sciences Testing, Inc. for Emissions Testing.
$62,751 from Wheeling Power Company for Electric Service.
$20,429 from Appalachian Power Company for Simulator Learning Center.
$4,233 from Appalachian Power Company for Building and Property Leases.

b. Reference KPCO-R-KPSC_2_41(b)_Attachment 1 for Kentucky Power Costs billed to other AEP affiliates.

Additional services provided to AEP Affiliates by Kentucky Power included the following:

$56,703,203 to Wheeling Power Company for Jointly Owned Facility Services of Mitchell.

$297,457 to AEP Kentucky Transmission Company, Inc for Use of Jointly Owned Assets.

c. The following list of agreements from 2019 were filed in March 2020 in accordance with annual 807 KAR 5:080 filings. All service agreements have been filed with the Public Service Commission.

- Amended and Restated Subscription Agreement with Grid Assurance LLC
- Amended and Restated Urea Handling Agreement Amendment No. 1
- Amended and Restated Rail Car Maintenance Agreement Amendment No. 1
- Affiliated Transactions Agreement for Sharing Capitalized Spare parts Amendment No. 1
- Barge Transportation Agreement Amendment No. 2
- Amended and Restated Cook Coal Terminal Transfer Agreement Amendment
- Affiliated Transactions Agreement for Sharing Materials and Supplies Amendment No. 1

Witness: Brian K. West

Kentucky Power Company
Charges to Affiliates by FERC Account, Allocation Factor and Allocation Type
Test Year Ended March 2020

Kentucky Power has a variety of transactions with affiliates on a normal basis. Transactions with affiliates generally fall into two categories. The first category, service payments, is a billing made when an affiliate provides a service to Kentucky Power, such as Appalachian Power providing assistance in distribution maintenance, generation engineering, or other affiliates providing assistance during storm recovery efforts. The second category, convenience payments, occurs when an affiliate company receives an invoice and the cost of that invoice should be borne by multiple AEP companies. For example, a legal invoice for a system-wide issue may be paid by one affiliate company, and that company then bills the other affiliates who benefit from the service.

Charges to/from affiliates are accumulated using a work order system. All affiliate services and convenience payments are billed to/from Kentucky Power at cost, per FERC affiliate requirements.

			TEST YEAR 12 MONTHS ENDED MARCH 2020		
Affiliate	FERC Account	Allocation Factor	Direct	Allocated	Total
Appalachian Power Company	1070 - Construction Work In Progress	39 - 100% to One Company	155,579		155,579
	1080 - Accum Prov for Deprec of Plant	39 - 100% to One Company	1,243		1,243
	1630 - Stores Expense Undistributed	39 - 100% to One Company	222,292		222,292
		58 - Total Assets		71	71
	1840 - Clearing Accounts	08 - Number of Electric Retail Cust		933	933
		31 - Number of Vehicles		516	516
		39 - 100% to One Company	177,619		177,619
		48 - MW Generating Capability		72	72
		63 - Total Gross Utility Plant		6,757	6,757
	4560 - Other Electric Revenues	39 - 100% to One Company	0		0
	5000 - Oper Supervision & Engineering	39 - 100% to One Company	1,034		1,034
		48 - MW Generating Capability		5,502	5,502
	5060 - Misc Steam Power Expenses	39 - 100% to One Company	77		77
		40 - Equal Share Ratio		1,748	1,748
	5100 - Maint Supv & Engineering	48 - MW Generating Capability		2,457	2,457
	5120 - Maintenance of Boiler Plant	39 - 100% to One Company	8,961		8,961
	5130 - Maintenance of Electric Plant	39 - 100% to One Company	16,822		16,822
	5140 - Maintenance of Misc Steam Plt	39 - 100% to One Company	3,528		3,528
		40 - Equal Share Ratio		76	76
	5370 - Hydraulic Expenses	39 - 100% to One Company	1,079		1,079
	5460 - Oper Supervision & Engineering	39 - 100% to One Company	17,039		17,039
	5600 - Oper Supervision & Engineering	58 - Total Assets		716	716
	5620 - Station Expenses	39 - 100% to One Company	1,489		1,489
	5660 - Misc Transmission Expenses	39 - 100% to One Company	17		17
	5710 - Maintenance of Overhead Lines	39 - 100% to One Company	(15,876)		(15,876)
	5800 - Oper Supervision & Engineering	39 - 100% to One Company	163		163
	5830 - Overhead Line Expenses	39 - 100% to One Company	325		325
	5860 - Meter Expenses	39 - 100% to One Company	153		153
	5880 - Miscellaneous Distribution Exp	39 - 100% to One Company	1,031		1,031
		58 - Total Assets		301	301
	5930 - Maintenance of Overhead Lines	39 - 100% to One Company	5,642		5,642
	5940 - Maint of Underground Lines	39 - 100% to One Company	(52)		(52)
	5950 - Maint of Lne Trnf,Rglators&Dvi	39 - 100% to One Company	384		384
	9010 - Supervision - Customer Accts	08 - Number of Electric Retail Cust		160	160
	9030 - Cust Records & Collection Exp	39 - 100% to One Company	205,078		205,078
	9120 - Demonstrating & Selling Exp	08 - Number of Electric Retail Cust		7,207	7,207
	9200 - Administrative & Gen Salaries	39 - 100% to One Company	2,198		2,198

Kentucky Power Company
Charges to Affiliates by FERC Account, Allocation Factor and Allocation Type
Test Year Ended March 2020

Kentucky Power has a variety of transactions with affiliates on a normal basis. Transactions with affiliates generally fall into two categories. The first category, service payments, is a billing made when an affiliate provides a service to Kentucky Power, such as Appalachian Power providing assistance in distribution maintenance, generation engineering, or other affiliates providing assistance during storm recovery efforts. The second category, convenience payments, occurs when an affiliate company receives an invoice and the cost of that invoice should be borne by multiple AEP companies. For example, a legal invoice for a system-wide issue may be paid by one affiliate company, and that company then bills the other affiliates who benefit from the service.

Charges to/from affiliates are accumulated using a work order system. All affiliate services and convenience payments are billed to/from Kentucky Power at cost, per FERC affiliate requirements.

