



**Atmos Energy Corporation  
Health and Welfare Benefit Plan**

**Medical Benefit**

**Summary Plan Description**

Effective January 1, 2026

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# SCHEDULE OF COVERAGE

## HIGH DEDUCTIBLE MEDICAL BENEFIT OPTION

**(NOTE: The High Deductible Medical Benefit Option is structured to be compatible with a health savings account (an “HSA”).)**

<b>Deductibles and Out-of-Pocket Maximums</b>		
	Network	Out-of-Network
Individual Deductible	\$3,400	\$5,000
Family Deductible	\$6,800	\$10,000
Individual Out-of-Pocket Maximum*	\$3,400	\$10,000
Family Out-of-Pocket Maximum*	\$6,800	\$20,000
Percentage of Covered Expenses (other than Preventive Care) Payable after Deductibles are Satisfied	100%	70%**
Percentage of Covered Expenses for Preventive Care Payable	100%	Deductible + 30% coinsurance
Percentage of Covered Expenses Payable after Out-of-Pocket Maximum is Reached	100%	100%
<b>What You Pay</b>		
Primary Care Physician	Deductible Only	Deductible + 30% Coinsurance
Specialist		
Urgent Care		
ER Visit		Emergency: Deductible Only**
		Non-Emergency: Deductible + 30% Coinsurance**
<b>MDLIVE Telemedicine</b>	<b>HDHP</b>	
General Medicine	\$20 copay	
Dermatology	\$20 copay	
Psychiatrist (Evaluation)	\$20 copay	
Ongoing Psychiatrist	\$20 copay	
Therapist	\$20 copay	

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Calendar Year Maximum Benefits	
Outpatient Physical Therapy	35 visits
Spinal Manipulations (Chiropractic Services)	35 visits
Skilled Nursing Facility	25 days
Home Health	60 visits
Employee Assistance Program	Up to 8 visits at no charge
HSA Deposit	
Individual	\$500
Family	\$1,000

\* Please see the “**Out-of-Pocket Maximum Feature**” in the “**INTRODUCTION**” Section of this Benefit Booklet for information describing when Out-of-Network expenses will count toward the Network Out-of-Pocket Maximums and that the Individual Out-of-Pocket Maximum will apply separately to each covered family member until the Family Out-of-Pocket Maximum is met.

\*\* Except as provided in the section “**Managed Health Care Out-Of-Network Benefits,**” Out-of-Network Covered Expenses are subject to the Allowable Amount which will be the **lesser of:** (i) the Provider’s billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor will be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

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## PREFERRED PROVIDER ORGANIZATION PLAN

<b>Deductibles and Out-of-Pocket Maximums</b>		
	<b>Network</b>	<b>Out-of-Network</b>
Combined Individual Deductible*		\$600
Combined Family Deductible*		\$1,200
Office Visit Co-payment for Primary Care Physician	\$20**	N/A***
Office Visit Co-payment for Specialist	\$60**	N/A***
Urgent Care Co-payment	\$35**	N/A***
ER Visit	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance****
Individual Out-of-Pocket Maximum****	\$2,100	\$4,000
Family Out-of-Pocket Maximum****	\$4,200	\$8,000
Percentage of Covered Expenses (other than Preventive Care) Payable after Deductibles are Satisfied	80%	70%*****
Percentage of Covered Expenses for Preventive Care Payable	100%	Deductible + 30% Coinsurance
Percentage of Covered Expenses Payable after Out-of-Pocket Maximum is Reached	100%	100%
<b>MDLIVE Telemedicine</b>		
<b>PPO</b>		
General Medicine		\$20 copay
Dermatology		\$20 copay
Psychiatrist (Evaluation)		\$20 copay
Ongoing Psychiatrist		\$20 copay
Therapist		\$20 copay
<b>Calendar Year Maximum Benefits</b>		
Outpatient Physical Therapy		35 visits
Spinal Manipulations (Chiropractic Services)		35 visits
Skilled Nursing Facility		25 days
Home Health		60 visits
Employee Assistance Program		Up to 8 visits at no charge

\* The Combined Individual and Combined Family Deductibles do not apply to office visits to a Primary Care Physician or Specialist or to wellness benefits or the Urgent Care Co-payment. The Combined Individual and Combined Family Deductibles apply to the Out-of-Pocket Maximums. Emergency Room visits are subject to the applicable deductible and coinsurance.

