PPL Retiree Health Plan
Summary Plan Description
(For PPL Bargaining Unit Retirees Retiring on or After April 1, 1993)

January 2018

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Introduction

This document summarizes the main plan provisions of the PPL Corporation (PPL) Retiree Health Plan ("The Plan") for Retired Bargaining Unit Employees hired prior to July 1, 2014, represented by IBEW Local 1600, who retire from:

- PPL Electric Utilities Corporation
- PPL EU Services Corporation
- PPL Services Corp.
- PPL Global, LLC
- PPL TransLink, Inc.
- PPL Strategic Development, LLC

It also describes the benefits as they apply to retirees who retired prior to July 1, 2016 from the following former PPL companies.

- PPL Solutions, LLC

It also describes the benefits as they apply to retirees who retired prior to June 1, 2015 from the following former PPL companies.

- PPL EnergyPlus, LLC
- PPL Generation, LLC
- PPL Brunner Island, LLC
- PPL Holtwood, LLC
- Lower Mount Bethel Energy, LLC
- PPL Martins Creek, LLC
- PPL Montour, LLC
- PPL Susquehanna, LLC
- PPL Interstate Energy Company
- PPL Energy Services Group, LLC
- PPL Energy Suppy, LLC
- PPL EnergyPlus Retail, LLC

Overview

Medical care is one of our most expensive and basic needs. When you are sick or injured, you need access to medical care that you can afford. The PPL Retiree Health Plan for Bargaining Unit Retirees has been designed to provide valuable protection to help you meet the cost of medical care when you or a covered family member is ill or injured.

The medical options available to you and your qualified dependent(s) are based on Medicare eligibility, which generally takes place at age 65, but may occur earlier. It is important for you to know that medical coverage will change when you and/or a dependent(s) becomes eligible for Medicare.

This is a Summary Plan Description of medical and prescription drug coverage for eligible bargaining unit retirees and provides a description of the benefits under the Plan as well as the current rules on

eligibility and other administrative procedures. However, it does not provide all the details of the Plan. These can be found in the plan documents and/or official contracts.

In the case of any conflict between the descriptions contained in this summary and the provisions of the plan document and/or official contracts, the document and/or contracts will govern.

To the extent that this summary provides any description of Social Security or Medicare benefits, it is intended only as an outline of current law and in no way represents authoritative legal advice. If you have any questions about Social Security or Medicare benefits, please contact the local Social Security Administration or your personal legal advisor.

If you are not eligible for Medicare

Your medical and prescription drug coverage provided is similar to the plan that currently covers eligible active PPL Bargaining Unit employees. You and the Company share in the cost of coverage with each paying a portion of the total cost. The portion you pay depends on a variety of factors, including your covered dependents and the coverage option you select.

You may select any eligible doctor or hospital for medical treatment. The amount of your benefit depends on whether you use in-network or out-of-network providers. You get the highest level of benefits when you use in-network providers because you cannot be billed for amounts in excess of the allowable charge. The Plan provides coverage for out-of-network care, but you get a lower level of benefits and you must pay the difference between the Usual, Customary and Reasonable (UCR) allowance and the provider's charge. If you are enrolled in the PPO options, the prescription drug program allows you to pay a copayment when you use a participating retail pharmacy or Express Scripts mail-order.

You may change or waive your coverage election at annual enrollment or if you lose other coverage, or experience a qualified status change. As long as you remain eligible, you will not lose your PPL coverage if you elect to waive your coverage under the Plan for a period of time during retirement.

If you are eligible for Medicare

When you become eligible for Medicare, Medicare is the primary payer of benefits and pays most of your medical expenses. If you are eligible, your group health coverage with PPL will end. At this time you will work with OneExchange or the Aon Retiree Health Exchange who will assist you in selecting and enrolling in an individual medical and an individual prescription drug plan.

Pre-65, Non-Medicare Eligible Retirees

Eligibility Employees hired before July 1, 2014 are eligible for pre-65 (non medicare) Retiree Medical

For all purposes of this Plan, the term "retire" and "retirement" means to terminate employment with all PPL companies and to elect to commence immediately your monthly annuity benefits under a PPL retirement plan. If you terminate employment before you are eligible to commence the payment of your monthly annuity, or you elect to postpone the commencement of monthly annuity payments, you would be ineligible under this Plan. A "retiree" is an active employee who has chosen to retire. Displacement, severance, or layoff provisions of your collective bargaining agreement may make specific exceptions to this general rule and will be followed if applicable

You are eligible to continue your medical coverage after you retire if you are an eligible Bargaining Unit retiree of PPL (also referred to as the Company) or any of its subsidiary companies that participate in the Plan.

Note: Your coverage will end on the first day of the month that you become eligible for Medicare (whether or not you enroll in Medicare).

Service

For purposes of eligibility for retiree medical coverage, service is generally defined as:

- Your term of employment with the Company while you are participating in the PPL Retirement Plan and
- An adjustment to your service for any period of employment that you work for a PPL Company that participates in the Retiree Medical Program but does not participate in the PPL Retirement Plan.

Dependents

Your eligible dependents are eligible to participate in the option you select, provided you enroll them.

Eligible dependents include:

- Your legally married spouse
- Your child(ren) up to age 26. This includes:
  - Natural and legally adopted children and children placed with you for adoption;
  - Stepchildren;
  - Any child for whom you or your spouse is a court-appointed legal guardian;
  - Any other child with whom you or your married spouse maintain a parent-child relationship and have a legal guardianship;
- Your dependent child(ren) over age 26, provided the child is incapable of self-support because of physical or mental disability that occurred prior to their attaining age 26.

This Plan has been carefully designed to maximize benefits for eligible PPL retirees, with optimum efficiency, coverage, and cost containment. For the Plan to operate for the benefit of all concerned, retirees and their dependents are required to abide by the terms of eligibility and rules of coverage. Any attempt by a retiree or dependent to obtain benefits not intended to be provided herein will result in the ineligibility of the offending person for further coverage, as well as possible legal liability for the cost of claims erroneously paid.

Following are examples of abuses that will result in ineligibility for future benefits and possible legal liability: enrolling ineligible dependents, failing to remove dependents who have become ineligible, changing doctors or pharmacies solely to avoid limitations, making false or misleading claims, failing to correct claims information you have been asked to verify.

Joining the Plan

When you retire, you may elect or waive medical and prescription drug coverage. This election will remain in effect from year to year unless you elect to change or terminate it during an open enrollment, due to a qualified change in status or when you become entitled to Medicare.

If your dependent is not eligible for Medicare when you are (or visa versa), coverage will continue under the pre-Medicare plan for the individual who is not eligible to enroll in Medicare and the Medicare-eligible person will enroll through OneExchange or the Aon Retiree Health Exchange for medical and prescription drug coverage.

Enrollment

If you are eligible for retiree medical coverage, you will need to complete your enrollment. You will elect your coverage option- individual or family coverage and designate which dependent(s) are to be covered by the Plan. When you confirm your enrollment choices, you will also agree to pay the required contribution, if any.

You may waive your coverage and re-enroll during open enrollment or if you have a change in status.

When Coverage Begins

Unless you choose to waive your coverage, coverage begins on the first day of the month of your retirement and coverage for your dependent(s) will generally take effect on the same date as your own.

If you choose to waive your coverage and re-enroll at a later date, your coverage will begin on the day of the qualifying event or January 1st of the following year, if you enrolled during annual open enrollment.

When Coverage Ends

Your coverage as a retiree will continue until:

- You are no longer eligible for benefits;
- You neglect to pay the required contributions;
- The PPL Retiree Medical Plan is terminated by the Company;
- You elect to revoke your election;
- You become eligible for Medicare and you are no longer eligible for the pre-Medicare retiree medical coverage; or
- You die.

Coverage for your eligible dependent(s) stop on the last day of the month in which:

- You neglect to pay the required contributions;
- Your dependent(s) no longer meets the terms of eligibility;
- You elect to stop dependent coverage;
- Your coverage terminates;
- PPL terminates dependent coverage under this medical plan;
- Your dependent dies; or
- You fail to provide documentation to verify dependent eligibility.

COBRA Continuation of Coverage

According to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), your spouse and your covered dependent children are eligible to continue group health care coverage if benefits are lost under certain circumstances (called "qualifying events"). You will be required to pay the full cost of coverage plus an administrative fee.

Under a federal law called "COBRA," eligible dependents under the Plan who are the spouse, former spouse or dependent child of a participant may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or a dependent child ceasing to be an eligible dependent. These are called "qualifying events."

Note that the eligible dependents are required to notify the Plan Administrator in writing of a divorce or a dependent child losing dependent status within 31 days of the event or they will lose the right to continue coverage under the Plan.

If an eligible dependent elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify eligible dependents of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date the eligible dependent becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary.

Survivor Continuation Coverage

Eligible surviving spouses and dependents of retired employees may be eligible to continue coverage under the Plan at full cost of the plan. HRA contributions cease upon the death of the retiree.

Cost

You and the Company share in the cost of your coverage during retirement. PPL has set a cap that limits to the maximum amount PPL pays toward the cost of medical coverage. Once annual retiree medical plan costs exceed these defined caps, retirees are required to pay the amount of plan costs in excess of the cap as a contribution toward the cost of the plan. The amount you pay for retiree medical coverage depends on the option you choose and if you enroll eligible dependents.

Maximum Company Contribution

The Company's maximum annual contribution for individual coverage is $7,200 and family coverage is $14,400. If the Company's share of the cost of coverage exceeds the maximum contribution, you must pay the amount in excess.

Calculating Your Cost of Coverage

Example: Please note that the numbers in this example are for illustrative purposes only and do not represent the actual cost of coverage. Let's assume the following are the total cost of coverage.

		PPO90	**Your Choice High**	**Your Choice Low**
Retiree		$11,416.2	$ 10,254.48	$9,294.24
Family		$22,832.40	$20,509.08	$18,588.60

PPL will provide $7,200 for individual coverage and $14,400 for family coverage.

IF YOU ENROLL IN:	**THE TOTAL COST OF COVERAGE IS:**	**THE COMPANY WILL CONTRIBUTE:**	**YOUR ANNUAL/MONTHLY COST IS:**
PPO90- Retiree	$11,416.20	$7,200	$4,216.20 / $351.35
PPO90- Family	$22,832.40	$14,400	$8,432.40 / $702.70

Until you are eligible for Medicare, the Company will pay up to the cap and you will pay the remainder of the cost of coverage. When you become eligible for Medicare, your plan and costs will change.

Changing Your Coverage

Each year, you will have the opportunity to make changes to your coverage for the following Plan Year during the annual open enrollment period. Changes you make during open enrollment will take effect on January 1 of the following year.

Family Status Changes

In general, you can change your benefits choices only during the annual open enrollment period. You can, however, make certain changes to your benefits choices during the year if you have a qualified change in family status. These include:

- Marriage or divorce;
- Birth, adoption, legal guardianship or death of a dependent;
- Dependent's loss of eligibility;
- Qualified Medical Child Support Order to add a dependent to your medical coverage;
- A change in your or your spouse's employment that affects eligibility for coverage.

Note: All marriages, divorces and deaths should be reported to Your Benefits Resources™.

Additional events that allow you to make changes to your benefits choices during the year are listed in the below chart.

You must make your elections **within 31 days of the qualifying event** for your election to become effective. If you miss the 31-day deadline, your current elections will remain in effect and you will not be able to change your coverage until the next annual open enrollment period or you experience another qualifying event.

The benefit change must be consistent with, and on account of, your change in family status. You will be required to provide documentation when adding a spouse or dependent child.

Qualified changes in status are listed in the following table.

Qualifying Status Change	Coverage Changes
Marriage	♦ Add coverage for you and/or your eligible dependents, or ♦ Drop coverage for yourself (for example, if you will be covered under your spouse's plan)
Birth, adoption or placement for adoption of a child; legal guardianship	♦ Add coverage for you and/or your eligible dependents
Changes in employment status that affect coverage (you or your dependents)	♦ Cancel coverage for you and/or your covered dependents, or ♦ Add coverage for you and/or your covered dependents
Changes in your or your eligible dependent's coverage (including coverage changes under another employer's plan) due to an annual enrollment change, significant change in cost or coverage or significant change in level of benefits. (Special limitations may apply when the life event is a change in cost or coverage.)	♦ Cancel coverage for you and/or your covered dependents, or ♦ Add coverage for you and/or your covered dependents
Divorce	♦ Cancel coverage for your former spouse and/or dependent children who are no longer eligible. You may be required to continue coverage for your dependent children under the terms of a qualified medical child support order (QMCSO).
Death of an eligible dependent	♦ Cancel coverage for your deceased dependent and any dependent children who are no longer eligible. If your spouse dies and he or she was covering your children under his or her plan, you may add coverage for those children if

Qualifying Status Change	Coverage Changes
	they are otherwise eligible.
Loss of your dependent's eligibility (i.e., a dependent child who no longer meets the age limitations under the plan)	♦ Cancel coverage for your dependent child
Change in eligibility for Medicare or Medicaid coverage	♦ Cancel coverage for you and/or your covered dependents, or ♦ Add coverage for you and/or your covered dependents

Special Enrollment Periods

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides special enrollment rights to you and your eligible dependents under certain circumstances. If you decline to enroll yourself or your dependents because of other medical coverage, you may be able to enroll yourself or your dependents later if you request enrollment within 31 days after your other coverage ends. 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/or your dependents provided you request enrollment within 31 days of the life event.

If you qualify for this HIPAA special enrollment, you must contact Your Benefits Resources™ at 1-855-775-6080 within 31 days of the event.

The Company will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible; or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For either of these two enrollment opportunities, you will have 60 days—instead of 31—from the date of the Medicaid/CHIP eligibility change to request enrollment in the health plan, effective on the date you make your election. This 60-day enrollment period only applies to Medicaid/CHIP eligibility changes.

Medical Options

Under the PPL Retiree Health Plan, you may choose from the following medical options:

- Preferred Provider Organization 90 (PPO90) Option
- Your Choice High
- Your Choice Low
- No Coverage

Your Capital BlueCross Medical ID Card

The BlueCross symbol on your medical identification (ID) card is recognized throughout the country and around the world. Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor or other health care professional whenever you need medical care.

When you or one of your dependents receives health care services:

- Show your ID card to the doctor or other professional health care provider; and
- Ask the service provider to file a claim for you.