			TEST YEAR 12 MONTHS ENDED MARCH 2020		
Affiliate	FERC Account	Allocation Factor	Direct	Allocated	Total
		58 - Total Assets		48,970	48,970
	9210 - Office Supplies and Expenses	39 - 100% to One Company	463		463
		58 - Total Assets		3,164	3,164
	9230 - Outside Services Employed	58 - Total Assets		17	17
		61 - Total Fixed Assets		2,036	2,036
	9250 - Injuries and Damages	61 - Total Fixed Assets		1,081	1,081
	9260 - Employee Pensions & Benefits	39 - 100% to One Company	20,035		20,035
	9302 - Misc General Expenses	39 - 100% to One Company	17,197		17,197
	9310 - Rents	39 - 100% to One Company	9		9
		48 - MW Generating Capability		(1)	(1)
	9350 - Maintenance of General Plant	39 - 100% to One Company	127,110		127,110
Appalachian Power Company Total			970,637	81,781	1,052,418
AEP Kentucky Transmission Company, Inc.	1070 - Construction Work In Progress	39 - 100% to One Company	299,885		299,885
	1630 - Stores Expense Undistributed	58 - Total Assets		1	1
	1840 - Clearing Accounts	63 - Total Gross Utility Plant		59	59
	5600 - Oper Supervision & Engineering	58 - Total Assets		1,020	1,020
	5620 - Station Expenses	58 - Total Assets		15,854	15,854
	5630 - Overhead Line Expenses	58 - Total Assets		1,141	1,141
	5660 - Misc Transmission Expenses	58 - Total Assets		9,090	9,090
	5690 - Maintenance of Structures	58 - Total Assets		82	82
	5700 - Maint of Station Equipment	58 - Total Assets		10,958	10,958
	5710 - Maintenance of Overhead Lines	58 - Total Assets		(546)	(546)
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		1	1
	9200 - Administrative & Gen Salaries	58 - Total Assets		521	521
	9210 - Office Supplies and Expenses	58 - Total Assets		32	32
	9230 - Outside Services Employed	58 - Total Assets		0	0
	9350 - Maintenance of General Plant	39 - 100% to One Company	3,777		3,777
AEP Kentucky Transmission Company, Inc. Total			303,663	38,213	341,876
AEP Generation Resources	1630 - Stores Expense Undistributed	39 - 100% to One Company	(0)		(0)
		58 - Total Assets		2	2
	1840 - Clearing Accounts	31 - Number of Vehicles		17	17
		63 - Total Gross Utility Plant		31	31
	1860 - MDD-Internal Billing Only	39 - 100% to One Company	457		457
	5000 - Oper Supervision & Engineering	39 - 100% to One Company	4,964		4,964
		48 - MW Generating Capability		792	792
	5010 - Fuel	39 - 100% to One Company	94,865		94,865
	5060 - Misc Steam Power Expenses	39 - 100% to One Company	166,785		166,785

Kentucky Power Company
Charges to Affiliates by FERC Account, Allocation Factor and Allocation Type
Test Year Ended March 2020

Kentucky Power has a variety of transactions with affiliates on a normal basis. Transactions with affiliates generally fall into two categories. The first category, service payments, is a billing made when an affiliate provides a service to Kentucky Power, such as Appalachian Power providing assistance in distribution maintenance, generation engineering, or other affiliates providing assistance during storm recovery efforts. The second category, convenience payments, occurs when an affiliate company receives an invoice and the cost of that invoice should be borne by multiple AEP companies. For example, a legal invoice for a system-wide issue may be paid by one affiliate company, and that company then bills the other affiliates who benefit from the service.

Charges to/from affiliates are accumulated using a work order system. All affiliate services and convenience payments are billed to/from Kentucky Power at cost, per FERC affiliate requirements.

			TEST YEAR 12 MONTHS ENDED MARCH 2020		
Affiliate	FERC Account	Allocation Factor	Direct	Allocated	Total
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		3	3
	9200 - Administrative & Gen Salaries	58 - Total Assets		1,341	1,341
	9210 - Office Supplies and Expenses	58 - Total Assets		82	82
	9230 - Outside Services Employed	58 - Total Assets		0	0
	9250 - Injuries and Damages	61 - Total Fixed Assets		9	9
	9310 - Rents	48 - MW Generating Capability		(0)	(0)
AEP Generation Resources Total			267,072	2,276	269,348
AEP Service Corporation	1070 - Construction Work In Progress	39 - 100% to One Company	77,584		77,584
	1840 - Clearing Accounts	31 - Number of Vehicles		614	614
		63 - Total Gross Utility Plant		204	204
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		9	9
	9200 - Administrative & Gen Salaries	58 - Total Assets		5,066	5,066
	9210 - Office Supplies and Expenses	39 - 100% to One Company	8		8
		58 - Total Assets		308	308
	9230 - Outside Services Employed	58 - Total Assets		2	2
	9350 - Maintenance of General Plant	39 - 100% to One Company	22,985		22,985
AEP Service Corporation Total			100,576	6,202	106,779
AEP West Virginia Transmission Company, Inc.	1070 - Construction Work In Progress	39 - 100% to One Company	93,779		93,779
	1630 - Stores Expense Undistributed	58 - Total Assets		9	9
	1840 - Clearing Accounts	63 - Total Gross Utility Plant		633	633
	5600 - Oper Supervision & Engineering	58 - Total Assets		307	307
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		11	11
	9200 - Administrative & Gen Salaries	58 - Total Assets		5,911	5,911
	9210 - Office Supplies and Expenses	58 - Total Assets		361	361
	9230 - Outside Services Employed	58 - Total Assets		2	2
AEP West Virginia Transmission Company, Inc. Total			93,779	7,233	101,012
Ohio Power Company	1070 - Construction Work In Progress	39 - 100% to One Company	11,027		11,027
	1080 - Accum Prov for Deprec of Plant	39 - 100% to One Company	9		9
	1630 - Stores Expense Undistributed	39 - 100% to One Company	11,445		11,445
		58 - Total Assets		45	45
	1840 - Clearing Accounts	08 - Number of Electric Retail Cust		1,457	1,457
		31 - Number of Vehicles		642	642
		39 - 100% to One Company	3,184		3,184
		63 - Total Gross Utility Plant		3,941	3,941
	5600 - Oper Supervision & Engineering	58 - Total Assets		1	1
	5700 - Maint of Station Equipment	39 - 100% to One Company	607		607
	5860 - Meter Expenses	39 - 100% to One Company	1,352		1,352

Kentucky Power Company
Charges to Affiliates by FERC Account, Allocation Factor and Allocation Type
Test Year Ended March 2020

Kentucky Power has a variety of transactions with affiliates on a normal basis. Transactions with affiliates generally fall into two categories. The first category, service payments, is a billing made when an affiliate provides a service to Kentucky Power, such as Appalachian Power providing assistance in distribution maintenance, generation engineering, or other affiliates providing assistance during storm recovery efforts. The second category, convenience payments, occurs when an affiliate company receives an invoice and the cost of that invoice should be borne by multiple AEP companies. For example, a legal invoice for a system-wide issue may be paid by one affiliate company, and that company then bills the other affiliates who benefit from the service.

Charges to/from affiliates are accumulated using a work order system. All affiliate services and convenience payments are billed to/from Kentucky Power at cost, per FERC affiliate requirements.