\*\* The Network Co-payments apply toward the Out-of-Pocket Maximums.

\*\*\* There is no Co-payment for Out-of-Network office visits; Except as provided in the section “**Managed Health Care Out-Of-Network Benefits**,” Out-of-Network office visits are subject to the Deductible and coinsurance and reimbursed at the Out-of-Network level, subject to the Allowable Amount as defined in this Plan.

\*\*\*\* Please see the “**Out-of-Pocket Maximum Feature**” in the “**INTRODUCTION**” Section of this Benefit Booklet for information describing when Out-of-Network expenses will count toward the Network Out-of-

## SCHEDULE OF COVERAGE

Pocket Maximum limit and that the Individual Out-of-Pocket Maximum will apply separately to each covered family member until the Family Out-of-Pocket Maximum is met.

\*\*\*\*\* Except as provided in the section "**Managed Health Care Out-Of-Network Benefits,**" Out-of-Network Covered Expenses are subject to the Allowable Amount which will be the **lesser of:** (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor will be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

## SCHEDULE OF COVERAGE

### EXCLUSIVE PROVIDER ORGANIZATION PLAN

<b>Deductibles and Out-of-Pocket Maximums</b>	
Individual Deductible	\$400
Family Deductible	\$800
Individual Out-of-Pocket Maximum*	\$1100
Family Out-of-Pocket Maximum*	\$2200
Office Visit Co-payment for Primary Care Physician	\$20**
Office Visit Co-payment for Specialist	\$60**
Urgent Care Co-payment	\$35**
Individual Co-payment	\$20**
Emergency Room Co-payment	\$200**
Percentage of Covered Expenses (other than Preventive Care) Payable for Network Covered Services after Deductibles are Satisfied	100%
Percentage of Covered Expenses for Preventive Care Payable for Network Covered Services	100%
Percentage of Covered Expenses Payable for Network Covered Services after Out-of-Pocket Maximum is Reached	100%
<b>MDLIVE Telemedicine</b>	
	<b>EPO</b>
General Medicine	\$20 copay
Dermatology	\$20 copay
Psychiatrist (Evaluation)	\$20 copay
Ongoing Psychiatrist	\$20 copay
Therapist	\$20 copay
<b>Calendar Year Maximum Benefits</b>	
Outpatient Physical Therapy	35 visits
Spinal Manipulations (Chiropractic Services)	35 visits
Skilled Nursing Facility	25 days
Home Health	60 visits
Employee Assistance Program	Up to 8 visits at no charge

\* Please see the “**Out-of-Pocket Maximum Feature**” in the “**INTRODUCTION**” Section of this Benefit Booklet for information describing that the Individual Out-of-Pocket Maximum will apply separately to each covered family member until the Family Out-of-Pocket Maximum is met.

\*\* Co-payments for a Primary Care Physician or Specialist office visit, Urgent Care, a Nurse Practitioner or Emergency Room care do not apply toward the Individual and Family Deductibles but do apply toward the Out-of-Pocket Maximums. The Individual and Family Deductibles apply to the Out-of-Pocket Maximums. Once the Out-of-Pocket Maximums are met, Co-payments will not apply.

## SCHEDULE OF COVERAGE

### PRESCRIPTION DRUG BENEFIT

**Except as otherwise noted, the Prescription Drug benefits outlined below are included with all Medical Benefit Options in the Medical Plan except the High Deductible Medical Benefit Option\*.**

Prescription Drug Plan Design	High Deductible*		PPO		EPO	
	Retail (30-day supply)	Mail Service Program (90-day supply)	Retail (30-day supply)	Mail Service Program (90-day supply)	Retail (30-day supply)	Mail Service Program (90-day supply)
Out-of-Pocket Maximum (Individual/Family)	Combined with Medical Out-of-Pocket Maximum		\$4,950/\$9,900**		\$5,550/\$11,100**	
Generic Drug Coinsurance	75%	75%	75%	75%	75%	75%
Generic Drug Maximum	\$10	\$20	\$10	\$20	\$10	\$20
Preferred Brand Name Drug Coinsurance	75%	75%	75%	75%	75%	75%
Preferred Brand Name Drug Minimum	\$25	\$50	\$25	\$50	\$25	\$50
Preferred Brand Name Drug Maximum	\$75	\$150	\$75	\$150	\$75	\$150
Non-Preferred Brand Name Drug Coinsurance	65%	65%	65%	65%	65%	65%
Non-Preferred Brand Name Drug Minimum	\$55	\$110	\$55	\$110	\$55	\$110
Non-Preferred Brand Name Drug Maximum	\$150	\$300	\$150	\$300	\$150	\$300