The following information will be displayed on your ID card:

- Your name
- ID number (an alpha prefix followed by a UMI – Unique Member Identifier)
- Group number
- Copayment for in-network physician and specialist office visits, urgent care, and emergency room visits (if applicable)
- "PPO in Suitcase" symbol – your ID card includes a logo of a suitcase with "PPO" inside it. This PPO suitcase logo lets hospitals and doctors know that you are a member of a PPO Blue Plan and have access to BlueCross BlueShield PPO or BlueCard providers nationwide
- Customer Service toll-free number (on back of card) – 1-866-675-2242
- The toll-free number you must use for admission at a non-participating facility (on back of card) – 1-866-675-2242
- The toll-free number you would call before you receive any mental health and substance abuse services 1-866-322-1657 (on back of card)

If your card is lost or stolen, call Capital Customer Service immediately. Only you or your covered dependents are permitted to use this card. It is illegal to loan your card to people who are not eligible to use your Capital BlueCross benefits.

To request additional ID cards, contact Customer Service or request cards online by going online at www.capbluecross.com.

BlueCard PPO Program

The PPL PPO and Your Choice Options are part of the BlueCard PPO program offered by the National BlueCross BlueShield Association. The following are specific provisions provided under the BlueCard PPO program:

When a member obtains covered services through the BlueCard program outside the geographic area served by Capital BlueCross, the amount a member pays for covered services is calculated on the **lower** of:

- The billed charges for a member's covered services; or
- The negotiated prices that the local BlueCross BlueShield Plan agrees to charge for BlueCard program participants.

The BlueCard PPO Worldwide Program

This program provides assistance with medical problems you may incur while traveling outside of the United States. Services include:

- Making referrals and appointments for you with nearby physicians and hospitals;
- Verbal translation from a multilingual service representative;
- Providing assistance if special help is needed;
- Making arrangements for medical evacuation services; and
- Processing inpatient hospitalization claims.

For outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE (2583) or the Customer Service telephone number on your ID card.

Care Away From Home

The Capital BlueCross PPO and Your Choice options also cover care when you are away from home. If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic. If the illness or injury is a true emergency as determined by Capital BlueCross, it will be paid at the in-network benefit level and is subject to any applicable copayment, which is waived if you are admitted as an inpatient. If the treatment results in a hospital admission, you have certain precertification responsibilities; please refer to "Precertification and Predetermination Process" for more information.

If the illness or injury is not an emergency, as determined by Capital BlueCross, and you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level.

If you or covered dependents are away from home:

- Emergency care will be reimbursed at the higher in-network level in an emergency situation.
- For non-emergency care, you or your eligible dependents are required to use network providers in order to be reimbursed at the higher benefit level.
- If you or covered dependents receive covered services from an out-of-network provider, benefits will be paid at the lower out-of-network level.
- Dependents should schedule visits for eligible preventive services, including routine physical examinations, with in-network physicians while at home.

Services provided for a student while away at school:

- Care provided by the school's medical center is usually included in the tuition, and therefore, not normally filed under the parent's health insurance Plan.
- For emergency care to be reimbursed at the higher in-network level, the condition must be a true emergency situation.
- If other medical care is needed and is not provided by the school's medical center, the student is required to use in-network providers to receive the higher level of benefits.

Eligible Providers

If you want to enjoy the highest level of coverage, it is your responsibility to ensure that you receive care from a Capital BlueCross participating provider as outlined as your option's in-network care. You should check any provider recommendations to make sure the doctor or facility is an in-network or participating provider. Call 1-800-810-BLUE (2583) or log on www.capbluecross.com to find a participating provider for medical services. Call Express Scripts at 1-800-841-5346 for assistance finding an Express Scripts in-network pharmacy. Eligible providers include:

Facility Providers

- Hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- Alcohol abuse treatment facility
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/Night psychiatric facility
- Drug abuse treatment facility
- Free-standing dialysis facility

- Free-standing nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Home infusion therapy provider
- Hospice
- Outpatient alcohol abuse treatment facility
- Outpatient drug abuse treatment facility
- Outpatient physical rehabilitation facility
- Pharmacy provider
- Skilled nursing facility

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

*Registered nurses employed by a health care facility or by an anesthesiology group are excluded from eligibility.

Preferred Provider Organization and Your Choice Options

With the Capital BlueCross Preferred Provider Organization (PPO) and Your Choice options, each time you need care, you can choose to see an in-network provider who is part of the managed care network or an out-of-network provider. In either case, you coordinate your own care—you do not need to select a primary care physician (PCP).

- When you receive care from a Capital BlueCross in-network provider, your out-of-pocket costs are less than they would be if you received care from an out-of-network provider because the Plan's in-network benefits are more generous than the out-of-network benefits. Under the PPO90 option, you pay a copayment for each visit or service, and the Plan pays the rest. In-network benefits under the PPO90 option generally don't require that a deductible be met before the Plan pays benefits. Note that the Your Choice options do require that a deductible be met before the Plan pays benefits, even on an in-network basis. You don't need to complete claim forms when you use an in-network provider.
- When you receive care from a provider who does not participate in the Capital BlueCross PPO network, you must pay an annual deductible before the Plan pays benefits. Then you and the Plan share the cost of the services you receive. When you seek care from an out-of-network provider, you have two choices:

– If you use a provider who has a participating agreement with Capital BlueCross, you will pay less because the provider will accept Capital BlueCross's allowable or usual, customary and reasonable (UCR) charge as payment in full.

- If you use a provider who does not have a participating agreement with Capital BlueCross, you may pay more if the provider charges are more than Capital BlueCross's allowable or usual, customary and reasonable limit. You pay the balance billing amount (which may be substantial) that exceeds the limit, in addition to any applicable deductible and coinsurance amounts. In addition, you will be responsible for filing claims when you use non-participating providers.

You can view the provider directory on Capital's Web site www.capbluecross.com or call BlueCard Access (1-800-810-2583) for more information.

Member Services

For help with a claim or a question about your benefits, you can call Capital BlueCross Customer Service toll-free at 1-866-675-2242 or log onto the website, www.capbluecross.com. A Capital BlueCross Customer Service representative can help you with any coverage inquiry.

24-Hour Nurse Line

The Capital 24-Hour Nurse Line is staffed with registered nurses who are available to answer questions on health-related issues 24 hours a day, every day of the year. The service is designed to offer health and medical information, education and support. The service also offers assessments and advice, and suggests appropriate levels of care for symptomatic callers in the event members are unable to reach their physician. Members are encouraged to call 1-800-452-BLUE when they have the need for health information/education, or want assistance in determining how to best handle specific medical symptoms. Nurses are prepared to provide the following services:

- Answers to a members question on a health-related topic;
- Send information/educational materials as appropriate to the members home; or
- Refer a member to an Audio Library for comprehensive information on a specific top, disease or procedure.
- If the call is for symptomatic reasons, the nurses will:
- Conduct an assessment of the member's symptoms;
- Direct the member to dial 911 in the event the symptoms described warrant it;
- Suggest the appropriate level of care in the event the member's physician is not available.

For answers to health care questions, you can phone the Nurse Line—your 24-hour toll-free health support resource. Or, you can e-mail a registered nurse through Capital BlueCross's Web site, www.capbluecross.com.

The Nurse Line addresses your total health care needs, rather than focusing on one specific disease, condition or illness, through interaction with both the patient and the physician. The Nurse Line promotes the philosophy of shared decision-making by helping you work with your physicians in the task of choosing treatment options that take into account your values and preferences. The Nurse Line provides you with health care support services, including assistance in the self-management of certain health conditions. You have 24-hour access, 7 days a week, to health information and personalized support for health decisions.

Contact the Nurse Line at 1-800-452-BLUE(2583) for information about these programs.

Capital BlueCross's Web Site

As a Capital BlueCross member, you have access to health and wellness information, services related to your health care coverage, and tools for managing your own health and well-being at your personal Web page. Go to www.capbluecross.com and log onto in order to:

- Customize the content of your pages, including health and wellness content and links to other sites
- Access a variety of services related to your Capital BlueCross coverage, order an ID card or claim form, investigate a claim or find a physician
- Access valuable health resources. You can also complete the Better Health Works Personal Profile, which helps you identify your personal health risks and set goals to improve your wellness. You can also find a variety of interactive fitness trackers and calculators, as well as a daily recipe, complete with nutrition information.
- Record your activity in the Online Activity Tracker

Health Promotion
Capital BlueCross realizes the importance of a healthy lifestyle. You can contact Capital BlueCross to sign up for:

Condition Management: provides support for members living with heart failure, coronary artery disease, diabetes and asthma. Call 1-888-803-BLUE(2583).

Case Management: provides support for families facing complex medical needs. If you are newly diagnosed or need assistance with a complex medical need, please contact Capital at 1-888-320-BLUE(2583) for a case manager.

Precious Baby Prints®: supports you during pregnancy, delivery and follow-up care. Contact Capital at 1-888-320-BLUE(2583)

You can contact Log onto www.capbluecross.com and connect to see the Search and Save Center and to send secure email to Customer Service at Capital BlueCross.

Capital Blue Virtual Care: provides virtual doctor visit to diagnose, recommend treatment and prescribe medication for common illness conditions. See contact information below. Download the Virtual Care app on your smart phone or access www.virtualcarecbc.com.

Contact Information

Here is how you can reach Customer Service for each benefit under the PPL Employee Health Plan:

Benefit and Administrator	Phone Number	Web Site Address
Medical Capital BlueCross	1-866-675-2242	www.capbluecross.com
Prescription Drugs Express Scripts	1-800-841-5346	www.express-scripts.com
Capital Blue Virtual Care	1-833-433-5914	www.virtualcarebcb.com

Your Benefits

Here is a look at how some commonly used services are covered by the PPO option and Your Choice Options.

PPO90 Option (PPO90 for those hire prior to 1/1/15)

The Summary of Benefits Chart below outlines the major provisions of the PPO90 option.

Deductibles and out-of-pocket expenses

The individual deductible applies to each covered individual. When an individual meets their deductible, the plan will pay benefits for that individual's claims (only for expenses that do not have a co-payment). Those with family coverage have a family maximum deductible. Which means when one individual in the family meets the individual deductible that individual's claims are paid at the plan level benefits. When another family member or a combination of the other family members meets the remaining family deductible, the entire family's claims will be paid at the plan level benefits. For PPO90the out-of-pocket maximum works in the same way, when one individual meets the out-of-pocket maximum for the year, that individual's claims are paid at 100%* for the rest of the year. When another family member or a combination of the other family members meet the family maximum out-of-pocket, the entire family's claims are paid at 100%* for the rest of the plan year.

*the plan pays these percentages for approved in-network claims only, refer to the charts below for details

2018 Preferred Provider Organization 90 Option (PPO90) (open only to employees hired prior to 1/1/15)		
Medical Benefits	**In-network**	**Out-of-network**
Calendar Year Deductible (Individual/Family)	$500/$1,000; does not apply to services that require a copayment	$2,200/$4,400
Coinsurance	Plan pays 90% after deductible until out-of-pocket maximum is met, then 100% of UCR	Plan pays 70% of UCR after deductible until out-of-pocket maximum is met, then 100% of UCR
Annual Out-of-Pocket Maximum (Individual/Family)	$2,500/$5,000 including deductible	$4,800/$9,600 including deductible
Lifetime Maximum	None	None
Precertification Requirements (For all inpatient care)	Provider responsibility	Member responsibility ($300 penalty for failure to pre-certify)
Primary Care Physician Office Visit (Internist, general practitioner, family practice, pediatrician)	100% after $40 copayment per visit	30% of UCR after deductible
Specialist Office Visit (All other doctors not listed above)	100% after $50 copayment per visit	30% of UCR after deductible

2018 Preferred Provider Organization 90 Option (PPO90) (open only to employees hired prior to 1/1/15)		
Medical Benefits	**In-network**	**Out-of-network**
Preventive Care ***Adult*** ♦ Routine physical exams ♦ Routine gynecological exams, including annual PAP test ♦ Immunizations (Rubella, Influenza, Pneumococcal) ♦ Mammograms as required; annual mammograms – women age 40 & over ***Pediatric*** ♦ Routine child/well baby exams ♦ Pediatric immunizations	 100%, no deductible 100%, no deductible 100%, no deductible 100%, no deductible 100%, no deductible 100%, no deductible	 Not covered 30% of UCR, after deductible 30% of UCR after deductible 30% of UCR after deductible 30% of UCR after deductible 30% of UCR after deductible
Routine Eye Exams	Not covered	Not covered
Routine Hearing Exams	100%	Not covered
Hearing Aids	Not covered	Not covered
Allergy Injections	10% after deductible	30% of UCR after deductible
Allergy Testing and Treatment	100% after $50 copayment per visit	30% of UCR after deductible
Emergency Care	100% after $100 copayment; waived if admitted as an inpatient	100% after $100 copayment; waived if admitted
Ambulance	100%, no deductible	100%, no deductible
Inpatient Hospital Expenses-including Inpatient Mental Health Hospital expenses. (Limit 365 days from date of admission)	10% after deductible	30% of UCR after deductible
Hospital Outpatient Expenses	10% after deductible	30% of UCR after deductible
Inpatient Physical Rehabilitation	10% after deductible	30% of UCR after deductible
Surgery and Anesthesia ♦ Inpatient or Outpatient Facility ♦ Presurgical Testing	 10% after deductible 10% after deductible	 30% of UCR after deductible 30% of UCR after deductible
Maternity/Birthing Center/Newborn Care	10% after deductible	30% of UCR after deductible
Assisted Fertilization Procedures (Excludes in-vitro fertilization, embryo transplants, ART, ICSI, GIFT and ZIFT)	10% after deductible $2,000 per benefit period for assisted fertilization implantation.	30% of UCR after deductible
Chiropractic Care (Spinal manipulations)	100% after $50 copayment per visit Limited to 25 visits per calendar year maximum combined for in- and out-of-network care	30% of UCR after deductible
Diagnostic Services (Lab, x-ray and other tests)	10% after deductible	30% of UCR after deductible

2018 Preferred Provider Organization 90 Option (PPO90) (open only to employees hired prior to 1/1/15)		
Medical Benefits	**In-network**	**Out-of-network**
Durable Medical Equipment	10% after deductible	30% of UCR after deductible
Home Health Care	10% after deductible	30% of UCR after deductible (limit 50 visits per calendar year)
Prosthetic Devices (Requires Healthcare Management Services approval)	10% after deductible	30% of UCR after deductible
Dental Services (TMJ treatment)	Not covered	Not covered
Oral Surgery (See covered services for specific information) ♦ Provider's Office ♦ Outpatient Facility	 100% after $50 copayment per visit 10%; after deductible	 30% of UCR after deductible 30% of UCR after deductible
Limits on Oral Surgery: Removal of impacted teeth which are partially or totally covered by bone Surgical extraction – root recovery (surgical removal of residual root) Surgical exposure of impacted or unerupted tooth to aid eruption		
Skilled Nursing Facility – Medically Necessary (Excludes custodial care)	10% after deductible	30% of UCR after deductible
Outpatient Rehabilitative (professional)	10% after deductible (With physician recommendation subject to approved treatment plan)	30% of UCR after deductible
Speech and Occupational Therapy (professional) Limit on Speech and Occupational Therapy: Speech Therapy: 30 visits per calendar year Occupational Therapy: 30 visits per calendar year	10% after deductible	30% of UCR after deductible
Physical Therapy	10% after deductible Maximum: 60 visits per year	30% of UCR after deductible
Mental Health and Substance Abuse Inpatient and Outpatient	10% after deductible	30% of UCR after deductible
Private Duty Nursing	10% after deductible Maximum: 240 hours per year	30% after in-network deductible
Chemotherapy, Dialysis, Radiation and Respiratory Service	10% after deductible	30% of UCR after deductible
Hospice Care/Facility	10% after deductible	30% of UCR after deductible

Your Choice Options

The Your Choice High qualifies as a High Deductible Health Plan (HDHP) as outlined under the Medicare Modernization Act of 2004. Generally, an HDHP requires that you meet a high deductible

before the Plan begins to pay expenses. Certain benefits, such a preventive care, are not subject to the deductible.
The Your Choice option is similar to the PPO options in that there is a network of Preferred Providers as well as in- and out-of-network provisions. Capital BlueCross is the administrator of this program and provides the PPO network of physicians. However, in most cases, no benefits are paid under this option until you have met the deductible applicable to your level of coverage, even on an in-network basis.