			TEST YEAR 12 MONTHS ENDED MARCH 2020		
Affiliate	FERC Account	Allocation Factor	Direct	Allocated	Total
	5880 - Miscellaneous Distribution Exp	39 - 100% to One Company	10,479		10,479
		58 - Total Assets		345	345
	5930 - Maintenance of Overhead Lines	39 - 100% to One Company	983		983
	5940 - Maint of Underground Lines	39 - 100% to One Company	2		2
	5950 - Maint of Lne Trnf,Rglators&Dvi	39 - 100% to One Company	18		18
	9010 - Supervision - Customer Accts	08 - Number of Electric Retail Cust		248	248
	9050 - Misc Customer Accounts Exp	39 - 100% to One Company	(379)		(379)
	9120 - Demonstrating & Selling Exp	08 - Number of Electric Retail Cust		11,258	11,258
	9200 - Administrative & Gen Salaries	58 - Total Assets		31,892	31,892
	9210 - Office Supplies and Expenses	58 - Total Assets		2,175	2,175
	9230 - Outside Services Employed	58 - Total Assets		11	11
		61 - Total Fixed Assets		2,722	2,722
	9350 - Maintenance of General Plant	39 - 100% to One Company	168		168
Ohio Power Company Total			38,894	54,736	93,630
Indiana Michigan Power Company	1070 - Construction Work In Progress	39 - 100% to One Company	16,802		16,802
	1080 - Accum Prov for Deprec of Plant	39 - 100% to One Company	6		6
	1630 - Stores Expense Undistributed	58 - Total Assets		72	72
	1830 - Prelimin Surv&Investgtn Chrgs	39 - 100% to One Company	0		0
	1840 - Clearing Accounts	08 - Number of Electric Retail Cust		584	584
		31 - Number of Vehicles		369	369
		63 - Total Gross Utility Plant		5,140	5,140
	5000 - Oper Supervision & Engineering	48 - MW Generating Capability		2,188	2,188
	5060 - Misc Steam Power Expenses	40 - Equal Share Ratio		3,496	3,496
	5100 - Maint Supv & Engineering	48 - MW Generating Capability		976	976
	5120 - Maintenance of Boiler Plant	39 - 100% to One Company	1,625		1,625
	5130 - Maintenance of Electric Plant	39 - 100% to One Company	744		744
	5140 - Maintenance of Misc Steam Plt	40 - Equal Share Ratio		152	152
	5600 - Oper Supervision & Engineering	58 - Total Assets		0	0
	5860 - Meter Expenses	39 - 100% to One Company	250		250
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		219	219
	5930 - Maintenance of Overhead Lines	39 - 100% to One Company	61		61
	5940 - Maint of Underground Lines	39 - 100% to One Company	17		17
	5960 - Maint of Strt Lghtng & Sgnal S	39 - 100% to One Company	5		5
	9010 - Supervision - Customer Accts	08 - Number of Electric Retail Cust		100	100
	9120 - Demonstrating & Selling Exp	08 - Number of Electric Retail Cust		4,507	4,507
	9200 - Administrative & Gen Salaries	58 - Total Assets		49,462	49,462
	9210 - Office Supplies and Expenses	58 - Total Assets		3,124	3,124

Kentucky Power Company
Charges to Affiliates by FERC Account, Allocation Factor and Allocation Type
Test Year Ended March 2020

Kentucky Power has a variety of transactions with affiliates on a normal basis. Transactions with affiliates generally fall into two categories. The first category, service payments, is a billing made when an affiliate provides a service to Kentucky Power, such as Appalachian Power providing assistance in distribution maintenance, generation engineering, or other affiliates providing assistance during storm recovery efforts. The second category, convenience payments, occurs when an affiliate company receives an invoice and the cost of that invoice should be borne by multiple AEP companies. For example, a legal invoice for a system-wide issue may be paid by one affiliate company, and that company then bills the other affiliates who benefit from the service.

Charges to/from affiliates are accumulated using a work order system. All affiliate services and convenience payments are billed to/from Kentucky Power at cost, per FERC affiliate requirements.

			TEST YEAR 12 MONTHS ENDED MARCH 2020		
Affiliate	FERC Account	Allocation Factor	Direct	Allocated	Total
	9230 - Outside Services Employed	58 - Total Assets		17	17
		61 - Total Fixed Assets		1,270	1,270
	9310 - Rents	39 - 100% to One Company	0		0
		48 - MW Generating Capability		(1)	(1)
Indiana Michigan Power Company Total			19,511	71,677	91,188
AEP Texas Company	1070 - Construction Work In Progress	39 - 100% to One Company	514		514
	1080 - Accum Prov for Deprec of Plant	39 - 100% to One Company	14		14
	1630 - Stores Expense Undistributed	39 - 100% to One Company	172		172
		58 - Total Assets		51	51
	1840 - Clearing Accounts	08 - Number of Electric Retail Cust		1,024	1,024
		31 - Number of Vehicles		579	579
		39 - 100% to One Company	1,795		1,795
		58 - Total Assets		816	816
		63 - Total Gross Utility Plant		4,382	4,382
	5600 - Oper Supervision & Engineering	58 - Total Assets		987	987
	5860 - Meter Expenses	39 - 100% to One Company	1,532		1,532
	5880 - Miscellaneous Distribution Exp	39 - 100% to One Company	3,715		3,715
		58 - Total Assets		282	282
	5930 - Maintenance of Overhead Lines	39 - 100% to One Company	279		279
	9010 - Supervision - Customer Accts	08 - Number of Electric Retail Cust		175	175
	9120 - Demonstrating & Selling Exp	08 - Number of Electric Retail Cust		7,913	7,913
	9200 - Administrative & Gen Salaries	58 - Total Assets		35,215	35,215
	9210 - Office Supplies and Expenses	58 - Total Assets		2,323	2,323
	9230 - Outside Services Employed	58 - Total Assets		12	12
		61 - Total Fixed Assets		2,218	2,218
	9310 - Rents	39 - 100% to One Company	2		2
	9350 - Maintenance of General Plant	39 - 100% to One Company	27		27
AEP Texas Company Total			8,050	55,978	64,028
Southwestern Electric Power Company	1070 - Construction Work In Progress	39 - 100% to One Company	36		36
	1080 - Accum Prov for Deprec of Plant	39 - 100% to One Company	12		12
	1630 - Stores Expense Undistributed	39 - 100% to One Company	3,250		3,250
		58 - Total Assets		44	44
	1830 - Prelimin Surv&Investgtn Chrgs	39 - 100% to One Company	0		0
	1840 - Clearing Accounts	08 - Number of Electric Retail Cust		526	526
		31 - Number of Vehicles		366	366
		39 - 100% to One Company	(0)		(0)
		48 - MW Generating Capability		58	58

Kentucky Power Company
Charges to Affiliates by FERC Account, Allocation Factor and Allocation Type
Test Year Ended March 2020

Kentucky Power has a variety of transactions with affiliates on a normal basis. Transactions with affiliates generally fall into two categories. The first category, service payments, is a billing made when an affiliate provides a service to Kentucky Power, such as Appalachian Power providing assistance in distribution maintenance, generation engineering, or other affiliates providing assistance during storm recovery efforts. The second category, convenience payments, occurs when an affiliate company receives an invoice and the cost of that invoice should be borne by multiple AEP companies. For example, a legal invoice for a system-wide issue may be paid by one affiliate company, and that company then bills the other affiliates who benefit from the service.