\* Participants enrolled in the High Deductible Medical Benefit Option will be responsible for paying 100% of the cost of Prescription Drugs (other than toward preventative maintenance Prescription Drugs) until the Deductible is satisfied. Amounts paid for Prescription Drugs will count toward the Participant's Deductible. Preventive maintenance Prescription Drugs (as determined by the Claims Administrator) will be covered in accordance with the table above. Amounts a Participant pays toward preventive maintenance Prescription Drugs will count toward the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met, both preventative maintenance Prescription Drugs and non-preventative maintenance Prescription Drugs will be covered at 100%.

\*\* A Participant covered under Family coverage will not be required to exceed the annual out-of-pocket maximum limit applicable to individuals under the ACA for the plan year. For 2026, the ACA individual out-of-pocket maximum amount is \$10,600 and includes any combination of medical and prescription drug out-of-pocket expenses.

# INTRODUCTION

## INTRODUCTION

This “Benefit Booklet” provides you with a summary of the benefits provided by the Atmos Energy Corporation Group Medical Plan (the “**Plan**”) as in effect on January 1, 2026. Capitalized terms used in this Benefit Booklet have special meanings and they are either defined as they are used or are defined in the “**DEFINITIONS**” section.

Prior to January 1, 2026, the Plan may have treated you differently. Atmos Energy Corporation (“**Atmos Energy**” or “**Employer**”) reserves the right to change, amend, modify, alter or terminate the Plan at any time and in any manner.

This Benefit Booklet serves as the Summary Plan Description for the Plan. This Summary Plan Description is incorporated by reference into the Plan and contains the terms and provisions of the Plan. Because the Summary Plan Description is intended to be written in a nontechnical, easily understood manner, many of the complicating details and special exceptions found in the Plan have been omitted. Many of the technical legal concepts which are required in the Plan and which may affect your rights as described in this Summary Plan Description have been omitted in order to make this Summary Plan Description more easily understood by the average Participant. Thus, in order to obtain a full detailed understanding of the Plan’s terms, you should also examine the other Plan documents which are available from the Plan Administrator. In the event any of the terms of the Plan as described in this Summary Plan Description are subject to more detailed rules and limitations or other special meaning as set forth in the other Plan documents, the other Plan documents will control.

Blue Cross and Blue Shield of Texas (sometimes referred to as “**BCBSTX**”) is the Claims Administrator for the Plan.

You should read this Benefit Booklet carefully to familiarize yourself with the Plan’s provisions and keep it handy for reference. To help you understand the terms of the Plan and what you need to do to get your maximum benefits, contact the Customer Service Helpline.

## MEDICAL BENEFIT OPTIONS

The following Medical Benefit Options are available under the Plan. As explained below, not all options are available to all Participants.

- High Deductible Medical Benefit Option (HDHP)\*
- Preferred Provider Organization (PPO) Medical Benefit Option
- Exclusive Provider Organization (EPO) Medical Benefit Option

\* The High Deductible Medical Benefit Option is designed to be compatible with a Health Savings Account (“**HSA**”). See the subsection entitled “**High Deductible Medical Benefit Option and HSA**” for further information.

In general, you cannot make mid-year changes to your Medical Benefit Option election, but please see the section entitled “**PARTICIPATION AND ELIGIBILITY**” for exceptions to this rule.

## MANAGED HEALTH CARE NETWORK BENEFITS

Network Benefits are available under the PPO, EPO and HDHP Medical Benefit Options through Providers listed in your Network directory. To receive In-Network Benefits, **you must** choose Providers within the Network for all care (**other than for emergencies**).

The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider Directory to make your selections. You may obtain a Provider directory by calling the Customer Service Helpline at 1-866-314-0266 or by accessing the website at [www.bcbstx.com](http://www.bcbstx.com).

**Remember EPO only ...for Participants who elect the EPO Medical Benefit Option, you must choose Providers within the Network for all care (other than for emergencies or unless otherwise authorized by the Claims Administrator).**

## INTRODUCTION

Services and supplies must be provided by Network Providers that have specifically contracted with the Claims Administrator to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill the Claims Administrator – not you – for services provided. The Provider has agreed to accept as payment in full the lesser of:

- The billed charges;
- The Allowable Amount as determined by the Claims Administrator; or
- Other contractually determined payment amounts.