Deductibles and out-of-pocket expenses
The deductible amount you are required to meet for the Your Choice options is based on the level of coverage you have. If you have "employee plus one" or "employee plus two or more" coverage, one person or a combination of those covered must meet the family deductible before the plan will begin paying benefits. The out-of-pocket maximum works different than the deductible, when one individual meets the out-of-pocket maximum for the year, that individual's claims are paid at 100%* for the rest of the year. When another family member or a combination of the other family members meet the family maximum out-of-pocket, the entire family's claims are paid at 100%* for the rest of the plan year.

The Summary of Benefits Chart below outlines the major provisions of the Your Choice High Option.

2018 Your Choice High		
Medical Benefits	**In-network**	**Out-of-network**
Calendar Year Deductible	$1,750 employee-only; $3,500 employee plus one or more	$3,500 employee-only; $7,000 employee plus one or more
Coinsurance	Plan pays 80% after deductible is met until out-of-pocket maximum is met, then 100% of UCR	Plan pays 60% of UCR after deductible until out-of-pocket maximum is met, then 100% of UCR
Annual Out-of-Pocket Maximum	$3,250 individual; $ 6,500 family	$6,500 individual; $13,000 family
Lifetime Maximum	None	None
Health Savings Account (HSA) Eligibility	You may be eligible to enroll in an HSA	
PPL Contribution to HSA if eligible	Not Applicable	
Retiree Maximum Contribution to HSA	Limits as set by the IRS apply each calendar year from ALL sources, including former employers	
Precertification Requirements (For all inpatient care)	Provider responsibility	Member responsibility ($300 penalty for failure to precertify)
Primary Care Physician Office Visit (Internist, general practitioner, family practice, pediatrician)	20% after deductible	40% of UCR after deductible
Specialist Office Visit (All other doctors not listed above)	20% after deductible	40% of UCR after deductible

2018 Your Choice High		
Medical Benefits	**In-network**	**Out-of-network**
Preventive Care ***Adult*** ♦ Routine physical exams ♦ Routine gynecological exams, including annual PAP test ♦ Immunizations (Rubella, Influenza, Pneumococcal) ♦ Mammograms as required; annual mammograms – women age 40 & over ***Pediatric*** ♦ Routine child/well baby exams ♦ Pediatric immunizations	 100%, no deductible 100%, no deductible 100%, no deductible 100%, no deductible 100%, no deductible	 Not covered Not covered Not covered Not covered Not covered Not covered
Routine Eye Exams	Not covered	Not covered
Routine Hearing Exams	100%, no deductible	Not covered
Hearing Aids	Not covered	Not covered
Allergy Injections	20% after deductible	40% of UCR after deductible
Allergy Testing and Treatment	20% after deductible	40% of UCR after deductible
Emergency Care/Urgent Care	20% after deductible	20% after in-network deductible
Ambulance	20% after deductible	20% after deductible
Inpatient Hospital Expenses (Limit 365 days from date of admission)	20% after deductible	40% of UCR after deductible
Hospital Outpatient Expenses	20% after deductible	40% of UCR after deductible
Inpatient Physical Rehabilitation	20% after deductible	40% of UCR after deductible
Surgery and Anesthesia ♦ Inpatient or Outpatient Facility ♦ Presurgical Testing	 20% after deductible 20% after deductible	 40% of UCR after deductible 40% of UCR after deductible
Maternity/Birthing Center/Newborn Care	20% after deductible	40% of UCR after deductible
Infertility Diagnostic Services	20% after deductible	40% of UCR after deductible
Assisted Fertilization Procedures (Excludes in-vitro fertilization, embryo transplants, ART, ICSI, GIFT and ZIFT)	20% after deductible $2,000 per benefit period for assisted fertilization implantation.	40% of UCR after deductible
Chiropractic Care (Spinal manipulations)	20% after deductible Limited to 25 visits per calendar year maximum combined for in- and out-of-network care	40% of UCR after deductible
Diagnostic Services (Lab, x-ray and other tests)	20% after deductible	40% of UCR after deductible
Durable Medical Equipment	20% after deductible	40% of UCR after deductible

2018 Your Choice High		
Medical Benefits	**In-network**	**Out-of-network**
Home Health Care	20% after deductible	40% of UCR after deductible (limit 50 visits per calendar year)
Prosthetic Devices (Requires Healthcare Management Services approval)	20% after deductible	40% of UCR after deductible
Dental Services (TMJ treatment)	Not covered	Not covered
Oral Surgery (See covered services for specific information)		
♦ Provider's Office	20% after deductible	40% of UCR after deductible
♦ Outpatient Facility	20% after deductible	40% of UCR after deductible
Limits on Oral Surgery: Removal of impacted teeth which are partially or totally covered by bone Surgical extraction – root recovery (surgical removal of residual root) Surgical exposure of impacted or unerupted tooth to aid eruption		
Skilled Nursing Facility – Medically Necessary (excludes custodial care)	20% after deductible	40% of UCR after deductible
Outpatient Rehabilitative (professional)	20% after deductible	40% of UCR after deductible
	(With physician recommendation subject to approved treatment plan)	
Speech and Occupational Therapy (professional) Limit on Speech and Occupational Therapy: Speech Therapy: 30 visits per calendar year Occupational Therapy: 30 visits per calendar year	20% after deductible	40% of UCR after deductible
Physical Therapy	20% after deductible	40% of UCR after deductible
	Combined maximum: 60 visits in- and out-of-network per year	
Private Duty Nursing	20% after deductible	20% of UCR after in-network deductible
	Maximum: 240 hours per year	
Chemotherapy, Dialysis, Radiation and Respiratory Service	20% after deductible	40% of UCR after deductible
Mental Health and Substance Abuse	20% after deductible	40% of UCR after deductible
Hospice Care/Facility	20% after deductible	40% of UCR after deductible

The Summary of Benefits Chart below outlines the major provisions of the Your Choice Low option

2018 Your Choice Low Option		
Medical Benefits	**In-network**	**Out-of-network**
Calendar Year Deductible	$2,500 employee-only; $5,000 employee plus one or more	$5,000 employee-only; $10,000 employee plus one or more

2018 Your Choice Low Option		
Medical Benefits	**In-network**	**Out-of-network**
Coinsurance	Plan pays 60% after deductible is met until out-of-pocket maximum is met, then 100% of UCR	Plan pays 50% of UCR after deductible until out-of-pocket maximum is met, then 100% of UCR
Annual Out-of-Pocket Maximum	$5,000 individual; $10,000 family	$6,350 individual; $12,7000 family
Lifetime Maximum	None	None
Health Savings Account (HSA) Eligibility	You may be eligible to enroll in an HSA	
PPL Contribution to HSA	Not Applicable	
Retiree Maximum Contribution to HSA	Limits as set by the IRS apply each calendar year from ALL sources	
Precertification Requirements (For all inpatient care)	Provider responsibility	Member responsibility ($300 penalty for failure to precertify)
Primary Care Physician Office Visit (Internist, general practitioner, family practice, pediatrician)	40% after deductible	50% of UCR after deductible
Specialist Office Visit (All other doctors not listed above)	40% after deductible	50% of UCR after deductible
Preventive Care ***Adult*** ♦ Routine physical exams ♦ Routine gynecological exams, including annual PAP test ♦ Immunizations (Rubella, Influenza, Pneumococcal) ♦ Mammograms as required; annual mammograms – women age 40 & over ***Pediatric*** ♦ Routine child/well baby exams ♦ Pediatric immunizations	 100%, no deductible 100%, no deductible 100%, no deductible 100%, no deductible 100%, no deductible	 Not covered Not covered Not covered Not covered Not covered Not covered
Routine Eye Exams	Not covered	Not covered
Routine Hearing Exams	100%, no deductible	Not covered
Hearing Aids	Not covered	Not covered
Allergy Injections	40% after deductible	50% of UCR after deductible
Allergy Testing and Treatment	40% after deductible	50% of UCR after deductible
Emergency Care/Urgent Care	40% after deductible	40% after in-network deductible
Ambulance	40% after deductible	60% after deductible
Inpatient Hospital Expenses (Limit 365 days from date of admission)	40% after deductible	50% of UCR after deductible
Hospital Outpatient Expenses	40% after deductible	50% of UCR after deductible
Inpatient Physical Rehabilitation	40% after deductible	50% of UCR after deductible

2018 Your Choice Low Option		
Medical Benefits	**In-network**	**Out-of-network**
Surgery and Anesthesia ♦ Inpatient or Outpatient Facility ♦ Presurgical Testing	 40% after deductible 40% after deductible	 50% of UCR after deductible 50% of UCR after deductible
Maternity/Birthing Center/Newborn Care	40% after deductible	50% of UCR after deductible
Infertility Diagnostic Services	40% after deductible	50% of UCR after deductible
Assisted Fertilization Procedures (Excludes in-vitro fertilization, embryo transplants, ART, ICSI, GIFT and ZIFT)	40% after deductible $2,000 per benefit period for assisted fertilization implantation.	50% of UCR after deductible
Chiropractic Care (Spinal manipulations)	40% after deductible Limited to 25 visits per calendar year maximum combined for in- and out-of-network care	50% of UCR after deductible
Diagnostic Services (Lab, x-ray and other tests)	40% after deductible	50% of UCR after deductible
Durable Medical Equipment	40% after deductible	50% of UCR after deductible
Home Health Care	40% after deductible	50% of UCR after deductible (limit 50 visits per calendar year)
Prosthetic Devices (Requires Healthcare Management Services approval)	40% after deductible	50% of UCR after deductible
Dental Services (TMJ treatment)	Not covered	Not covered
Oral Surgery (See covered services for specific information) ♦ Provider's Office ♦ Outpatient Facility Limits on Oral Surgery: Removal of impacted teeth which are partially or totally covered by bone Surgical extraction – root recovery (surgical removal of residual root) Surgical exposure of impacted or unerupted tooth to aid eruption	 40% after deductible 40% after deductible	 50% of UCR after deductible 50% of UCR after deductible
Skilled Nursing Facility – **Medically Necessary** (excludes custodial care)	40% after deductible	50% of UCR after deductible
Outpatient Rehabilitative (professional)	40% after deductible (With physician recommendation subject to approved treatment plan)	50% of UCR after deductible
Speech and Occupational Therapy (professional) Limit on Speech and Occupational Therapy: Speech Therapy: 30 visits per calendar year Occupational Therapy: 30 visits per calendar year	40% after deductible	50% of UCR after deductible
Physical Therapy	40% after deductible Combined maximum: 60 visits in- and out-of-network per year	50% of UCR after deductible

2018 Your Choice Low Option		
Medical Benefits	**In-network**	**Out-of-network**
Private Duty Nursing	40% after deductible Maximum: 240 hours per year	50% of UCR after in-network deductible
Chemotherapy, Dialysis, Radiation and Respiratory Service	40% after deductible	50% of UCR after deductible
Mental Health and Substance Abuse	40% after deductible	50% of UCR after deductible
Hospice Care/Facility	40% after deductible	50% of UCR after deductible

ConsumerMedical: Available to anyone covered by a PPL Medical Plan. This valuable benefit provides you and your family with free expert medical guidance for any condition. Receive answers to your questions and recommendations for top-rated specialists and hospitals. Talk to Consumer Medical today at 1-888-361-3944 or go to their website at www.myconsumermedical.com. Enter "PPL" in the Company Code field.

Covered Services – Medical

The PPL Employee Health Plan provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. Unless noted to the contrary, covered services apply to the PPO90 and the Your Choice options.

See the Summary of Benefits Chart for additional information related to deductibles, copayments, coinsurance, out-of-pocket maximums and limitations.

Note: This section only describes covered services provided by Capital BlueCross under the medical component of the program. See the covered services for prescription drug benefits.

Acupuncture: Acupuncture (manual or electro-acupuncture), as an adjunct to traditional anesthesia, may be considered **medically necessary** when the following requirements are met:

- Administered in accordance with all requirements concerning anesthesia;
- Ordered by the attending physician in connection with a covered surgery, obstetrical procedure, or shock therapy; and
- Administered by an acupuncture-trained physician other than the attending physician or his/her assistant.

Acupuncture services including chronic back pain and chronic or migraine headaches are covered, with no visit limit.

Allergy Extract/Injections: Benefits are provided for allergy extract and allergy injections.

Ambulance Services: Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- From a member's home, work location, the scene of an accident or medical emergency to a hospital, or skilled nursing facility; or
- Between hospitals; or
- Between a hospital and a skilled nursing facility;

when such facility is the closest institution that can provide covered services appropriate for the member's condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service.

Local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured in non-emergency situations to or from a hospital for required treatment certified by attending physician as medically necessary:

- From a hospital to your home; or
- From a skilled nursing facility to your home.

Assisted Fertilization: Your Plan covers services in connection with the treatment of infertility when such services are ordered by a physician and are determined to be medically necessary and appropriate. In-vitro fertilization, embryo transplants, ART, GIFT, ICSI and ZIFT are not covered. Precertification for assisted fertilization services can be preapproved by contacting Capital BlueCross. They will determine if the service requested and the requested treatment setting is the most appropriate for your care.