Charges to/from affiliates are accumulated using a work order system. All affiliate services and convenience payments are billed to/from Kentucky Power at cost, per FERC affiliate requirements.

			TEST YEAR 12 MONTHS ENDED MARCH 2020		
Affiliate	FERC Account	Allocation Factor	Direct	Allocated	Total
		58 - Total Assets		292	292
		63 - Total Gross Utility Plant		4,280	4,280
	5000 - Oper Supervision & Engineering	48 - MW Generating Capability		4,465	4,465
	5060 - Misc Steam Power Expenses	40 - Equal Share Ratio		1,748	1,748
	5100 - Maint Supv & Engineering	48 - MW Generating Capability		1,996	1,996
	5110 - Maintenance of Structures	39 - 100% to One Company	981		981
	5120 - Maintenance of Boiler Plant	39 - 100% to One Company	4,132		4,132
	5130 - Maintenance of Electric Plant	39 - 100% to One Company	720		720
	5140 - Maintenance of Misc Steam Plt	39 - 100% to One Company	2,126		2,126
		40 - Equal Share Ratio		76	76
	5600 - Oper Supervision & Engineering	58 - Total Assets		352	352
	5830 - Overhead Line Expenses	39 - 100% to One Company	285		285
	5860 - Meter Expenses	39 - 100% to One Company	(69)		(69)
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		168	168
	5930 - Maintenance of Overhead Lines	39 - 100% to One Company	407		407
	9010 - Supervision - Customer Accts	08 - Number of Electric Retail Cust		90	90
	9120 - Demonstrating & Selling Exp	08 - Number of Electric Retail Cust		4,071	4,071
	9200 - Administrative & Gen Salaries	58 - Total Assets		30,172	30,172
	9210 - Office Supplies and Expenses	58 - Total Assets		1,933	1,933
	9230 - Outside Services Employed	58 - Total Assets		10	10
		61 - Total Fixed Assets		1,125	1,125
	9310 - Rents	39 - 100% to One Company	0		0
		48 - MW Generating Capability		(1)	(1)
Southwestern Electric Power Company Total			11,879	51,771	63,650
Public Service Company of Oklahoma	1070 - Construction Work In Progress	39 - 100% to One Company	847		847
	1630 - Stores Expense Undistributed	58 - Total Assets		27	27
	1840 - Clearing Accounts	08 - Number of Electric Retail Cust		546	546
		31 - Number of Vehicles		317	317
		58 - Total Assets		143	143
		63 - Total Gross Utility Plant		2,639	2,639
	5000 - Oper Supervision & Engineering	48 - MW Generating Capability		3,741	3,741
	5060 - Misc Steam Power Expenses	40 - Equal Share Ratio		1,748	1,748
	5100 - Maint Supv & Engineering	39 - 100% to One Company	6,017		6,017
		48 - MW Generating Capability		1,669	1,669
	5120 - Maintenance of Boiler Plant	39 - 100% to One Company	7,295		7,295
	5130 - Maintenance of Electric Plant	39 - 100% to One Company	453		453
	5140 - Maintenance of Misc Steam Plt	39 - 100% to One Company	2,901		2,901

Kentucky Power Company
Charges to Affiliates by FERC Account, Allocation Factor and Allocation Type
Test Year Ended March 2020

Kentucky Power has a variety of transactions with affiliates on a normal basis. Transactions with affiliates generally fall into two categories. The first category, service payments, is a billing made when an affiliate provides a service to Kentucky Power, such as Appalachian Power providing assistance in distribution maintenance, generation engineering, or other affiliates providing assistance during storm recovery efforts. The second category, convenience payments, occurs when an affiliate company receives an invoice and the cost of that invoice should be borne by multiple AEP companies. For example, a legal invoice for a system-wide issue may be paid by one affiliate company, and that company then bills the other affiliates who benefit from the service.

Charges to/from affiliates are accumulated using a work order system. All affiliate services and convenience payments are billed to/from Kentucky Power at cost, per FERC affiliate requirements.

			TEST YEAR 12 MONTHS ENDED MARCH 2020		
Affiliate	FERC Account	Allocation Factor	Direct	Allocated	Total
		40 - Equal Share Ratio		76	76
	5600 - Oper Supervision & Engineering	58 - Total Assets		172	172
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		180	180
	5930 - Maintenance of Overhead Lines	39 - 100% to One Company	457		457
	9010 - Supervision - Customer Accts	08 - Number of Electric Retail Cust		93	93
	9120 - Demonstrating & Selling Exp	08 - Number of Electric Retail Cust		4,216	4,216
	9200 - Administrative & Gen Salaries	58 - Total Assets		19,022	19,022
	9210 - Office Supplies and Expenses	58 - Total Assets		1,275	1,275
	9230 - Outside Services Employed	58 - Total Assets		6	6
		61 - Total Fixed Assets		1,507	1,507
	9310 - Rents	48 - MW Generating Capability		(1)	(1)
Public Service Company of Oklahoma Total			17,970	37,374	55,343
AEP Indiana Michigan Transmission Company, Inc.	1070 - Construction Work In Progress	39 - 100% to One Company	24,819		24,819
	1630 - Stores Expense Undistributed	39 - 100% to One Company	587		587
		58 - Total Assets		15	15
	1840 - Clearing Accounts	63 - Total Gross Utility Plant		1,050	1,050
	5600 - Oper Supervision & Engineering	58 - Total Assets		1	1
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		19	19
	9200 - Administrative & Gen Salaries	58 - Total Assets		10,065	10,065
	9210 - Office Supplies and Expenses	58 - Total Assets		614	614
	9230 - Outside Services Employed	58 - Total Assets		4	4
AEP Indiana Michigan Transmission Company, Inc. Total			25,406	11,767	37,173
Wheeling Power Company	1070 - Construction Work In Progress	39 - 100% to One Company	3,720		3,720
	1080 - Accum Prov for Deprec of Plant	39 - 100% to One Company	424		424
	1630 - Stores Expense Undistributed	58 - Total Assets		2	2
	1840 - Clearing Accounts	08 - Number of Electric Retail Cust		41	41
		31 - Number of Vehicles		26	26
		63 - Total Gross Utility Plant		170	170
	4263 - Penalties	39 - 100% to One Company	1,393		1,393
	4310 - Other Interest Expense	39 - 100% to One Company	1,976		1,976
	5600 - Oper Supervision & Engineering	58 - Total Assets		29	29
	5880 - Miscellaneous Distribution Exp	58 - Total Assets		15	15
	5930 - Maintenance of Overhead Lines	39 - 100% to One Company	20,600		20,600
	9010 - Supervision - Customer Accts	08 - Number of Electric Retail Cust		7	7
	9120 - Demonstrating & Selling Exp	08 - Number of Electric Retail Cust		314	314
	9200 - Administrative & Gen Salaries	58 - Total Assets		1,489	1,489
	9210 - Office Supplies and Expenses	58 - Total Assets		100	100

Kentucky Power Company
Charges to Affiliates by FERC Account, Allocation Factor and Allocation Type
Test Year Ended March 2020

Kentucky Power has a variety of transactions with affiliates on a normal basis. Transactions with affiliates generally fall into two categories. The first category, service payments, is a billing made when an affiliate provides a service to Kentucky Power, such as Appalachian Power providing assistance in distribution maintenance, generation engineering, or other affiliates providing assistance during storm recovery efforts. The second category, convenience payments, occurs when an affiliate company receives an invoice and the cost of that invoice should be borne by multiple AEP companies. For example, a legal invoice for a system-wide issue may be paid by one affiliate company, and that company then bills the other affiliates who benefit from the service.