You are responsible for paying Deductibles, Co-payments, and Co-Share Amounts determined by the Plan Medical Benefit Option in which you enroll.

You may be required to pay for limited or non-covered services. No claim forms are required when you receive Network Benefits.

### MANAGED HEALTH CARE OUT-OF-NETWORK BENEFITS

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available.

If you go to an Out-of-Network Provider, benefits will be paid at the Out-of-Network Benefits level. If you choose an Out-of-Network Provider, you may have to submit claims for the services provided. You will be responsible for:

- Billed charges above the Claims Administrator's Allowable Amount, except as provided below;
- Co-payment and Co-Share Amounts;
- Deductibles;
- Preauthorization; and
- Limited or non-covered services.

For some types of Out-of-Network benefits, your Provider may not bill you for more than the Network cost sharing amounts (i.e., Deductibles, Co-payments and Co-Share Amounts). If you receive the types of care listed below your cost sharing will be calculated as if you received care from a Network Provider:

- Emergency care;
- Care provided by Out-of-Network Providers during your visit to a Network Facility; and
- Air ambulance services from Out-of-Network Providers.

There are limited instances when an Out-of-Network Provider may send you a bill for up to the amount of the Provider's billed charges. You are only responsible for the payment of the Out-of-Network Provider's billed charges if, at least 72 hours in advance of receiving services (or as otherwise required by applicable law), you signed a written notice that informed you of:

- The Provider's Out-of-Network status;
- In the case of services received from an Out-of-Network provider at a Network Facility, a list of Network Providers at the Facility who could provide such services; and
- A good faith estimate of the Provider's charges.

Your Provider cannot ask you to be responsible for paying billed charges above the in-network cost-sharing amount for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, and other specialists as determined by applicable law, unless you have provided advance written consent in accordance with federal requirements.

**Remember EPO only...**for Participants who elect the EPO Medical Benefit Option, if you **choose** to use Out-of-Network Providers, **no benefits will be available**. You will be responsible for all charges billed by the Out-of-Network Provider other than for emergencies.

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## INTRODUCTION

### PRESCRIPTION DRUG PROGRAM

Benefits are available for Covered Drugs under the **PRESCRIPTION DRUG PROGRAM** as explained later in this Benefit Booklet.

### IMPORTANT TELEPHONE NUMBERS

#### Customer Service Helpline:

**Toll free: 1-866-314-0266**

*Customer Service Representatives can:*

- Identify your Plan Service Area;
- Give you information about Network and *Plan* Providers;
- Distribute claim forms;
- Answer your questions on claims;
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers);
- Provide information on the features of your Plan;
- Record comments about Providers; and
- Provide information regarding the Prescription Drug Program.

You can reach the Customer Service Helpline Monday through Friday from 8:00 a.m. to 8:00 p.m., Central Time.

#### Mental Health Helpline:

**Toll free: 1-800-528-7264**

Network Physicians, Professional Other Providers, Participants, or anyone else seeking treatment for Mental Health Care, Serious Mental Illness, or Chemical Dependency for Participants can call the Mental Health Helpline at any time, day or night.

#### Medical Preauthorization Helpline:

**Toll-free: 1-800-441-9188**

To satisfy all medical preauthorization requirements for Inpatient Hospital Admissions, outpatient services, *Extended Care Expense*, or Home Infusion Therapy, call the Medical Preauthorization Helpline, Monday through Friday, 7:30 a.m. – 6:00 p.m., Central Time.

### HDHP, PPO, AND EPO MEDICAL BENEFIT OPTIONS

#### Providers participating in a Blue Cross and Blue Shield Provider network.

The Claims Administrator has arranged with certain health care providers to participate in a network. These health care providers, called Network Providers, have agreed to discount their charges for Eligible or Covered Expenses. If Network Providers are used, the amount of Eligible or Covered Expenses for which you are responsible will generally be less than the amount owed if Out-of-Network Providers had been used.

You will be issued an Identification Card (ID Card) showing that you are eligible for the network discounts. You must show this ID Card every time health care services are given. This is how the provider knows that you are covered under a network plan. Otherwise, you could be billed for the provider's normal charge.