Dental Services Related to Accidental Injury: Dental services (excluding orthodontia) rendered by a physician or dentist which are required as the result of accidental injury to the jaw, sound natural teeth, mouth or face that occur on or after your effective date. Injury caused by chewing or biting will not be considered accidental injury.

Diabetes Treatment: Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items:

Equipment and Supplies: The following chart summarizes the diabetic equipment and supplies available through the PPL Health Plan:

Description	Items That Fall Under Description	Available Through Capital BlueCross	Available Through Express Scripts
Insulin (INS)	All brands of insulin and glucagon (injectable used for blood sugar emergencies)	No	Retail and Mail Service
Syringes and Needles (SRN & NDL)	All brands of needles and syringes (most syringes come with appropriate needle attached)	Yes*	Retail and Mail Service
Diabetic Supplies (DBS)	Lancing Devices, Alcohol Swabs, Diabetic Meter Strips, Diabetic Meter Control Solutions, Insulin Pens, Urine Ketone Strips	Yes*	Retail and Mail Service
Pharmacological Agents for Controlling Blood Sugar (DBT)	All diabetic oral medications (i.e., Actos, Avandia, Glucotrol and Glucophage)	No	Retail and Mail Service
Blood Glucose Meters (DBM)	All brands of diabetic meters	Yes*	Retail and Mail Service
Diabetic Lancets (DBL)	All brands of lancets for lancing devices used by diabetics when testing blood with diabetic	Yes*	Retail and Mail Service

Description	Items That Fall Under Description	Available Through Capital BlueCross	Available Through Express Scripts
	meters		
Insulin Infusion Devices (DEV)	Insulin pump (i.e., Minimed Pump), Insulin Pump tubing and Insulin Reservoir for Insulin Pump	Yes*, predetermination of medical necessity is required by Capital BlueCross	Not covered
Insulin Infusion Device Refill Cartridge (DEV)	Insulin Pump Refill (i.e., Minimed Cartridge with tubing attached)	Yes*, predetermination of medical necessity is required by Capital BlueCross	Not covered
*From Durable Medical Equipment supplier, contact Capital BlueCross Member Service to find a participating/in-network supplier.			

Outpatient Diabetes Education: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following services when rendered through an outpatient diabetes education program:

Visits which are medically necessary and appropriate upon the diagnosis of diabetes;

- Subsequent visits under circumstances whereby your physician:
  - Identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management; or
  - Identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes.
- Outpatient Diabetes Education Program is a program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Capital BlueCross's criteria. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

Diagnostic Services: Benefits will be provided for the following covered services when ordered by a professional provider:

- Diagnostic x-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound or nuclear medicine;
- Diagnostic pathology consisting of laboratory and pathology tests;
- Diagnostic medical procedures consisting of ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing approved by the Plan; and
- Allergy testing consisting of percutaneous, intracutaneous and patch tests.

Durable Medical Equipment: The rental (but not to exceed the total cost of purchase) or, at the option of the Plan, the purchase, adjustment, repair and replacement of durable medical equipment when prescribed by a professional provider within the scope of their license and required for therapeutic use.

Emergency Accident Care: Medical care for the emergency treatment of traumatic bodily injuries resulting from an accident.

Emergency Medical Care: Medical care for emergency treatment of a sudden onset of a medical condition manifesting itself by acute symptoms that require immediate attention and the absence of immediate medical attention could reasonably result in:

- Permanently placing the health of an individual in jeopardy;

- Causing other serious medical consequences;
- Causing serious impairment to bodily functions; or
- Causing serious and permanent dysfunction of any bodily organ or part.

Some examples of emergencies are:

- Heart attack or suspected heart attack
- Poisoning
- Severe shortness of breath
- Uncontrolled or severe bleeding
- Loss of consciousness
- Suspected overdose of medication
- Severe burns
- High fever (especially in infants)

Enteral Formulae: Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits are exempt from all deductible requirements.

Additional coverage for enteral formulae is provided when administered on an outpatient basis, when medically necessary and appropriate for your medical condition, when considered to be the sole source of nutrition, and:

- When provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
- When provided orally and identified as one of the following types of defined formula;
  - With hydrolyzed (pre-digested) protein or amino acids; or
  - With specialized content for special metabolic needs; or
  - With modular components; or
  - With standardized nutrients.

These additional benefits are subject to the program deductible, copayments and maximum amounts, if applicable.

Once it is determined that you meet the above criteria, coverage for enteral formulae will continue as long as it represents at least 50% of your daily caloric requirement.

Additional coverage for enteral formulae excludes the following:

- Blenderized food, baby food, or regular shelf food when used with an enteral system;
- Milk or soy-based infant formulae with intact proteins;
- Any formulae, when used for the convenience of you or your family members;
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;
- The following formulae when provided orally; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Gender Reassignment Surgery: Benefits for Gender Reassignment are provided for treatment of gender identity disorders subject to the terms and conditions under this coverage with Capital. These benefits include:

- Mental health services with a focus on gender identity and related issues.
- Hormone therapy.
- Gender reassignment surgery--upper body (breast area) and/or lower body (genital area) with appropriate diagnosis codes.
- Medical or surgical complications resulting from gender reassignment surgery

This coverage is provided to the same extent as coverage is provided for similar services for treatment of other conditions. No benefits are provided for sex change surgical procedures to reverse previous gender reassignment surgery or for services and procedures that are considered to be cosmetic procedures. Cosmetic procedures that may be used to make a person look more feminine include, but are not limited to, procedures such as: plastic surgery of the nose; face lift; lip enhancement; facial bone reduction; plastic surgery of the eyelids; liposuction of the waist; reduction of the thyroid cartilage; hair removal; hair transplants; and surgery of the larynx, including shortening of the vocal cords. Cosmetic procedures that may be used to make a person look more masculine include, but are not limited to, procedures such as: chin implants; nose implants; and lip reduction.

Hearing Care Services: Benefits include coverage for an audiometric examination, when prescribed by a professional provider.

Home Health Care Services: Services rendered by a home health care agency or a hospital program for home health care for which benefits are available as follows:

- Skilled nursing services of an RN or LPN
- Physical therapy, occupational therapy and speech therapy as described in the "Summary of Benefits" chart
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care
- Oxygen and its administration
- Medical social service consultations
- Health aide services to an individual who is receiving covered nursing or therapy services as described in the "Summary of Benefits" chart

You must be essentially confined at home and home health care services must be rendered for treatment of the same illness or injury for which the individual was in the facility provider. No home health care benefits will be provided for:

- Dietitian services
- Homemaker services
- Maintenance therapy
- Dialysis treatment
- Custodial care
- Food or home-delivered meals

Home Infusion Therapy Services: Benefits will be provided when performed by a home infusion therapy provider in a home setting. This benefit includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with home infusion

therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy.

Hospice Care Services: Hospice care services will be provided to members with a life expectancy of 180 days or less, as certified by a physician. Services rendered by a home health care agency or a hospital program for hospice care for which benefits are available as follows:

- Skilled nursing services of an RN or LPN, excluding private duty nursing services
- Physical therapy, occupational therapy and speech therapy as described in the Summary of Benefits Chart
- Medical and surgical supplies provided by the home health care agency or hospital program for hospice care
- Oxygen and its administration
- Medical social service consultations
- Health aide services to a member who is receiving covered nursing or therapy services
- Family counseling related to the member's terminal condition

No hospice care benefits will be provided for:

- Dietitian services
- Homemaker services
- Maintenance therapy
- Dialysis treatment
- Custodial care
- Food or home-delivered meals

Hospital Services

Bed and Board: Bed, board and general nursing services, when medically necessary, in a facility provider when the member occupies:

- A room with two or more beds; or
- A private room; or
- A bed in a special care unit—a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services: Hospital services and supplies, when medically necessary, including, but not restricted to:

- Use of operating, delivery and treatment rooms and equipment
- Drugs and medicines provided in an inpatient facility, dispensed by a hospital on an outpatient basis or dispensed by a skilled nursing facility
- Whole blood, administration of blood, blood processing and blood derivatives. Limited to two pints per calendar year
- Anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider, and the administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery
- Medical and surgical dressings, supplies, casts and splints
- Diagnostic services
- Therapy services

Emergency Accident Care: Hospital services and supplies for the outpatient emergency treatment of traumatic bodily injuries resulting from an accident.

Emergency Medical Care: Hospital services and supplies for the outpatient emergency treatment of a sudden onset of a medical condition manifesting itself by acute symptoms that require immediate medical attention.

Pre-Admission Testing: Tests and studies required in connection with the member's admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Surgery
Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider other than the surgeon or assistant at surgery.

Maternity Services:
Hospital, surgical and medical services rendered by a provider for:

Normal Pregnancy: Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy, but is not considered a complication of pregnancy.

Complications of Pregnancy: Physical effects directly caused by pregnancy, but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

Nursery Care: Ordinary nursery care of the newborn infant, including inpatient medical visits by a professional provider. A newborn child is eligible from the moment of birth to a maximum of 31 days from date of birth. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent.

Maternity Admissions: Group health plans 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, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Maternity Home Health Care Visit: Benefits for one maternity home health care visit will be provided at the member’s home within 48 hours of discharge when the discharge from a facility provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery; or (b) 96 hours of inpatient care following a cesarean delivery. This visit shall be made by a provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at the mother's sole discretion, occur at the office of the provider. The visit is subject to all the terms of the contract and is exempt from any copayment, coinsurance or deductible amounts.

Inpatient Medical Services
Medical Care Visits: Medical care by a professional provider to a member who is an inpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided.

Intensive Medical Care: Medical care rendered to a member whose condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

Concurrent Care: Medical care rendered concurrently with surgery during one hospital stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical care by two or more professional providers rendered concurrently during one hospital stay when the nature or severity of the member's condition requires the skills of separate physicians.

Consultation: Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations, which are required by hospital rules and regulations.

Routine Newborn Care: Professional provider visits to examine the newborn infant while the mother is an inpatient.

Outpatient Medical Care Services (Physician Visits): Medical care not related to surgery, pregnancy or mental illness, except as specifically provided. Benefits include medical care visits and consultation for the examination, diagnosis and treatment of an injury or illness.

Orthotic Devices: Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device that is medically necessary and which restricts or eliminates motion of a weak or diseased body part.

Pediatric Preventive Benefits
Benefits are limited to members under age 17 and are not subject to program deductibles or maximums. Benefits are exempt from all deductibles or maximums.

Adult Preventive Benefits
The adult preventive care program provides the following coverage for eligible enrollees beginning at age 18. Benefits are exempt from all deductibles or maximums.

Women's Care
Routine Gynecological Examination and Papanicolaou (Pap) Smear: Benefits are provided for one routine gynecological examination, including a pelvic examination and clinical breast examination, and one routine papanicolaou smear per calendar year for all female members. Benefits are exempt from all deductibles or maximums.

Mammographic Screening: Benefits will be provided for:
- A routine mammographic screening for all female members 40 years of age or older
- Mammographic examination for all female members regardless of age when prescribed by a physician
- Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified

Mental Health and Substance Abuse
Mental health and substance abuse benefits are paid under the medical benefits of this plan.

Private Duty Nursing Services
Private duty nursing services of an actively practicing Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in the member's home or is not a member of the member's immediate family. Benefits are limited to a combined in- and out-of-network maximum of 240 hours per year.

- For a member who is an inpatient in a facility provider, only when the Plan determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff
- For a member at home, only when the Plan determines that the nursing services require the skills of a RN or of a LPN

Prosthetic Appliances
Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances). After cataract surgery, if surgery includes a lens transplant, contact lenses or glasses are not covered. If surgery does not include a lens transplant, one pair of contact lenses or glasses is eligible for each cataract surgery.

Skilled Nursing Facility Services
Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital. No benefits are payable:

- After the member has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care
- When confinement in a skilled nursing facility is intended solely to assist the member with the activities of daily living or to provide an institutional environment for the convenience of a member
- For the treatment of alcohol abuse, drug abuse or mental illness (for these services refer to the mental health/substance abuse component of the Employee Health Plan)

Spinal Manipulations (Chiropractic Care)
Benefits will be provided for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column. Refer to the Summary of Benefits Chart for specifics about your coverage.

Surgical Services
Surgery: Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services. If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure, and no allowance shall be made for additional procedures except where the Plan deems that an additional allowance is warranted.

Special Surgery: Sterilization, regardless of medical necessity and appropriateness.

Cleft Palate Surgery: Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

Oral Surgery: Oral surgery benefits are provided for the following limited oral surgical procedures in an outpatient setting when preauthorized by the Plan, its Designated Agent or in an inpatient setting, if determined to be medically necessary and appropriate:

- Extraction of impacted third molars when partially or totally covered by bone
- Extraction of teeth in preparation for radiation therapy
- Mandibular staple implant when not done to prepare the mouth for dentures
- Maxillary or mandibular frenectomy
- Facility provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by the Plan or its Designated Agent to be medically necessary and appropriate due to the age and/or medical condition of the member
- Accidental injury to the jaw or structures contiguous to the jaw
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth

Mastectomy and Breast Cancer Reconstruction Surgery: Under the Women's Health and Cancer Rights Act, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes:

- 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 at all stages of the mastectomy, including lymphedemas.

Benefits are also provided for one home health care visit, as determined by the member's physician, when received within 48 hours after discharge, if such discharge occurred within 48 hours after an admission for a mastectomy.

Assistant at Surgery: Services of a physician who actively assists the operating surgeon in the performance of covered surgery. The condition of the member or the type of surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a professional provider who performs and bills for another surgical procedure during the same operative session.

Anesthesia: Administration of anesthesia for covered surgery when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery.

Benefits will also be provided for the administration of anesthesia for oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Second Surgical Opinion: A consulting opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

- The second opinion consultant must not be the physician who first recommended elective surgery
- Elective surgery is covered surgery that may be deferred and is not an emergency
- Use of a second surgical opinion is at the member's option

- If the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services
- If the consulting opinion is against elective surgery and the member decides to have the elective surgery, the surgery is a covered service. In such instances, the member will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Therapy Services
Benefits will be provided for the following covered services only when such services are ordered by a professional provider and approved by Capital BlueCross:
- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Respiration therapy
- Physical therapy (refer to the Summary of Benefits Chart for limitations)
- Occupational therapy (Refer to the Summary of Benefits Chart for limitations)
- Speech therapy (Refer to the Summary of Benefits Chart for limitations)
- Infusion therapy; when performed by a facility provider and for self-administration if the components are furnished by and billed by a facility provider
- Cardiac rehabilitation

Transplant Services
Subject to the provisions of the contract, benefits will be provided for covered services furnished by a hospital which are directly and specifically related to transplantation of organs, bones or tissue.