Charges to/from affiliates are accumulated using a work order system. All affiliate services and convenience payments are billed to/from Kentucky Power at cost, per FERC affiliate requirements.

			TEST YEAR 12 MONTHS ENDED MARCH 2020		
Affiliate	FERC Account	Allocation Factor	Direct	Allocated	Total
	9230 - Outside Services Employed	58 - Total Assets		1	1
		61 - Total Fixed Assets		114	114
Wheeling Power Company Total			28,113	2,306	30,419
Other - Affiliates Grand Total Billings less than $25K Total	1070 - Construction Work In Progress	39 - 100% to One Company	2,663		2,663
	1630 - Stores Expense Undistributed	40 - Equal Share Ratio		7	7
		58 - Total Assets		62	62
	1840 - Clearing Accounts	08 - Number of Electric Retail Cust		47	47
		31 - Number of Vehicles		61	61
		40 - Equal Share Ratio		244	244
		58 - Total Assets		742	742
		63 - Total Gross Utility Plant		4,226	4,226
	1860 - MDD-Internal Billing Only	58 - Total Assets		141	141
	4010 - Operation Expense	39 - 100% to One Company	5,248		5,248
	4264 - Civic & Political Activities	39 - 100% to One Company	6,838		6,838
	5000 - Oper Supervision & Engineering	39 - 100% to One Company	557		557
	5570 - Other Expenses	39 - 100% to One Company	208		208
	5600 - Oper Supervision & Engineering	58 - Total Assets		920	920
	5880 - Miscellaneous Distribution Exp	40 - Equal Share Ratio		10	10
		58 - Total Assets		59	59
	9010 - Supervision - Customer Accts	08 - Number of Electric Retail Cust		8	8
	9120 - Demonstrating & Selling Exp	08 - Number of Electric Retail Cust		365	365
	9200 - Administrative & Gen Salaries	39 - 100% to One Company	14,394		14,394
		40 - Equal Share Ratio		4,686	4,686
		58 - Total Assets		40,844	40,844
	9210 - Office Supplies and Expenses	39 - 100% to One Company	887		887
		40 - Equal Share Ratio		276	276
		58 - Total Assets		2,504	2,504
	9230 - Outside Services Employed	40 - Equal Share Ratio		2	2
		58 - Total Assets		14	14
		61 - Total Fixed Assets		86	86
	9310 - Rents	39 - 100% to One Company	2		2
		40 - Equal Share Ratio		1	1
Other - Affiliates Grand Total Billings less than $25K Total Total			30,796	55,307	86,103
Grand Total			1,916,346	476,621	2,392,966

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_42 Describe the utility's lobbying activities and provide a schedule showing the name, salary, and job title of each individual whose job function involves lobbying on the local, state, or national level.

RESPONSE

Kentucky Power Company monitors state and local legislative issues that may affect Kentucky Power or its customers. As issues emerge, a corporate strategy is developed in concert with AEP headquarters in Columbus to assure alignment with the other states in which AEP operates. Amy Elliott, External Affairs manager, monitors the activities at the state level. Most of Ms. Elliott's efforts with elected officials are education-related. AEP has a Federal Affairs office in Washington, D.C. responsible for lobbying activities at the national level, and Kentucky Power receives an allocation of those expenses.

During the test year period, 2.4% of Ms. Elliott's salary was directly charged to Account 426.4 (Civic & Political Activities). Please see KPCO_R_KPSC_2_42_Confidential Attachment1.

Approximately 5.15% of the costs associated with the AEPSC Federal Affairs office in Washington, D.C. or $104,033 (includes $42,275 in labor costs) were allocated to Kentucky Power by AEPSC for federal lobbying activities. The costs were allocated using the total asset allocation factor established in the Company's Cost Allocation Manual.

Witness: Deryle B. Mattison

Registered Lobbyist	Annual Salary	Lobbying Wages
Amy Elliott	[redacted]	

DATA REQUEST

KPSC 2_43 Regarding demand-side management, conservation, and energy-efficiency programs, provide the following:

a. A list of all programs currently offered by the utility.
b. The total cost incurred for these programs by the utility in each of the three most recent calendar years.
c. The total energy and demand reductions realized through these programs in each of the three most recent calendar years.
d. The total cost for these programs included in the historical test period and expected energy reductions to be realized from these programs.

RESPONSE

a.

Targeted Energy Efficiency

b.

The total expenses, total energy and demand reductions in 2017 and 2018 include programs that were discontinued by Commission order in 2018. Total program expenditures, excluding lost revenue and incentive payments, were:

Year 2017: $5,875,294
Year 2018: $1,113,236
Year 2019: $284,800

c.
Year 2017
Energy kWh: 24,372,823
Demand KW: 2,271
Year 2018
Energy kWh: 2,780,508
Demand KW: 569
Year 2019
Energy kWh: 195,188
Demand KW: 63

d.
Test year: $278,937
Energy kWh: 178,694
Demand KW: 59

Witness: Scott E. Bishop

DATA REQUEST

KPSC 2_44 Provide the following tax data for the most recent calendar year:

a. Income taxes;
(1) Federal operating income taxes deferred – accelerated tax depreciation;
(2) Federal operating income taxes deferred other (explain);
(3) Federal income taxes – operating;
(4) Income credits resulting from prior deferrals of federal income taxes;
(5) Investment tax credit net;
(a) Investment credit realized;
(b) Investment credit amortized – Revenue Act of 1971;
(6) The information in Item 44(a)(1–5) for state income taxes;
(7) A reconciliation of book to taxable income as shown in Schedule M1 and a calculation of the book federal and state income tax expense for the test year using book taxable income as the starting point;
(8) A reconciliation of book to taxable income as shown in Schedule M2 and a calculation of the book federal and state income tax expense for the test year using book taxable income as the starting point;
(9) A copy of federal and state income tax returns for the taxable year ended during the test year, including supporting schedules; and
(10) A schedule of franchise fees paid to cities, towns, or municipalities, including the basis of these fees.

An analysis of other operating taxes as shown in Schedule J.

RESPONSE

a. (1) Please refer to KPCO_R_KPSC_2_44_Attachment1.xlsx, tab DFIT-Per Books as Adjusted for the requested 2019 calendar year information.
(2) Please refer to KPCO_R_KPSC_2_44_Attachment1.xlsx, tab DFIT-Per Books as Adjusted for the requested 2019 calendar year information.