You may call Member Services to determine which providers participate in the Network. The telephone number for Member Services is 866-314-0266.

### NETWORK PROVIDERS

The PPO and HDHP Medical Benefit Options pay for Eligible or Covered Expenses received from both Network or Out-of-Network Providers. Under the PPO and HDHP Medical Benefit Options, if you use Network Providers, the Plan pays a greater portion of Eligible or Covered Expenses. This is called the Network level.

If you use Out-of-Network Providers, the PPO and HDHP Medical Benefit Options pay a lesser portion of Eligible or Covered Expenses. This is called the Out-of-Network level. In certain cases, a higher level of benefits are payable. For example, payment is made at the Network level

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for Emergency Care given at an Out-of-Network Hospital. Other benefits are also payable at the Network level for certain Out-of-Network Providers as required by the No Surprises Act and other applicable laws. See the subsection entitled “**Out-of-Network Providers Paid at Network Level**” for additional information.

The EPO Medical Benefit Option only pays for Eligible or Covered Expenses received from Network Providers. **In order to receive benefits under the EPO Medical Benefit Option, you must receive care from a Network Provider.** Emergency Care benefits will be provided under the EPO Medical Benefit Option regardless of whether they are provided by a Network Provider.

A directory of the Network Providers is available from the Claims Administrator. The types of Providers that participate in the Network include, but are not limited to, the following:

- Ambulatory Surgical Centers;
- Chiropractors;
- Durable Medical Equipment Providers;
- Home Health Care Providers;
- Home IV Providers;
- Hospices;
- Hospitals;
- Physical Therapists;
- Physicians;
- Podiatrists;
- Rehabilitation Facilities; and
- Skilled Nursing Facilities.

This Plan also covers certain specialized Providers and facilities. These are types of Providers and facilities which are not represented in the Network. These Providers and facilities are not subject to the Network/Out-of-Network level of coverage. Instead, these types of Providers and facilities are covered up to the Allowable Amount at the Network level.

### **Out-of-Network Providers Paid At Network Level**

Under the PPO and HDHP Medical Benefit Options, the following services are payable at the

Network level, even if received from an Out-of-Network Provider:

- Emergency services
- Air ambulance services
- **Radiology, anesthesiology, pathology and Neonatology services** provided in an Inpatient Hospital, Outpatient facility which is part of a Hospital; or Ambulatory Surgical Center; and **Emergency Care.**
- Care provided by Out-of-Network Providers during your visit to a Network Facility that you were not advised of in advance and/or did not agree to as described under the subsection “**MANAGED HEALTH CARE OUT-OF-NETWORK BENEFITS**” in the “**INTRODUCTION**” section of this Benefit Booklet.

### **Network Provider Charges Not Covered**

A Network Provider has contracted with the Claims Administrator to participate in the Network. Under this contract, a Network Provider may not charge you or the Claims Administrator for any services or supplies that are not Medically Necessary.

You may agree with the Network Provider to pay any charges for services and supplies which are not Medically Necessary. In this case, the Network Provider may make charges to you. However, these charges are not Eligible or Covered Expenses under this Plan and are not payable by the Claims Administrator.

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

The PPO and HDHP Medical Benefit Options pay the Out-of-Network percentage of Eligible or Covered Expenses as shown in the Schedule of Coverage for Out-of-Network Provider services. The EPO Medical Benefit Option does not pay for medical treatments, services or supplies received Out-of-Network.

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## HDHP, PPO AND EPO MEDICAL BENEFIT OPTIONS

### Deductibles

Except as otherwise provided in this Plan, each covered person must satisfy certain Deductibles when enrolled in the Plan before any payment is made for certain Eligible or Covered Expenses. Then the medical benefits pay the percentage of Eligible or Covered Expenses shown in the Schedule of Coverage. The amount of each Deductible is shown in Schedule of Coverage. In no event will a Deductible apply to preventive care.

#### Individual Deductible

You must pay the individual Deductible each Calendar Year before any benefits are payable. The individual Deductible applies to all Eligible or Covered Expenses unless a Copayment applies. If the service requires a Copayment, you will not be required to meet the Deductible before benefits are paid. For charges that apply a Copayment, benefits are payable after the Copayment is met. The Copayment will not apply to the Deductible. In no event will a Deductible apply to preventive care.