If a human organ, bone or tissue transplant is provided from a donor to a human transplant recipient:
- When both the recipient and the donor are members, each is entitled to the benefits of the contract
- When only the recipient is a member, both the donor and the recipient are entitled to the benefits of the contract subject to the following additional limitations:
  - The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, other BlueCross BlueShield coverage, or any government program; and
  - Benefits provided to the donor will be charged against the recipient's coverage under this contract.
  - When only the donor is a member, the donor is entitled to the benefits of the contract, subject to the following additional limitations:
  - The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of the contract; and
  - No benefits will be provided to the non-member transplant recipient.

If any organ or tissue is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the member recipient's contract limit.

What Is Not Covered – Medical

The services that follow are not covered under your medical options. Unless noted to the contrary, non-covered services apply to all options—PPO90 , Your Choice High and Your Choice Low.

Note: This section only describes non-covered services under the medical component of the program administered by Capital BlueCross. See separate sections for non-covered services under prescription drug benefits.

Your program will not provide benefits for services, supplies or charges:

- Which are not medically necessary and appropriate as determined by the Plan
- Which are not prescribed by or performed by or upon the direction of a professional provider
- Rendered by other than providers
- Which are experimental/investigative in nature
- Rendered prior to the member's effective date
- Incurred after the date of termination of the member's coverage except as provided in the contract
- For any illness or injury suffered after the member's effective date as a result of any act of war
- For which a member would have no legal obligation to pay
- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group
- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer the member all the benefits of the contract and the member so elects this coverage as primary
- For any amounts the member is required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you file a claim for the benefits or compensation.
- To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act
- For prescription drugs and medications, except those that are administered to an inpatient in a facility provider (outpatient prescription drugs are covered under the Prescription Drug Program)
- Which are submitted by a certified registered nurse and another professional provider or other provider for the same services performed on the same date for the same member
- Rendered by a provider who is a member of the member's immediate family
- Performed by a professional provider or other professional provider enrolled in an education or training program when such services are related to the education or training program
- For ambulance services, except as provided herein
- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. However, benefits are payable to correct a condition resulting from an accident. For example, surgery to correct congenital birth defects and surgery to correct functional impairment which results from any covered disease or injury.
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home

modifications, whether or not specifically recommended by a professional provider or other provider

- For inpatient admissions which are primarily for diagnostic studies
- For inpatient admissions primarily for physical therapy
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care
- For respite care
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided in the Covered Services section of this booklet.
- For oral surgery procedures, unless specifically provided
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma
- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet
- For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids
- For treatment of obesity, except for medical and surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex and approved by Capital BlueCross. Morbid obesity is defined as a condition of consistent and uncontrollable weight with comorbidities (e.g., hypertension, cardiovascular disease, dyslipidemia, diabetes mellitus Type II and sleep apnea). Patient selection is a critical process requiring psychiatric evaluation and a multi-disciplinary team approach for patients over age 18.
- No benefits are provided for sex change surgical procedures to reverse previous gender reassignment surgery or for services and procedures that are considered to be cosmetic procedures. Cosmetic procedures that may be used to make a person look more feminine include, but are not limited to, procedures such as: plastic surgery of the nose; face lift; lip enhancement; facial bone reduction; plastic surgery of the eyelids; liposuction of the waist; reduction of the thyroid cartilage; hair removal; hair transplants; and surgery of the larynx, including shortening of the vocal cords. Cosmetic procedures that may be used to make a person look more masculine include, but are not limited to, procedures such as: chin implants; nose implants; and lip reduction.
- For in-vitro fertilization
- For reversal of sterilization
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (these services may be covered by the Vision plan, if elected)
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services
- For nutritional counseling and services intended to produce weight loss
- For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law
- For screening examinations including x-ray examinations made without film, except as provided herein
- For immunizations required for foreign travel

- For treatment of sexual dysfunction that is not related to organic disease or injury
- For Mental Health and Substance Abuse, services provided by someone not licensed by the state to treat the condition for which the claim is made
- For any care related to autistic disease of childhood, learning disabilities, and mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change
- For equipment costs or equipment rental costs related to services performed on high cost technological equipment as defined by the Plan, such as but not limited to, computed tomography (CT) scanners, magnetic resonance imagers (MRI) and extracorporeal shock wave lithotripters
- For otherwise covered services ordered by a court or other tribunal as part of the member's or dependent's sentence
- For therapy services for which no expectation of restoring or improving a level of function exists, or for maintenance treatment when no additional functional progress is expected to occur, unless medically necessary and appropriate
- For any illness or injury suffered after the member's effective date during the member's commission of a felony
- For any other medical or dental service or treatment except as provided in the contract or as mandated by law
- For any care, treatment or service which has been disallowed by Capital BlueCross.

Prescription Drug Benefits

Administration of the prescription drug plan is through Express Scripts. The coverage differs by your coverage choice under the PPL Retiree Health Plan:

- For the PPO90 Option – Copayments apply to retail and mail order prescription medication.
- For the Your Choice Options – Prescription medication is subject to the deductible and coinsurance. Participants may want to shop around to obtain the best price for their medication.
-

There are two convenient methods for purchasing prescription drugs:

- **Retail Pharmacy:** You show your identification card from your prescription drug administrator for use when purchasing drugs at a local retail pharmacy.
- **Mail Service**: For prescriptions used daily for an extended period, such as those used to control high blood pressure, you can use the mail service feature administered by your prescription drug administrator.

Retail Pharmacy

PPO90 Participants

When you fill your prescription at an Express Scripts participating retail pharmacy, your copayment will be $10 for generic drugs, $30 for brand-name drugs that are on Express Scripts' list of preferred medications, and $50 for brand-name drugs that are not on Express Scripts' list of preferred medications.

If you choose to take a brand when a generic substitute is available, you will pay the brand copayment plus the difference between the cost of the brand-name drug and the generic substitute. This is known as a "pay the difference" provision. If a generic substitute is not available, you will pay just the brand-name copayment for the brand-name drug. If your doctor certifies you must take a brand-name drug due to medical necessity, you will not be required to pay the difference between the cost of the brand-name drug and the generic substitute.

Preferred Provider Organization 90 Option (PPO90)		
Prescription Drugs	**In-network**	**Out-of-network**
Inpatient – administered by Capital BlueCross ♦ PPO90 ♦	10%; no copayment after deductible	30% of UCR after deductible
Retail Administered by Express Scripts Up to 31-day supply	$10 copayment for generic $30 copayment for preferred brand[1] $50 copayment for non-preferred brand[1]	Not covered
Mail Service Administered by Express Scripts Up to 90-day supply	$20 copayment for generic $60 copayment for preferred brand[1] $100 copayment for non-preferred brand[1]	Not covered
[1] As determined by Express Scripts Preferred list of medications (Formulary) available on www.express-scripts.com		

Your Choice High Participants

When you fill your prescription at an Express Scripts participating retail pharmacy, the Plan's benefit is 80% of the negotiated price, after you meet the annual deductible.

Your Choice High Option		
Prescription Drugs	**In-network**	**Out-of-network**
Inpatient Administered by Capital BlueCross	20% after deductible	Not covered
Retail Up to 31-day supply Administered by Express Scripts	20% after deductible	Not covered
Mail Service Up to 90-day supply Administered by Express Scripts	20% after deductible	Not covered

Your Choice Low Participants

When you fill your prescription at an Express Scripts participating retail pharmacy, the Plan's benefit is 60% of the negotiated price, after you meet the annual deductible.

Your Choice Low Option

Your Choice Low Option		
Prescription Drugs	**In-network**	**Out-of-network**
Inpatient Administered by Capital BlueCross	40% after deductible	Not covered
Retail Up to 31-day supply Administered by Express Scripts	40% after deductible	Not covered
Mail Service Up to 90-day supply Administered by Express Scripts	40% after deductible	Not covered

Your Prescription Drug Card
If you are covered under the PPO90 or the Your Choice Options, you receive a prescription drug card from Express Scripts.

It is important that you use your card at the pharmacy at all times. However, if you have lost your card and need to have a prescription filled, you may have your prescription filled at a participating pharmacy ***without*** your drug card. You will have to pay the full cost up front which will not include the Plan's normal discount. You can then file a claim with Express Scripts for reimbursement minus the applicable copayment or your share of the cost. It is important that you contact your prescription drug administrator immediately to obtain a replacement card. All registered members on www.express-scripts.com can print a temporary prescription card from the member Web site.

Mail Order

PPO90 Participants
When you order your prescription drugs through the mail, your copayment will be $20 for generic drugs, $60 for brand-name drugs that are on Express Scripts list of preferred medications, and $100 for brand-name drugs that are not on Express Scripts list of preferred medications.

Your Choice Participants
When you fill your prescription at a Express Scripts participating retail pharmacy, the Plan's benefit is 80% of the negotiated price, after you meet the annual deductible for the Your Choice High and 60% of the negotiated price, after you meet the annual deductible for the Your Choice Low.

To use the mail service program, ask your physician to prescribe needed medications for up to a 90-day supply plus refills. Then, complete a prescription mail-order form from your prescription drug administrator and return it along with your prescription and copayment to the address shown on the form. Your medications will be delivered to you within 14 days from the date the mail order pharmacy receives your order, along with instructions for future prescriptions and/or refills. (For emergency or urgent prescription situations, you should use your retail pharmacy.) You can get a copy of the form by calling your prescription drug administrator at the number on your prescription drug card.

Covered Services – Prescription Drugs

The following services are covered under the prescription drug component of the program administered by Express Scripts. Unless otherwise stated, all services are covered under the retail and mail service program:

- Federal legend drugs
- Diabetic supplies, including those listed in the diabetic equipment and supplies available through the PPL Health Plan chart in "Covered Services – Medical."
- Anorexients and anti-obesity drugs
- Compound Prescriptions containing at least one Federal Legend Medication
- Fertility drugs
- Contraceptives, including:
- Oral contraceptives
- Patches
- Rings
- Injectables
- Diaphragms
- Nicotrol inhalers
- Nasal sprays
- Zyban
- Genetically engineered drugs
- Immune altering drugs
- Pre-natal vitamins for females
- Cough/cold preparation
- Mental health drugs
- Annual flu vaccine at your in-network retail pharmacy
- Shingle vaccine at your in-network retail pharmacy

What Is Not Covered – Prescription Drugs

The following services are not covered under the prescription drug component of the program administered by your prescription drug administrator.

- Over-the-counter medications (except diabetic supplies)
- Prescription vitamins and food supplements
- Drugs dispensed by nursing home, physician or hospital that are covered through the Medical Plan
- Diabetic pumps (these are covered under the medical component of the Plan)
- Prenatal vitamins for males
- Yohimbine products
- Male sexual dysfunction drugs beyond a maximum supply as determined by prescription drug administrator
- Accutane, unless under age 25
- Growth hormones, unless approved through prior authorization
- Retin A, unless under age 25

Livongo

Express Scripts voluntary diabetes program that provides diabetes coaching and blood sugar monitoring. The program also provides free test strips and equipment to participants. You may contact Livongo at 1-800-945-4355 or visit www.welcome.livongo.com/ppl. Use registration code PPL.

Mental Health/Substance Abuse

Before seeking care at a Mental Health/Substance Abuse provider, you are able to have 6 free visits at a counselor through the Employee Assistance Program. Please contact them at 1-800-327-7059.

www.magellanhealth.com/member

All Mental Health Substance Abuse claims are handled in the same manner as medical claims.

Coordination of Benefits

If You Are Covered by More than One Medical Plan

In situations where you have other coverage that pays primary, the PPL Retiree Health Plan has a provision to ensure that payments from all of your group medical plans do not exceed the amount the PPL Retiree Health Plan would pay if it were your only coverage.

The rules described here apply to the PPO90 and Your Choice options. They do not apply to any private, personal insurance you may have.

Non-Duplication of Benefits

If you and your eligible dependents are covered under more than one group plan, the primary plan (the one responsible for paying benefits first) needs to be determined. If the PPL Retiree Health Plan is paying secondary, your PPL Retiree Health Plan coverage will ensure that, in total, you receive benefits up to what you would have received with PPL as your only source of coverage (but not in excess of that amount), based on the primary carrier's allowable amount. A summary of coordination rules (i.e., how PPL coordinates coverage with another group plan to ensure non-duplication of benefits) is provided below. If you have questions, contact Capital BlueCross.

Here is an example of how the PPL Retiree Health Plan coordinates benefits with other medical plans. Assume your spouse has a medically necessary procedure with a usual, customary and reasonable (UCR) charge of $100. If your spouse's plan (which we will assume is primary) pays 70% for that procedure, your spouse will receive a $70 benefit (70% of $100). Also assume that your PPL Retiree Health Plan medical option (which we will assume is your spouse's secondary coverage) would pay 80% for this medically necessary procedure. In this case, your spouse normally would receive an $80 benefit (80% of $100) from the PPL Retiree Health Plan. Because your spouse already received $70 from her or his primary plan, she or he would receive the difference ($10) from the PPL Retiree Health Plan.

Determining Primary Coverage

The insurance company underwriting the plan, which is the first to determine benefits, is the primary carrier. The other insurance company is the secondary carrier. To determine which medical plan pays first as the primary plan, here are some general guidelines:

- As a PPL retiree, the PPL Retiree Health Plan will consider claims for your medical expenses first. Even if you or a covered dependent becomes entitled to Medicare while you are an active retiree, the PPL Retiree Health Plan will become the secondary plan. If you or a covered dependent is covered by Medicare, please provide copies of your Medicare cards to Your Benefits Resources™.
- If your covered dependent has a claim, the Plan covering your dependent as an employee will pay first. If your claim is for a covered dependent child, the Plan covering the parent who has the earlier birthday in a calendar year will pay first. This is commonly known as the "birthday rule" and will apply in establishing the order of benefit determination under the Plan. However, if the other plan does not use the birthday rule, and instead uses a rule based on gender of the parent, the rule of the other plan will determine the order of benefits payments.
- In the event of divorce or legal separation, and in the absence of a qualified medical child support order, the plan covering the parent with court-decreed financial responsibility will pay first. If there is no court decree, the plan of the parent who has custody of the covered dependent child will pay first. (See the "Qualified Medical Child Support Order" section for more information.)

- If you are a PPL retiree employed elsewhere and covered under another employer's plan, that plan will be responsible for paying claims first for you and your dependents.
- If your other medical plan does not have a coordination of benefits provision, that plan will pay first for you and your covered dependents.
- If payment responsibilities are still unresolved, the plan that has covered the claimant the longest pays first.

After it is determined which plan pays benefits first, you will need to submit your initial claim to that plan. After the first plan pays your benefits (up to the limits of its coverage), you can then submit the claim to the other plan (the secondary plan) to consider your claim for any unpaid amounts. You will need to include a copy of the written explanation of benefits (EOB) from your primary plan.