(3) Please refer to KPCO_R_KPSC_2_44_Attachment1.xlsx, tab CFIT Schedules for the requested 2019 calendar year information.
(4) Please refer to KPCO_R_KPSC_2_44_Attachment1.xlsx, tab DFIT-Per Books as Adjusted for the requested 2019 calendar year information.
(5) (a) There is no Current Investment Tax Credit available or realized during 2019 calendar year.
(b) Please refer to KPCO_R_KPSC_2_44_Attachment1.xlsx, tab DFIT-Per Books as Adjusted, line 260 for the requested 2019 calendar year information.
(6) Please refer to KPCO_R_KPSC_2_44_Attachment1.xlsx, tab SIT Schedules for the requested 2019 calendar year information.
(7) Please refer to Section V, Exhibit 3, tabs CFIT and SIT Schedules for the requested test period information.
(8) Please refer to KPCO_R_KPSC_2_44_Attachment1.xlsx, tab Schedule M-2 for the requested 2019 calendar year information.
(9) Federal and state income tax returns for the 2019 taxable year are not yet available as they are not filed until the last quarter of 2020. Please refer to KPCO_R_KPSC_2_44_ConfidentialAttachment2.pdf for the requested 2018 Federal Tax Return and KPCO_R_KPSC_2_44_ConfidentialAttachment3.pdf for the requested 2018 Kentucky State Tax Return.
(10) Please refer to KPCO_R_KPSC_2_44_Attachment4.xls for the requested 2019 calendar year information.
b. Please refer to KPCO_R_KPSC_2_44_Attachment5.xlsx for the requested 2019 calendar year information.

Witness: Allyson L. Keaton

Documents redacted in their entirety

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_45 Provide the following information with regard to uncollectible accounts for the test year and three preceding calendar years (taxable year acceptable):

a. Reserve account balance at the beginning of the year;
b. Charges to reserve account (accounts charged off);
c. Credits to reserve account;
d. Current year provision;
e. Reserve account balance at the end of the year; and
f. Percent of provision to total revenue.

RESPONSE

Please refer to KPCO_R_KPSC_2_45_Attachment1 for the requested information. Kentucky Power factors its electric receivables; therefore, Kentucky Power does not maintain a reserve for these uncollectible accounts and the attached information includes receivables due the utility for transactions other than electric services.

Witness: Heather M. Whitney

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_46 Provide a detailed analysis of expenses incurred during the test year for professional services, as shown in Schedule K, and all workpapers supporting the analysis. At a minimum, the workpapers should show the payee, dollar amount, reference (i.e., voucher no., etc.), account charged, hourly rates and time charged to the company according to each invoice, and a description of the services provided.

RESPONSE

Please refer to KPCO_R_KPSC_2_46_Attachment1 for the requested information. See also Section II, Exhibit U, included in the Company's Application.

Witness: Brian K. West

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_47 Provide the following information for the utility. If any amounts were allocated, show a calculation of the factor used to allocate each amount.

a. A detailed analysis of all charges booked during the test year for advertising expenditures. Include a complete breakdown of Account No. 913 – Advertising Expenses and any other advertising expenditures included in any other expense accounts, as shown in Schedule L1. The analysis should specify the purpose of the expenditure and the expected benefit to be derived.
b. An analysis of Account No. 930 – Miscellaneous General expenses for the test year. Include a complete breakdown of this account as shown in Schedule 30b and provide detailed workpapers supporting this analysis. At a minimum, the workpapers should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule L2.
c. An analysis of Account No. 426 – Other Income Deductions for the test year. Include a complete breakdown of this account as show in Schedule 30c, and provide detailed workpapers supporting this analysis. At a minimum, the workpapers should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and brief description of each expenditure of $500 or more provided that lesser items are grouped by classes as shown in Schedule L3.

RESPONSE

a. Please see KPCO_R_KPSC_2_47_Attachment1 for the requested information.
b. Please see KPCO_R_KPSC_2_47_Attachment2 for the requested information.
c. Please see KPCO_R_KPSC_2_47_Attachment3 for the requested information.

Witness: Heather M. Whitney

Witness: Lerah M. Scott

Kentucky Power Company
KPSC Case No. 2020-00174
Commission Staff's Second Set of Data Requests
Order Dated June 30, 2020

DATA REQUEST

KPSC 2_48 Provide any information, when known, that would have a material effect on net operating income, rate base, or cost of capital that have occurred after the test year but were not incorporated in the filed testimony and exhibits.

RESPONSE

On June 19, 2020, Kentucky Power refinanced $65 million of WVEDA Mitchell Project, Series 2014A Bonds. Although that transaction occurred after the end of the test year, it was incorporated in the Company's Application and the testimony of Company Witness Messner in this case.
Kentucky Power will update this response if any information responsive to this request becomes known to it in the future.

Witness: Brian K. West

VERIFICATION

The undersigned, D. Brett Mattison, being duly sworn, deposes and says he is President & COO of Kentucky Power Company that he has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of his information, knowledge and belief after reasonable inquiry.

D. Brett Mattison

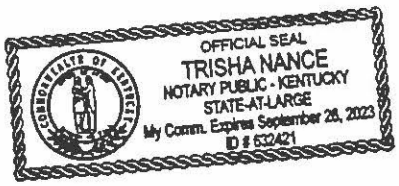
D. Brett Mattison

COMMONWEALTH OF KENTUCKY)
) Case No. 2020-00174
COUNTY OF BOYD)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by D. Brett Mattison, this 20 day of July 2020.

Trisha Nance

Notary Public



Notary ID Number: 632421

My Commission Expires: 9-26-2023

VERIFICATION

The undersigned, Brian K. West, being duly sworn, deposes and says he is Director Regulatory Services for Kentucky Power Company that he has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of his information, knowledge and belief after reasonable inquiry.

Brian K. West

State of Indiana)
) ss Case No. 2020-00174
County of Allen)

Subscribed and sworn to before me, a Notary Public, in and for said County and State, Brian K. West this 20th day of July, 2020.

Regiana M. Sistevaris

Digitally signed by Regiana M. Sistevaris
Date: 2020.07.20 07:11:56 -04'00'

Regiana M. Sistevaris, Notary Public

My Commission Expires: January 7, 2023

docVerify

KY Discovery Verification - Alex Vaughan.docx

DocVerify ID:	64666E61-85A0-410F-B932-157685E19E72
Created:	July 20, 2020 06:51:55 -8:00
Pages:	1
Remote Notary:	Yes / State: OH

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E-Signature Summary

E-Signature 1: Alex E Vaughan (AEV)
July 20, 2020 10:07:56 -8:00 [14DED881C04E] [184.62.110.67]
aevaughan@aep.com (Principal) (Personally Known)

E-Signature Notary: Brenda Williamson (BW)
July 20, 2020 10:07:56 -8:00 [A9F0F52446C1] [161.235.221.84]
bgwilliamson@aep.com
I, Brenda Williamson, did witness the participants named above electronically sign this document.

VERIFICATION

The undersigned, Alex E. Vaughan, being duly sworn, deposes and says he is a Director-Regulatory Pricing & Renewables for American Electric Power Service Corporation that he has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of his information, knowledge and belief after reasonable inquiry.

Alex E Vaughan
Signed on 2020/07/20 10:07:56 -8:00
Alex E. Vaughan

STATE OF OHIO)
) Case No. 2020-00174
COUNTY OF FRANKLIN)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by 07/20/2020, this ____ day of July 2020.

Brenda G. Williamson
Signed on 2020/07/20 10:07:56 -8:00

N

No

My

NOTARY PUBLIC STATE OF OHIO

Brenda G. Williamson
Commission # 2016-RE-579446
Electronic Notary Public
State of Ohio
My Comm Exp. Apr 25, 2021

Notary Stamp 2020/07/20 10:07:56 PST A9F0F52446C1

KY Discovery Verification - Heather Whitney.docx

DocVerify ID:	6F4C0A0E-0E15-4391-B9A5-CA4F60ED2A6C
Created:	July 20, 2020 07:12:39 -8:00
Pages:	1
Remote Notary:	Yes / State: OH

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E-Signature Summary

E-Signature 1: Heather M. Whitney (HMW)
July 20, 2020 10:23:05 -8:00 [C53C0E8B7882] [161.235.221.83]
hmwhitney@aep.com (Principal) (Personally Known)

E-Signature Notary: Brenda Williamson (BW)
July 20, 2020 10:23:05 -8:00 [8DF3BF6DBF2E] [161.235.221.84]
bgwilliamson@aep.com
I, Brenda Williamson, did witness the participants named above electronically sign this document.

VERIFICATION

The undersigned, Heather M. Whitney, being duly sworn, deposes and says she is the Director in Regulatory Accounting Services for American Electric Power Service Corporation that she has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of her information, knowledge and belief after reasonable inquiry.

Heather M. Whitney
Signed on 2020/07/20 10:23:05 -8:00

Heather M. Whitney

STATE OF OHIO)
) Case No. 2020-00174
COUNTY OF FRANKLIN)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by 07/20/2020, this ____ day of July 2020.

Brenda G Williamson
Signed on 2020/07/20 10:23:05 -8:00

Notary Public

NOTARY PUBLIC STATE OF OHIO

Brenda G. Williamson
Commission # 2016-RE-579446
Electronic Notary Public
State of Ohio
My Comm Exp. Apr 25, 2021

Notary Stamp 2020/07/20 10:23:05 PST 8DF3BF6DBF2E

VERIFICATION

The undersigned, Lerah M. Scott, being duly sworn, deposes and says she is a Regulatory Consultant for Kentucky Power Company that she has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of her information, knowledge and belief after reasonable inquiry.

Lerah M. Scott

COMMONWEALTH OF KENTUCKY)
) Case No. 2020-00174
COUNTY OF BOYD)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by Lerah M. Scott, this 20 day of July 2020.

Trisha Nance
Notary Public

Notary ID Number: 632421

My Commission Expires: 9-26-2023

OFFICIAL SEAL
TRISHA NANCE
NOTARY PUBLIC - KENTUCKY
STATE-AT-LARGE
My Comm. Expires September 26, 2023
ID # 632421

VERIFICATION

The undersigned, Everett G. Phillips, being duly sworn, deposes and says he is Vice President of Distribution Region Operations for Kentucky Power Company that he has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of his information, knowledge and belief after reasonable inquiry.

Everett G. Phillips

Everett G. Phillips

COMMONWEALTH OF KENTUCKY)
) Case No. 2020-00174
COUNTY OF BOYD)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by Everett G. Phillips, this 20 day of July 2020.

Trisha Nance

Notary Public

Notary ID Number: 632421

My Commission Expires: 9-26-2023

OFFICIAL SEAL
TRISHA NANCE
NOTARY PUBLIC - KENTUCKY
STATE-AT-LARGE
My Comm. Expires September 26, 2023
ID # 632421

KY Discovery Verification - Kim Kaiser.docx

DocVerify ID:	FC76DC3E-C14C-4472-B937-873D39121D12
Created:	July 20, 2020 08:32:30 -8:00
Pages:	1
Remote Notary:	Yes / State: OH

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E-Signature Summary

E-Signature 1: Kimberly K Kaiser (KK)
July 20, 2020 09:07:23 -8:00 [D2DCA1345318] [161.235.221.80]
kkkaiser@aep.com (Principal) (Personally Known)

E-Signature Notary: Brenda Williamson (BW)
July 20, 2020 09:07:23 -8:00 [3CDADAF325D0] [161.235.221.84]
bgwilliamson@aep.com
I, Brenda Williamson, did witness the participants named above electronically sign this document.

VERIFICATION

The undersigned, Kimberly Kaiser, being duly sworn, deposes and says she is Director of Compensation for American Electric Power Service Corporation that she has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of her information, knowledge and belief after reasonable inquiry.

Signed on 2020/07/20 09:07:23 -8:00

Kimberly Kaiser

STATE OF OHIO)
) Case No. 2020-00174
COUNTY OF FRANKLIN)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by 07/20/2020, this ____ day of July 2020.

Signed on 2020/07/20 09:07:23 -8:00

Notary Public

Brenda G. Williamson
Commission # 2016-RE-579446
Electronic Notary Public
State of Ohio
My Comm Exp. Apr 25, 2021

Notary Stamp 2020/07/20 09:07:23 PST 3CDADAF325D0

KY Discovery Verification - Jaclyn Cost.docx

DocVerify ID:	49053971-D5D8-4047-9B22-3415B6555F07
Created:	July 20, 2020 08:51:29 -8:00
Pages:	1
Remote Notary:	Yes / State: OH

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E-Signature Summary

E-Signature 1: Jaclyn N Cost (JC)
July 20, 2020 12:34:42 -8:00 [61FC351D24D4] [161.235.2.86]
jncost1@aep.com (Principal) (Personally Known)

E-Signature Notary: Brenda Williamson (BW)
July 20, 2020 12:34:42 -8:00 [DD5118799482] [161.235.221.84]
bgwilliamson@aep.com
I, Brenda Williamson, did witness the participants named above electronically sign this document.

VERIFICATION

The undersigned, Jaclyn N. Cost, being duly sworn, deposes and says she is a Regulatory Consultant Sr. for American Electric Power Service Corporation that she has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of her information, knowledge and belief after reasonable inquiry.

Jaclyn N Cost
Signed on 2020/07/20 12:34:42 -8:00

Jaclyn N. Cost

STATE OF OHIO)
) Case No. 2020-00174
COUNTY OF FRANKLIN)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by _____, this ____ day of July 2020.