The coordination of benefits prevents duplication and works to the advantage of all members of the group.

When this Plan is not the first to determine its benefits, and payments of the first plan are less than the scheduled fees or allowable expenses under this Plan, benefit payments under this Plan will equal the difference between the payment of the first plan and the allowable expense of this Plan. Payment will not exceed the allowable expense.

Important Reminder
Covered services and benefit levels under Medicare are subject to change by the federal government. Contact your local Social Security office to obtain the most recent information on Medicare costs and coverages. Remember, enrollment in Medicare is not automatic. You must apply for it with your local Social Security office.

Special Note
In certain situations, a disabled individual may be eligible for coverage under the PPL Retiree Health Plan and Medicare.

Benefits for Individuals Who Are Entitled to Medicare

Medicare is the primary payer if you (or your dependent) are covered by Medicare, do not have ESRD and you are not currently working for PPL (retired, on LTD, or any other leave). Contact Your Benefits Resources™ at 1-855-775-6080 when someone enrolls in Medicare. PPL post-65 retiree medical exchange and HRA is the plan available to those enrolled in Medicare under age 65 in addition to those who reach age 65.

Precertification and Predetermination Process

Medical
Precertification is needed for inpatient hospital admissions. Predetermination is needed to verify medical necessity of certain non-inpatient procedures.

Precertification is a process through which inpatient hospital stays are authorized by Capital BlueCross. Predetermination is a process through which certain procedures must be reviewed for medical necessity and predetermination.

The precertification and predetermination process is the same for both options:

- Precertification and predetermination for in-network care is generally the Provider's responsibility—see below for more details (see the Summary of Benefits Chart for limitations for predeterminations).
- If you receive out-of-network care, your provider may precertify or predetermine for you if he/she has a participating agreement with Capital BlueCross; if not, you are responsible to contact Capital BlueCross for authorization for your inpatient hospital stay or for certain procedures (see the Summary of Benefits Chart for limitations for predeterminations).

When Your Provider is Responsible for Precertification for Inpatient Hospital Admissions and Predetermination for Certain Non-inpatient Procedures

If you use a Capital BlueCross participating provider, the provider will contact Capital or its designated agent for you in order to determine whether services are medically necessary and appropriate. If Capital or its designated agent determines that an entire admission, procedure or requested service is not medically necessary and appropriate, you and your provider will be notified in writing that the service will not be paid under the Plan. If you and your provider decide to proceed with a service that is not medically necessary and appropriate, you will be responsible for full payment of the service. If a limited number of days or visits are approved, the unapproved days or visits will be your financial responsibility.

If the participating provider does not contact Capital or its designated agent prior to an admission, procedure or service when required, your care will be reviewed by Capital or its designated agent after your services are received. If Capital or its designated agent determines that an admission, procedure or service was not medically necessary and appropriate, you will not be financially liable for charges associated with those services.

For an emergency or maternity-related admission, a participating provider is responsible for contacting Capital or its designated agent following the admission, at which time the admission will be reviewed. If the admission is found to be not medically necessary and appropriate, *you will not be financially liable for charges associated with those services.*

When You Are Responsible for Precertification

- **For emergency or maternity-related admissions: You must contact Capital** or its designated agent to certify any emergency or maternity-related admission. For emergency or maternity-related admissions, you should call Capital or its designated agent within 48 hours of the admission, or as soon as reasonably possible. You can contact Capital via the toll-free Capital Customer Service number on the back of your ID card **(1-866-675-2242)**.
- **All planned admissions, procedures and services: You must contact Capital** or its designated agent ***PRIOR TO YOUR ADMISSION OR SERVICE***. You should call Capital or its designated agent seven to 14 days prior to your planned admission or service. Contact Capital via the toll-free Capital Blue Cross Customer Service number on the back of your ID card **(1-866-675-2242)**.

Non-participating providers are not obligated to contact Capital or its designated agent or to abide by any determination of medical necessity and appropriateness rendered by Capital or its designated agent. A non-participating provider may, therefore, bill you for services that are not medically necessary and appropriate.

If you do not call to precertify your admission to or a service by a non-participating provider, your care will be reviewed by Capital or its designated agent after your services are received, at which time it will be determined whether such services were medically necessary and appropriate.

- If an admission, procedure or service is found to be medically necessary and appropriate, your benefit program will pay up to the non-participating provider allowance for covered

services and your provider can bill you for any balance of the charges which are not covered under your benefit program.

- If the entire admission/service is determined not to be medically necessary and appropriate, you will be responsible for full payment.
- If a specific number of days or visits for an admission or service are approved and you continue to receive services beyond the approved number of days or visits, you will be responsible for full payment of those days or visits which are not approved.

Continued Stay Review

While you or your covered dependent are receiving services that require ongoing review, Capital or its designated agent will be in contact with medical personnel familiar with your case to make certain that continued service is appropriate. Determination of the need for continued service will be made in consultation with your physician(s). Capital or its designated agent, the facility or the provider will notify you if continued service is determined to be no longer medically necessary and appropriate. If you or your covered dependent elects to receive service after such notification, no further benefits will be provided for the remainder of the service.

Discharge Planning

Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, Capital or designated agent will help plan for and coordinate your discharge to ensure that any continued care is delivered in the most medically appropriate and cost-effective setting.

Prescription Drug Program

Precertification *Required* for Certain Services

Some medications require clinical prior authorization or prior approval before they can be filled. The reasons vary depending on the medication. For example, the quantity of the medication prescribed, or the frequency of its administration, may differ from a standard guideline provided by the FDA. The categories and/or medications that require clinical prior authorization may include but are not limited to:

- ADHD: after age 18
- Androgens, Anabolic Steroids and Human Growth Hormones
- Smoking Cessation (prescription)
- Obesity/Weight Loss
- Narcolepsy
- Interferons
- Botulinum Toxin
- Dermatologicals: Tazorac/Retin-A: after age 24
- Penlac
- Zomig and Emend: quantity limits depending on strength
- Impotency: quantity 8 per 30-day supply, 24 per 90-day supply
- Imitrex/Maxalt/Axert: quantity limits depending on strength
- Diflucan 150 mg: 2 tabs in 30 days, 6 tabs in 90 days
- Insomnia: 60 day supply in 90 days

To determine if you need a clinical prior authorization or to request approval, contact your prescription drug administrator.

Case Management

Case management is a process in which a Capital case manager, with input from you and your health care providers, assists with the planning and coordination of your health care needs. Patients with catastrophic illness or injury are referred to this program. If it is determined that case management intervention would be beneficial, you will be contacted regarding your participation in the program.

Throughout the country, certain hospitals have been identified as "centers of excellence" for treatment of complex medical conditions, which require high quality, specialized care. Such conditions can include illnesses requiring organ transplants, complex cases of open heart surgery, advancing cancer cases and other rare and/or serious diseases. For certain complex medical and specialized conditions requiring travel for admission to a center of excellence, the Plan will provide reimbursement of reasonable expenses related to travel and lodging for a companion to accompany the patient to the site of the center of excellence.

Requests for travel expense assistance will be reviewed by Capital BlueCross on a case by case basis. However, consideration will be given only for travel and lodging expenses if the center of excellence is located more than 100 miles away from your home address and the case is approved in advance by the Health Management Services unit. As with all in-patient hospitalization, admissions to a center of excellence must be recommended by a physician and preauthorized by the Capital unit. Financial assistance for travel-related expenses will be considered only for preauthorized admissions.

All requests for travel expense assistance should be directed to Capital BlueCross by calling 1-866-675-2242.

Filing Health Care Claims

In most cases, your provider will file claims for you. In some circumstances, however, you are responsible for filing claims.

PPO In-network

If you receive services from a PPO participating network provider, you will not have to file a claim. The provider is responsible for filing all claims.

PPO Out-of-network

If you receive services from an out-of-network provider, you may be required to file a claim. If the non-PPO provider has a participating agreement with Capital BlueCross program, the provider will file claims for you.

If a provider does not participate in the PPO network and does not have a participating arrangement with Capital BlueCross, you will most likely need to file the claim yourself. And you will be responsible for paying the provider the difference between Capital BlueCross's "reasonable and customary charge" and the actual charge. In many cases this can be a substantial difference. You should know the cost of the service and Capital BlueCross reimbursement prior to obtaining out-of-network services.

Take the following steps when you need to file a claim:

- ***Know Your Benefits*.** Review this information to see if the services you received are eligible under your medical program.
- ***Get an Itemized Bill*.** Itemized bills must include:
  - The name and address of the service provider

- The patient's full name
- The date of service or supply
- A description of the service/supply
- The amount charged
- The diagnosis or nature of illness
- For durable medical equipment, the doctor's certification
- For private duty nursing, the nurse's license number, charge per day and shift worked
- For ambulance services, the total mileage

Note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from provider) with your claim form. Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

- ***Copy Itemized Bills.*** You must submit originals, so you'll want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. Claim forms are available from Capital BlueCross Customer Service by calling 1-866-675-2242.
- ***Attach Itemized Bills to the Claim Form and Mail.*** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the form.

Remember that multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each patient.

Your claims must be submitted no later than the end of the calendar year following the calendar year for which benefits are payable.

Your Explanation of Benefits Statement

Once your claim is processed, you will receive an Explanation of Benefits (EOB) Statement. This Statement lists: the provider's charge; allowable amount, copayment, deductible and coinsurance amounts, if any, you are required to pay; total benefits payable; and total amount you owe (if any).

Prescription Drugs

You do not need to file a claim when you use your ID card to fill a prescription at a participating retail pharmacy.

To use the mail service program, complete a mail service drug form and send it along with your prescription to the mail service pharmacy at the address on the form. Include your copayment (PPO90) or your share of the cost (HDHP) for each prescription in the form of a check or money order. Or, you can use your credit card. Mail service forms can be obtained by contacting your prescription drug administrator.

No benefits are paid if you fill your prescription at a retail pharmacy that is not part of the Express Scripts network.

Under the HDHP option, if you fill your prescription at a retail pharmacy that does not participate in the Express Scripts network, or if you do not present your ID card at a Express Scripts pharmacy, you must pay the full cost of the drug and then file a claim with Express Scripts for reimbursement. You must file a claim form within 45 days. Forms can be obtained by contacting Express Scripts.

Your Right to Appeal
Timeframe for Initial Claim Determination

For urgent care claims and pre-service claims (claims that require approval of the benefit before receiving medical care), the Plan Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- 72 hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification)
- 15 days after receipt of a pre-service claim

For urgent care claims, if you fail to provide the Plan Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The Plan Administrator's receipt of the requested information
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time

For post-service claims (claims that are submitted for payment after receiving medical care), the Plan Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the Plan Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Plan Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the Plan Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan's procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters

- Is a communication that names you, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

If You Receive an Adverse Benefit Determination

The Plan Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

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

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination

- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor by that person's subordinate.
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental).
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision

In the case of a claim for urgent care, you have the right to an expedited review process in which:
- You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
- All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

Ordinarily, a decision regarding your appeal will be reached within:
- 72 hours after receipt of your request for review of an urgent care claim
- 30 days after receipt of your request for review of a pre-service claim
- 60 days after receipt of your request for review of a post-service claim

The Plan Administrator's notice of an adverse benefit determination on appeal will contain all of the following information:
- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request

Urgent Care Claims

Urgent care claims are those which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

Subrogation and Right of Reimbursement

The purpose of the PPL Retiree Health Plan is to provide medical coverage for qualified medical expenses that are not covered by a third party. If the PPL Retiree Health Plan pays benefits for any claim you incur as the result of negligence, willful misconduct or other actions of a third party (such as in the case of an accident), the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of any monies recovered from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement or otherwise. In addition, you will be required to assist the Plan Administrator in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan. In addition, the Plan is entitled to reimbursement of any claim paid for which you receive compensation from a third party, other than a family member, for medical expenses that have been paid by the Plan.

For Medical benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim.

When Coverage Ends

In general, pre age 65 coverage under the PPL Retiree Health Plan will end on the last calendar day of the month in which you turn 65. Coverage may also end for other reasons, such as:

- You are no longer eligible for benefits;

- You fail to make any required contributions;
- PPL terminates this Medical Plan;
- You die.

Your dependent's coverage will end if:

- Your coverage terminates;
- You fail to make any required contributions;
- Your dependent is no longer eligible for benefits;
- PPL terminates dependent coverage under this medical Plan;
- You or your dependent dies; or
- You fail to provide documentation to verify dependent eligibility.

On the date your coverage would otherwise end, you may be able to continue your coverage under the federal law known as COBRA. You may be eligible for post age 65 retiree coverage if eligible for Medicare (see below "Post 65 Medicare Eligible Retirees"). You may also be able to continue coverage if you are on an approved Family and Medical Leave Act (FMLA) leave, military leave or another approved personal leave of absence. If your dependent's coverage ends because of your death, coverage under the Plan may be continued as a survivor by paying the full cost. Survivor coverage can be continued until age 65 or when Medicare eligible as long as dependent eligibility and premium payments continue.

Your Rights to Continue Certain Coverage When It Would Otherwise End

COBRA Continuation of Coverage

Under the PPL Retiree Health Plan and certain federal laws, you are guaranteed certain rights and protections. This section summarizes your rights.

Continuing Medical Participation

According to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you, your spouse and your covered dependent children are eligible to continue group health care coverage if you lose your benefits under certain circumstances (called "qualifying events"). You will be required to pay the full cost of coverage plus an administrative fee.

Continued coverage is available for a maximum of 18, 29 or 36 months, depending on the circumstances under which you are eligible for the continuation as shown in the chart below. The maximum continuation period, if multiple circumstances should occur, is a total of 36 months. This means that if your dependents experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months, for a total of up to 36 months from the original qualifying event.

COBRA Continuation Period

	Maximum Continuation Period		
Qualifying events that result in loss of coverage	**Employee**	**Spouse**	**Child**
Employee's work hours are reduced	18 months	18 months	18 months
Employee terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee retires	18 months	18 months	18 months
Employee or dependent is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation coverage that begins as a result of termination or a reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse legally separate or divorce	N/A	36 months	36 months

	Maximum Continuation Period		
Qualifying events that result in loss of coverage	**Employee**	**Spouse**	**Child**
Employee becomes eligible for Medicare within 18 months before termination of employment or reduction in work hours	N/A	36 months*	36 months*
Child no longer qualifies as a dependent	N/A	N/A	36 months

* *36-month period is counted from the date the employee became entitled to Medicare.*

Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your spouse and your dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you, adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary. The COBRA provisions in this section also apply to any HMO offered to active retirees through the hospital.