07/20/2020

Brenda G Williamson
Signed on 2020/07/20 12:34:42 -8:00

NOTARY PUBLIC
STATE OF OHIO

Brenda G. Williamson
Commission # 2016-RE-579446
Electronic Notary Public
State of Ohio
My Comm Exp. Apr 25, 2021

Notary Stamp 2020/07/20 12:34:42 PST DD5118799482

KY Discovery Verification - Messner.docx

DocVerify ID:	B1E75312-DA60-4F8A-839B-D5FA1A97D34E
Created:	July 20, 2020 08:10:35 -8:00
Pages:	1
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E-Signature Summary

E-Signature 1: Franz Messner (FDM)
July 20, 2020 10:33:26 -8:00 [8970F1CE244C] [167.239.2.88]
fdmessner@aep.com (Principal) (Personally Known)

E-Signature Notary: Brenda Williamson (BW)
July 20, 2020 10:33:26 -8:00 [9E8BAD22D195] [161.235.221.84]
bgwilliamson@aep.com
I, Brenda Williamson, did witness the participants named above electronically sign this document.

VERIFICATION

The undersigned, Franz D. Messner, being duly sworn, deposes and says he is a Managing Director of Corporate Finance for American Electric Power Service Corporation that he has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of his information, knowledge and belief after reasonable inquiry.

Franz Messner
Signed on 2020/07/20 10:33:26 -8:00
Franz D. Messner

STATE OF OHIO)
) Case No. 2020-00174
COUNTY OF FRANKLIN)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by _____, this ____ day of July 2020.

07/20/2020

Brenda G Williamson
Signed on 2020/07/20 10:33:26 -8:00

NOTARY PUBLIC STATE OF OHIO

Brenda G. Williamson
Commission # 2016-RE-579446
Electronic Notary Public
State of Ohio
My Comm Exp. Apr 25, 2021

Notary Stamp 2020/07/20 10:33:26 PST 9E8BAD22D195

docVerify

KY Discovery Verification - Jason Stegall.docx

DocVerify ID:	93068482-DC86-427A-989B-A86046683B31
Created:	July 20, 2020 07:15:18 -8:00
Pages:	1
Remote Notary:	Yes / State: OH

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E-Signature Summary

E-Signature 1: Jason M. Stegall (JMS)
July 20, 2020 13:17:55 -8:00 [3662B5326110] [161.235.2.88]
jmstegall@aep.com (Principal) (Personally Known)

E-Signature Notary: Brenda Williamson (BW)
July 20, 2020 13:17:55 -8:00 [4B169D4DD20A] [161.235.221.84]
bgwilliamson@aep.com
I, Brenda Williamson, did witness the participants named above electronically sign this document.

VERIFICATION

The undersigned, Jason M. Stegall, being duly sworn, deposes and says he is a Manager-Regulatory Pricing & Analysis for American Electric Power Service Corporation that he has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of his information, knowledge and belief after reasonable inquiry.

Signed on 2020/07/20 13:17:55 -8:00

Jason M. Stegall

STATE OF OHIO)
) Case No. 2020-00174
COUNTY OF FRANKLIN)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by 07/20/2020, this ____ day of July 2020.

Signed on 2020/07/20 13:17:55 -8:00

NOTARY PUBLIC STATE OF OHIO

Brenda G. Williamson
Commission # 2016-RE-579446
Electronic Notary Public
State of Ohio
My Comm Exp. Apr 25, 2021

Notary Stamp 2020/07/20 13:17:55 PST 4B169D4DD20A

KY Discovery Verification - Allyson Keaton.docx

DocVerify ID:	5B6397AE-1CF9-40DE-9F7C-B0C4A48A478D
Created:	July 20, 2020 08:26:01 -8:00
Pages:	1
Remote Notary:	Yes / State: OH

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E-Signature Summary

E-Signature 1: Allyson Keaton (M)
July 20, 2020 11:06:18 -8:00 [6CA1298161F7] [161.235.221.82]
alkeaton@aep.com (Principal) (Personally Known)

E-Signature Notary: Brenda Williamson (BW)
July 20, 2020 11:06:18 -8:00 [36412AA5DAD5] [161.235.221.84]
bgwilliamson@aep.com
I, Brenda Williamson, did witness the participants named above electronically sign this document.

VERIFICATION

The undersigned, Allyson M. Keaton, being duly sworn, deposes and says she is a Tax Analyst Principle for American Electric Power Service Corporation that she has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of her information, knowledge and belief after reasonable inquiry.

Signed on 2020/07/20 11:06:18 -8:00

Allyson M. Keaton

STATE OF OHIO)
) Case No. 2020-00174
COUNTY OF FRANKLIN)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by __07/20/2020 ____, this ____ day of July 2020.

Signed on 2020/07/20 11:06:18 -8:00

Notary Public

N

M

NOTARY PUBLIC STATE OF OHIO

Brenda G. Williamson
Commission # 2016-RE-579446
Electronic Notary Public
State of Ohio
My Comm Exp. Apr 25, 2021

Notary Stamp 2020/07/20 11:06:18 PST 36412AA5DAD5

KY Discovery Verification - Scott Bishop.docx

DocVerify ID:	1E5E0E75-3053-4C16-8B36-6D3556C8645E
Created:	July 20, 2020 07:49:55 -8:00
Pages:	1
Remote Notary:	Yes / State: OH

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E-Signature Summary

E-Signature 1: Scott E. Bishop (SEB)
July 20, 2020 12:07:54 -8:00 [BCDACDB48CC9] [161.235.2.87]
sebishop@aep.com (Principal) (Personally Known)

E-Signature Notary: Brenda Williamson (BW)
July 20, 2020 12:07:54 -8:00 [683B491419BA] [161.235.221.84]
bgwilliamson@aep.com
I, Brenda Williamson, did witness the participants named above electronically sign this document.

VERIFICATION

The undersigned, Scott E. Bishop, being duly sworn, deposes and says he is a Regulatory Consultant Senior for Kentucky Power Company, that he has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of his information, knowledge and belief after reasonable inquiry.

Scott E. Bishop

COMMONWEALTH OF KENTUCKY)
) Case No. 2020-00174
COUNTY OF BOYD)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by Scott E. Bishop, this ____ day of July 2020.

07/20/2020

Notary Public

Brenda G. Williamson
Commission # 2016-RE-579446
Electronic Notary Public
State of Ohio
My Comm Exp. Apr 25, 2021

VERIFICATION

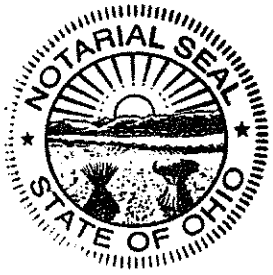
The undersigned, Andrew R. Carlin, being duly sworn, deposes and says he is a Director of Compensation and Executive Benefits for American Electric Power Service Corporation that he has personal knowledge of the matters set forth in the forgoing responses and the information contained therein is true and correct to the best of his information, knowledge and belief after reasonable inquiry.

Andrew R. Carlin

Andrew R. Carlin

STATE OF OHIO)
) Case No. 2020-00174
COUNTY OF FRANKLIN)

Subscribed and sworn to before me, a Notary Public in and before said County and State, by Andrew R. Carlin, this 20th day of July 2020.



Notary Public, State of Ohio
My Commission Expires
October 1, 2021

Cheryl L. Stevenson

Notary Public

Notary ID Number: 16-RE-608318

My Commission Expires: 10/01/2021