Second Qualifying Events

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- If your dependent(s) experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
- If you (the retiree) become entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced), and then a second qualifying event (i.e., your termination of employment or reduction in hours of work) happens within 18 months, your dependents may elect COBRA continuation for up to 36 months from the date you become entitled to Medicare.
- If you or your dependent is disabled (as determined by the Social Security Administration) on the date of a termination of employment or reduction in work hours or at any time during the first 60 days of COBRA continuation coverage due to such event, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of 29 months). To qualify for this disability extension, the Plan Administrator must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator within 30 days after this determination.

Important Note: If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualifying beneficiary who is a spouse or dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in work hours.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation upon legal separation, divorce or loss of a child's dependent status under the Plan, you or one of your dependents must notify the Plan Administrator of the legal separation, divorce or loss of dependent status within 60 days of the later of:

- The date of the event; or
- The date the individual would lose coverage under the Plan.

Your covered dependents then will be provided with instructions for continuing health coverage. Individuals already on COBRA continuation must notify the Plan Administrator within these deadlines if a legal separation, divorce or loss of a child's dependent status occurs, which would extend the period of COBRA coverage for your spouse or dependent child(ren).

Also, to extend coverage beyond 18 months because of disability, notice of the Social Security determination of disability must be provided to Your Benefits Resources™ during the initial 18-month period and within 60 days after the determination is issued. This extension will apply to each qualified beneficiary, whether disabled or not. If Social Security determines that the qualified beneficiary is no longer disabled, Your Benefits Resources™ must be notified within 30 days after this determination.

For other qualifying events (if your employment ends, your hours are reduced or you become entitled to Medicare), you and your covered dependents will be provided with instructions for continuing your health coverage. In the event of your death, the Company will notify your covered dependents how to continue health coverage.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of:

- The date you and/or your covered dependent(s) would lose coverage as a result of the qualifying event; or
- The date the Company notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

If you elect continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation but fail to pay the premium due within the 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day for which timely payment was made.

Cost

The cost of COBRA medical coverage is 102% of the full group cost of Plan coverage. (A spouse or dependent making separate elections will be charged the same rate as a single retiree, plus 2%.) The cost of coverage for the 19th through the 29th months of coverage under the disability extension (except as provided below) is:

- 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual; and
- 102% for any family members participating in a different coverage option than the disabled individual.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months, even if the individual is disabled. If a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through the 29th month), then the rate for the 19th through 36th months of the COBRA continuation is:

- 150% for all family members participating in the same coverage option as the disabled individual; and
- 102% for any family members in a different coverage option than the disabled individual.

Coverage During the Continuation Period

If the coverage under the plan is changed for active retirees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries may also change their coverage elections:

- During the annual enrollment periods;
- If a change in status occurs; or

- At other times under the Plan to the same extent that active retirees may do so.

When COBRA Continuation Coverage Ends

COBRA continuation of health coverage for any person will end when the first of the following occurs:

- The applicable continuation period ends.
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due.
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an retiree or otherwise) under another group health plan not offered by the Company that does not contain an exclusion or limitation affecting the person's pre-existing condition, or the other plan's pre-existing condition limit or exclusion does not apply or is satisfied because of the HIPAA rules.
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare.) In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.
- For newborns and children adopted by or placed for adoption with you (the retiree) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.
- Your coverage is terminated for cause as described in this Plan.
- The Company terminates all group health coverage for all retirees.

Contact Your Benefits Resources™ for further details. Also, please notify Your Benefits Resources™ if you or your spouse changes your address.

HIPAA Privacy Rights and Protected Health Information

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires group health plans to protect the confidentiality of private health information. The Plan will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law. By law, the Plan requires all of their business associates to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the HIPAA Notice of Privacy Practices, please contact the Human Resources Department.

If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, you should contact the insurer or the Plan's Privacy Officer.

Glossary of Terms and Definitions

Please note that the term "Administrator" refers to Capital BlueCross and Express Scripts.

Administrator – The third party vendor contracted by PPL to perform the administrative services under the Plan. The Administrators of the program are as follows:

- PPO Options
  - Medical – Capital BlueCross
  - Prescription Drug –Express Scripts

- Your Choice Options
  - Medical – Capital BlueCross
  - Prescription Drug –Express Scripts

Allowable Charge– The dollar amount that is determined by the Administrator to be reasonable for covered services provided under the Plan. This is an important term to know if you go outside the network for care. The amount the Plan pays for care through a non-participating provider is based on the allowable charge, not the provider's actual charge (see "Balance Billing" and "Provider's Reasonable Charge").

Authorization – The official agreement between the provider and the Administrator that care meets the definition of "medically necessary and appropriate."

Balance Billing – You may receive care from a provider who does not participate in the Administrator's Network (out-of-network care). In this case, the Plan's out-of-network benefit will be applied to the Administrator's allowable charge to determine the Plan payment. You may then be responsible for a balance billing liability equal to the difference between the Administrator's allowable charge and the provider's actual charge. The Plan does not pay benefits for out-of-network outpatient prescription drugs.

Administrators cover services that they or their designated agent(s) determine to be medically necessary and appropriate. Participating providers will accept this determination unless you elect to receive services which have been determined not to be medically necessary and appropriate, and you have been notified of this determination prior to receiving the services. A non-participating facility or professional provider is not obligated to accept this determination and may bill you for services determined not to be medically necessary and appropriate. You are solely responsible for payment of such services rendered by a non-participating facility or professional provider, subject to the conditions and limitations of your benefit program.

Under the Capital BlueCross programs, if you elect to receive services from a non-participating facility or professional provider, you should contact Capital BlueCross's Healthcare Management Services (Capital) or its designated agent to confirm the medical necessity and appropriateness of the services.

Birthing Facility/Birthing Center – A facility licensed by the state which, for compensation from its patients, is organized and staffed primarily to provide maternity care and is under the supervision of a Nurse-Midwife.

BlueCard Program – A feature under the PPO options that allows you or a covered dependent to receive care from BlueCross BlueShield providers around the country when you are away from home.

Coinsurance – The percentage of eligible expenses the Plan pays toward the medical service(s) you receive; you pay any remaining percentage of the cost of the service(s).

Copayment (or "copay") – The fixed up-front dollar amount you must pay to a participating provider at the time of the service for certain covered expenses. This SPD describes which covered services are subject to a copayment. A PPO participating provider will usually collect the copayment from you at the time the covered service is provided. Copay amounts do not apply toward your deductible or coinsurance and they do not accumulate toward the out-of-pocket maximum.

Custodial care – Any service or supply, including room and board, which:
- Is furnished mainly to help you meet your routine daily needs; or
- Can be furnished by someone who has no professional health care training or skills; or
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

Deductible – The annual amount you must pay for most services under a medical option before the Plan begins paying benefits. Expenses or amounts in excess of allowable charges or usual, customary and reasonable limits do not count toward the deductible.
Durable Medical Equipment – Items which can withstand repeated use; are primarily and customarily used to serve a productive medical purpose; are generally not useful to a person in the absence of illness, injury or disease; are appropriate for use in the home and do not serve as comfort or convenience items.

Emergency Accident Services – The initial treatment of bodily injuries resulting from an accident.

Emergency Care – The initial treatment of a sudden onset of a medical condition or injury. This shall not include treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law. The symptoms or injury must be of sufficient severity to warrant immediate attention.

Emergency Medical Services – The initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:
- Permanently placing your health in jeopardy;
- Causing other serious medical consequences;
- Causing serious impairment to bodily functions; or
- Causing serious and permanent dysfunction of any bodily organ or part.

Experimental/Investigative – The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Administrator or its designated agent to be medically effective for the condition being treated. The Administrator will consider an intervention to be experimental/investigative if:
- The intervention does not have FDA approval to be marketed for the specific relevant indication(s)

- Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes
- The intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies
- The intervention does not improve health outcomes
- The intervention is not proven to be applicable outside the research setting

If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Family Deductible – The deductible you pay for the entire family, regardless of its size, is specified under "family" deductible.

For PPO: To reach this total, you can count the expenses incurred by two or more family members. However, the deductible contributed toward the total by any one family member cannot be more than the amount of the individual deductible. If one family member meets the individual deductible and again needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

When two or more family members are injured in the same accident, only one family deductible will be applied to the aggregate of such charges.

For Your Choice High: To reach this total, one family member, or a combination of family members must reach this deductible before the plan will pay 80%.

For Your Choice Low: To reach this total, one family member, or a combination of family members must reach this deductible before the plan will pay 60%.

Health Care Management Services – A Capital BlueCross program which integrates all activity related to managing medical care from the time that an admission, surgical or diagnostic procedure, or certain services become necessary.

Home Health Care Agency – A provider of home health care licensed by the state and certified by Medicare which, for compensation from its patients:

- Provides skilled nursing and other services on a visiting basis in the home; and
- Is responsible for supervising the delivery of such services under a plan prescribed by the attending physician.

Hospice – A provider of hospice services licensed by the state, which, for compensation from its patients, is primarily engaged in providing palliative care to terminally ill individuals.

Hospice Care – A program which provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients and their families. Hospice services are centrally coordinated through an interdisciplinary team directed by a physician.

Hospital – A duly licensed provider that is a general or special hospital which has been approved by Medicare, the Joint Commission on Accreditation of Healthcare Organizations, or the American Osteopathic Hospital Association which, for compensation from its patients:

- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians; and

- Provides 24-hour nursing services by or under the supervision of registered nurses.

In-network Providers – Medical providers who participate in the Administrator's network. Under the PPO options, this means providers who participate with the BlueCross BlueShield national PPO or BlueCard network.

Medical Care – Professional services rendered by a professional provider or professional other provider for the treatment of an illness or injury.

Medically Necessary and Appropriate – Services or supplies provided by a health care provider that the Administrator determines are: appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and provided for the diagnosis, or the direct care and treatment of your condition, illness, disease or injury; and in accordance with standards of good medical practice; and not primarily for your or your provider's convenience; and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this means that you require acute care as an inpatient due to the nature of the services rendered for your condition, and you cannot receive safe or adequate care as an outpatient. The Administrator reserves the right to determine in its sole judgment whether a service is medically necessary and appropriate. No benefits will be provided unless the Administrator determines that the service or supply is medically necessary and appropriate.

Network – All providers approved as a network by the Pennsylvania Department of Health that have entered into a contractual agreement either directly or indirectly with the Administrator to provide health care services.

Non-participating Providers – Providers who do not have an agreement with the Administrator and do not accept the Administrator's allowance as payment in full. If you receive care from a non-participating provider, you may be subject to a balance billing liability, which could be substantial.

Out-of-network Providers – Medical providers who do not participate in the Capital BlueCross PPO network (PPO out-of-network providers may still be Capital BlueCross "participating providers"), or the local BlueCross BlueShield PPO network where care is received.

Out-of-pocket Maximum – The most you will pay for covered services each year under a medical option. This amount includes your annual deductible and your coinsurance liability and co-payments. The out-of-pocket maximum does not include amounts in excess of allowable charges or usual, customary and reasonable limits; penalties for failure to precertify services performed by an out-of-network provider for inpatient care; or charges for services that are not covered by the Health Plan.

Participating Providers – Participating providers who have an agreement with Capital BlueCross pertaining to payment for covered services and agree to accept Capital BlueCross's allowance as payment in full for covered services.

Physician – A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) and is licensed and legally entitled to practice medicine, perform surgery and dispense drugs.

Precertification – Process through which certain inpatient hospital services are pre-approved by the Administrator and the member is covered for services.

Predetermination – Process through which certain non-inpatient hospital services are verified for medical necessity by the Administrator and the member is covered for services.

Preferred Provider Organization (PPO) Program – An option that is based on a network including physicians, specialists, hospitals and other health care facilities. These providers agree to accept discounted fees when providing treatment to PPO participants. Using this provider network helps assure that members receive maximum coverage for eligible services. Participants are not required to select a primary care physician under a PPO.

Provider – A facility provider, professional provider, or a professional other provider, licensed where required and performing within the scope of such licensure.

Provider's Reasonable Charge – The provider's reasonable charge is the amount agreed to by the Administrator and the provider or an amount that the Administrator determines is reasonable for covered services provided to a member. In the case of professional providers (see the "Professional Providers" section for details), the provider's reasonable charge will not exceed the usual, customary and reasonable allowance.

Skilled Nursing Facility – A facility other provider approved by the state and certified by Medicare, which, for compensation from its patients, is primarily engaged in providing skilled nursing services on an inpatient basis to patients requiring 24-hour skilled nursing services but not requiring confinement in an acute care general hospital. Such care is rendered by or under the supervision of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

- Minimal care, custodial care, ambulatory care, or part-time care services; or
- Care or treatment of mental illness, alcohol abuse, drug abuse or pulmonary tuberculosis.

Specialist – A physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty other than family practice, general practice, internal medicine or pediatrics.

Substance Abuse – Any use of alcohol and/or drugs, which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Terminal Condition – A condition of the Plan participant, which has been diagnosed by a physician and for which the Plan participant has a prognosis of six months or less to live.

Usual, Customary and Reasonable (UCR) Allowance – Capital BlueCross reimbursement amounts are often referred to as UCR allowances. It is a method used to determine and pay providers on the basis of:

- **Usual** – The allowed amount determined by Capital BlueCross for a professional provider based upon that individual provider's charges for the procedure performed.
- **Customary** – The allowed amount determined by Capital BlueCross by considering relevant professional, economic and market factors, including but not limited to: charges of professional providers of the same or similar specialty for the procedure performed, the degree of professional involvement, the actual cost of equipment and facilities, or other factors which contribute to the cost of the procedure.

- **Reasonable** – The allowed amount (which may differ from the Usual or Customary allowed amounts) determined by Capital BlueCross by considering unusual clinical circumstances.

Allowed amounts are updated periodically to respond to changing economic and market circumstances. The timing of updates and methodology employed are subject to approval by the Insurance Department of the Commonwealth of Pennsylvania.

Post 65, Medicare Eligible Retirees

Eligibility

Employee hired before July 1, 2014 are eligible for post 65 benefits

When you attain age 65 or otherwise become eligible for Medicare, Medicare will become the primary payer of benefits and will pay most of your medical expenses. Your medical and prescription drug coverage will change as will the manner in which you pay your share of the cost of this coverage.

You are eligible to continue retiree medical coverage through Willis Towers Watson OneExchange or the Aon Retiree Health Exchange depending on when you retired and when you become eligible for Medicare. Retirees may also be eligible for the Health Reimbursement Account (HRA). However, if you have eligible covered dependents that are not eligible to enroll in Medicare, coverage will continue under the pre-Medicare portion of the Plan.

Which retiree health exchange applies to you:

OneExchange	Aon Retiree Health Exchange
You Retired Before May 1, 2016 **AND** Either you or your spouse turned **age 65** (or enrolled in Medicare) before May 1, 2016 and one of you already works with OneExchange to access your Health Reimbursement Account (HRA)	You Retired Before May 1, 2016 **AND** Neither you nor your spouse were age 65 (nor Medicare Eligible) before May 1, 2016 **OR** You Retired on or After May 1, 2016

Dependents

Your eligible dependents are eligible to participate in the program, provided you enroll them.

Eligible dependents include:

- Your legally married spouse
- Your child(ren) up to age 26. This includes:
  - Natural and legally adopted children and children placed with you for adoption;
  - Stepchildren;
  - Any child for whom you or your spouse is a court-appointed legal guardian;
  - Any other child with whom you or your married spouse maintain a parent-child relationship and have a legal guardianship;
- Your dependent child(ren) over age 26, provided the child is incapable of self-support because of physical or mental disability that occurred prior to their attaining age 26.

This Plan has been carefully designed to maximize benefits for eligible PPL retirees, with optimum efficiency, coverage, and cost containment. For the Plan to operate for the benefit of all concerned,

retirees and their dependents are required to abide by the terms of eligibility and rules of coverage. Any attempt by a retiree or dependent to obtain benefits not intended to be provided herein will result in the ineligibility of the offending person for further coverage, as well as possible legal liability for the cost of claims erroneously paid.

Following are examples of abuses that will result in ineligibility for future benefits and possible legal liability: enrolling ineligible dependents, failing to remove dependents who have become ineligible, changing doctors or pharmacies solely to avoid limitations, making false or misleading claims, failing to correct claims information you have been asked to verify.

Joining the Plan

When you turn 65 and are retired, you must enroll in Medicare and a Medicare supplement plan. If you do not enroll in a Medicare plan when you are first eligible, you may be subject to additional premiums for enrolling after your initial eligibility date. Please contact Medicare or the retiree health exchange that applies to youfor more information.

If your dependent is not eligible for Medicare when you are (or visa versa), coverage will continue under the pre-Medicare plan for the individual who is not eligible to enroll in Medicare and the Medicare-eligible person will enroll through the retiree health exchange that applies to you for medical and prescription drug coverage.

Enrollment

If you are eligible for retiree medical coverage, you will need to complete your enrollments. You will elect your coverage option for medical and prescription drug plan separately.

An eligible retiree (and spouse, if applicable) becomes a participant in the plan on the later of the effective date of the plan or the date that he or she has satisfied all of the following requirements:

- Becomes eligible for Medicare;
- Obtains an individual health insurance policy through the retiree health exchange that applies to you. (or any of its affiliates);
- Completes any enrollment forms or procedures required by the Plan Administrator.

When Coverage Begins

Unless you choose to waive your coverage, Coverage begins on the first day of the month that you become Medicare eligible.

If you choose to waive your coverage and re-enroll at a later date, your coverage will begin on the first day of the month following the date that you enroll or January 1st of the following year, if you enrolled during annual open enrollment. If you do not enroll in a Medicare plan when you are first eligible, you may be subject to additional premiums for enrolling after your initial eligibility date. Please contact Medicare or the retiree health exchange that applies to you for more information.

When Coverage Ends

Your coverage as a retiree will continue until:

- You are no longer eligible for benefits;
- You are rehired as an active employee;
- You are no longer eligible for Medicare;
- You neglect to pay the required contributions;
- You elect to revoke your election, or
- You die.

Coverage for your Medicare eligible dependent(s) stop on the last day of the month in which:

- You neglect to pay the required contributions;
- Your dependent(s) are no longer eligible;
- You elect to stop dependent coverage;
- Your dependent(s) die;
- PPL terminates dependent coverage under this Health Plan; or
- You fail to provide documentation to verify dependent eligibility.

Survivor Continuation Coverage

Because the post 65 plans are individual plans, surviving spouses and dependents of retired employees may continue coverage. However, surviving spouses are not eligible for an HRA contribution, but may use any remaining HRA balance from the deceased retiree.

Cost

The amount retirees pay for Medicare eligible retiree medical and prescription coverage depends on the option you choose. Retirees will pay premiums directly to the provider. PPL will provide retirees with a Health Reimbursement Account (HRA) to assist with the cost of coverage.

Health Reimbursement Account (HRA)

As a retiree, if you continue to qualify for retiree medical coverage when you become eligible for Medicare, the Company will set up and fund a Health Reimbursement Account (HRA) in your name.

The Health Reimbursement Account (HRA) is administered through the retiree health exchange that applies to you, which will manage account balances, make determinations regarding the qualification of expenses submitted for reimbursement and facilitate payments from the Trustee.

Funding the HRA

The HRA is a notional account with funds provided solely by the Company. Individual contributions are not permitted and will not be accepted by the Trustee.

Annual Contribution

The PPL contribution to your HRA will begin the first day of the month that you and/or your covered spouse are eligible for Medicare, this amount is pro-rated based on the months you are enrolled in Medicare. The date of commencement and the amount of the contribution will be determined by your marital status and/or your spouse's Medicare status.

Contributions will be made on behalf of you and/or your spouse only. No contribution will be made for any other eligible dependent – even if they are eligible for Medicare. If your spouse is eligible for Medicare before you, contributions will begin on behalf of your spouse only. If your spouse is not eligible for Medicare, but you are, a contribution will be made for you only. An additional contribution made on behalf of your spouse will begin once they are also eligible for Medicare. All contributions cease upon the death of the retiree.

The current annual contribution for qualified PPL retirees eligible for Medicare is as follows:

PPL Health Reimbursement Account (HRA) Contribution	
Your Marital Status	Annual Contribution
Single	**$1,950**
Married	**$3,900**
Married (Both you and your spouse are	**$2,925 (per person)** **$5,850 (per couple)**

	eligible PPL Retiree*)

* If both you and your spouse are eligible PPL retirees, the amount of the annual contribution will increase to take into account the fact that other married retirees may have the additional resource of their spouse's employer's retiree medical plan.

Eligible Expenses

The HRA will only reimburse expenses for the cost of qualified medical premiums such as:

- Medical premiums
- Dental premiums
- Vision premiums
- Medicare Part B premiums
- Copayments
- Deductibles
- Coinsurance

Non-Eligible Expenses

Treatment that is considered "cosmetic" or other treatment not considered tax-deductible by the IRS are not eligible for reimbursement under the HRA.

Reimbursements for Eligible Expenses

1. When you have eligible expenses, pay the bills at the time of service.

2. An HRA claim is considered valid for reimbursement if it is:
   a. For an eligible expense;
   b. Accompanied by independent third-party verification of the expense, such as an itemized bill or an Explanation of Benefits (EOB)
   c. Incurred by you or your spouse who is enrolled in Medicare
   d. Incurred during the period you are enrolled in the Plan, beginning the later of either the first day of the Plan year or your enrollment date, and ending on the earlier of the last day of the Plan year or the date you cease to be eligible.

3. You must use a claim form to submit expenses. Claim forms can be found on the website of the retiree health exchange that applies to you or you can call the retiree health exchange that applies to you to request a claim form. You may also start a claim online by creating an account and completing the appropriate steps. You can submit claim forms as soon as you incur an eligible expense.

   OneExchange 1-888-598-7807
   Aon Retiree Health Exchange 1-844-537-5302

4. Receipts must include the following information:
   • Name of provider or supplier
   • Name of patient
   • Identification of product or description of service
   • Amount paid
   • Date of service

5. If you are submitting a claim for your monthly premiums, attach a copy of the premium invoice from your plan or a copy of your bank statement/cashed check that verifies the payment.

Note: When submitting a claim, use the coverage period start date as the date of service, not the date of payment. For example, if you are requesting reimbursement of January premiums, use January 1 as

the service date. For other health care expenses, attach copies of the corresponding itemized receipts or Explanation of Benefits (EOB) from your health plan.

Your HRA Account Balance Rolls Over
Any unused balance in your HRA account at the end of the calendar year will roll over to the next year.

Overpayments from the HRA
If it is later determined that you or your eligible dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your eligible dependent will be required to refund the overpayment or erroneous reimbursement to the retiree health exchange that applies to you.

If you do not refund the overpayment or erroneous payment, the retiree health exchange that applies to you reserves the right to offset future reimbursements equal to the overpayment or erroneous payment. If attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

When You Die
When a retiree dies, all PPL HRA contributions will terminate as of the date of your death for both you and your eligible spouse.

The remaining balance in your HRA may be used to reimburse qualified medical expenses for your eligible spouse. However, your HRA account balance cannot be paid as a cash benefit to any beneficiary.

If you have no surviving spouse, your claims must be submitted within 180 days and any balance remaining in your HRA will be forfeited.

Changing Your Coverage
Each year, you will have the opportunity to make changes to your coverage for the following Plan Year during the annual open enrollment period. Changes you make during open enrollment will take effect on January 1 of the following year.

Family Status Changes
In general, you can change your benefits choices only during the annual open enrollment period. You can, however, make certain changes to your benefits choices during the year if you have a qualified change in family status. These include:

- Marriage or divorce;
- Dependent's loss of eligibility;
- A change in your or your spouse's employment that affects eligibility for coverage.

Note: All marriages, divorces and deaths should be reported to Your Benefits Resources.

Medical and Prescription Drug Options

You will work with the retiree health exchange that applies to you, who will assist you in evaluating plans available to you in the open market.

To give you the greatest flexibility for choosing coverage that provides the best benefits for you and your eligible dependents, your medical and prescription drug coverage elections are made separately.

When Is Medicare Primary?
If you are a PPL retiree who is covered under Medicare, Medicare will be primary to the supplemental coverage you enroll in.

If you are also covered under another employer's plan, the question of which plan is primary is generally answered by the following chart:

SITUATION	WHAT IS PRIMARY?	BASIC RULE
• You are retired and covered under Medicare and • also enrolled in a Medicare supplemental plan and • your spouse is still actively employed and you are covered as a dependent under your spouse's employer's health care plan.	In this case your spouse's plan would pay first, Medicare would pay second, and the Medicare supplemental plan would pay third.	The plan that covers the retiree as a dependent of an active employee is primary.
• You and your spouse are retired and covered under Medicare and • you are both covered under a Medicare supplemental and • you are also covered as a dependent under your spouse's former employer's retiree medical plan.	In this case, your health care claims would be submitted to Medicare first, then to the Medicare supplemental plan, then to your spouse's former employer's plan.	Medicare is primary if you and your spouse are both retired even if you cover each other under your respective retiree health care plans.

Denial of Claims

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the exchange receives your claim. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the exchange, you may file a written appeal.

Note: You cannot file suit in federal court until you have exhausted these appeals procedures.

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Administrative Information

This information about the administration of the Plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Plan.

Plan Name

The name of this Plan is the PPL Retiree Health Plan.

Plan Sponsor

PPL Services Corporation
c/o Employee Benefits

Two North Ninth Street
Allentown, PA 18101
1-610-774-5022, Option 4

Plan Administrator

PPL Services Corporation
c/o Employee Benefits
Two North Ninth Street
Allentown, PA 18101
1-610-774-5022, Option 4

The administration of the Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator will also have the discretion to determine all matters relating to interpretation and operation of the Plan. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding.

Agent for Service of Legal Process

General Counsel
PPL Services Corporation
Two North Ninth Street
Allentown, PA 18101
1-610-774-2699

Legal process also may be served on the Plan Administrator.

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to PPL is 23-3041441.

The Plan Number for the PPL Bargaining Unit Retiree Health Plan is 521.

Plan Year

The Plan year for the PPL Bargaining Unit Retiree Health Plan is January 1 through December 31.

Organizations Providing Insurance and/or Administrative Services

Listed below are the names, addresses and phone numbers of the organizations that provide administrative services. These services include administering claims and providing customer assistance.

Plan Component	Address	Phone Number	Web Site Address
Pre 65, Not Medicare Eligible			
Medical	Capital BlueCross PO Box 779503 Harrisburg, PA 17177-9503	1-866-675-2242	www.capbluecross.com
Prescription Drug	Express Scripts 100 Parsons Pond Dr. Franklin Lakes, NJ 07417	1-800-841-5346	www.express-scripts.com

Plan Component	Address	Phone Number	Web Site Address

Post 65, Medicare Eligible			
OneExchange	10975 South Sterling View Dr. South Jordan, UT 84095	1-888-598-7807	www.medicare.oneExchange.com/ppl
Aon Retiree Health Exchange	P.O. Box 785040 Orlando, FL 32878	1-844-537-5302	www.retiree.aon.com/ppl

Plan Funding/Sources of Contributions

The Plan is self-insured. Benefits from this Plan are paid from retiree contributions, as applicable, and from the general assets of PPL, as needed. PPL has contracted with third party administrators to administer these plans.

Plan Document

This booklet is intended to help you understand the main features of the Plan. It should not be considered a substitute for the Plan document, which governs the operation of the Plan. If you have any questions about information not covered in this booklet or if this booklet appears to conflict with the official Plan document, the text of the official Plan document will determine how questions will be resolved.

You can request a copy of the Plan document by contacting Employee Benefits via email at benefits@pplweb.com or via US Mail at:

PPL Employee Benefits
2 North Ninth St.
GENTW2
Allentown, PA 18101
1-610-774-5022, Option 4

Limitation on Assignment

Your rights and benefits under the Plan cannot be assigned, sold or transferred to your creditors or anyone else.

Future of the Plan

PPL intends to continue the Plan indefinitely. However, PPL reserves the right to amend, modify, suspend or terminate the Plan, in whole or in part, by action of the Human Resources Department and approval by the Vice President, Human Resources and Services. Any such action would be taken in writing and maintained with the records of the Plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time.

If the Plan is terminated, all benefits will end. If you retire at a time any particular benefits are in effect, PPL does not guarantee that those benefits, for you or your family, will continue for life or any other period of time.

Not a Contract of Employment

Your eligibility or your right to benefits under the PPL Retiree Medical Plan should not be interpreted as a guarantee of employment. The Company's employment decisions are made without regard to the benefits to which you are entitled upon employment.

This SPD provides detailed information about the Plan and how it works. This SPD does not constitute an expressed or implied contract or guarantee of employment.

Your Rights Under ERISA

As a participant in the PPL Retiree Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- You are entitled to examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements.
- You can obtain a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, which is available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You can obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- You are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage

- Continue group health coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing COBRA continuation coverage right.

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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the 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 of 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 you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, 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. To obtain the addresses and telephone numbers of the District offices, you may access the Department of Labor Employee Benefits Security Administration Web site at www.dol.gov/ebsa.