#### Family Deductible

The most your whole family will have to pay for individual Deductibles in any Calendar Year is the amount of the family Deductible shown in the Schedule of Coverage. The family Deductible applies no matter how large a family may be. Only Eligible or Covered Expenses which count toward your individual Deductible count toward the family Deductible.

### Out-of-Pocket Maximum Feature

Eligible or Covered Expenses are payable at the percentage shown in the Schedule of Coverage until the Out-of-Pocket Maximum shown in the Schedule of Coverage has been reached during a Calendar Year. Then, Eligible or Covered Expenses, other than billed charges above the Allowable Amount, are payable at 100% for the rest of that year. All Co-Share Amounts, Deductibles, and Copayments count toward the Out-of-Pocket Maximum.

Any amount that you pay toward a medical service or supply that is not an Eligible or Covered Expense will not count toward the Out-of-Pocket Maximum. The following amounts will not count toward the Out-of-Pocket Maximum:

- Services, supplies, or charges limited or excluded by the Plan;
- Billed charges above the Claims Administrator's Allowable Amount;
- Expenses not covered because a benefit maximum has been reached; and
- Penalties applied for failure to preauthorize.

**Note – HDHP and PPO Medical Benefit Option Participants:** Eligible or Covered Expenses for Out-of-Network Providers count toward the Network individual and Network family Out-of-Pocket Maximum. However, Eligible or Covered Expenses for Network Providers do not count toward the Out-of-Network individual and Out-of-Network family Out-of-Pocket Maximum.

#### Individual Out-of-Pocket Maximum

When the individual Out-of-Pocket Maximum is reached for any one person in a Calendar Year, Eligible or Covered Expenses, other than those listed in the subsection entitled “**Out-of-Pocket Maximum Feature**” in this “**INTRODUCTION**” Section of the Benefit Booklet, are payable at 100% for that same person for the rest of that year.

#### Family Co-Share Amount (Out-of-Pocket Maximum)

When the family Out-of-Pocket Maximum is reached for all covered family members in a Calendar Year, Eligible or Covered Expenses, other than those listed in the subsection entitled “**Out-of-Pocket Maximum Feature**” in this “**INTRODUCTION**” Section of the Benefit Booklet, are payable at 100% for the rest of that year.

# INTRODUCTION

## HDHP MEDICAL BENEFIT OPTION AND HSA

In accordance with federal regulations, eligible Employees who (i) enroll in the HDHP Medical Benefit Option, and (ii) are not enrolled in any other health plans that would disqualify HSA eligibility, including a traditional health care flexible spending account or Medicare benefits, may elect to participate in a Health Savings Account (“HSA”).

An HSA allows Employees to make contributions and accumulate earnings on such contributions pre-tax and it also allows withdrawals to be made on a pre-tax basis as long as the funds are used for eligible health care expenses. Furthermore, if you establish an HSA, participate in the HDHP Medical Benefit Option, and do not participate in any other health plan, Atmos Energy may make an annual contribution to your HSA. You do not have to make pre-tax contributions to an HSA in order to receive any company contributions to the HSA.

You can use your HSA as you would use a traditional flexible spending account in paying for a wide variety of out-of-pocket eligible healthcare expenses, including Deductibles and Co-Share Amounts; however, unlike a traditional flexible spending account, there is no “use it or lose it” rule. Amounts in your HSA carry over from year to year.

## HOW AN HSA WORKS

Eligible Employees can fund an HSA each year with pre-tax dollars deducted from their pay up to the maximum legally established amount for the type of coverage (single or family) they select, plus catch-up contributions, if applicable. The funds that are deposited into an HSA are portable if you leave Atmos Energy. In addition, each year Atmos Energy may contribute an additional amount to your HSA.

## FUNDING YOUR HSA

If you enroll in the HDHP Medical Benefit Option and establish an HSA through Atmos Energy, you may contribute, on an annual basis, a minimum of \$100. Individuals may contribute up to a maximum annual amount set by the IRS, and individuals who are age 55 or older and who are

not enrolled in Medicare, can contribute an additional amount pre-tax in addition to the applicable annual amount known as a catch-up contribution. The amount you may contribute may change from year to year. This information will be distributed each year during the Annual Enrollment Period. If you are eligible and elect to make pre-tax contributions to your HSA, your contributions will be made through payroll deductions. In addition to your contributions to the HSA, if you enroll in the HDHP Medical Benefit Option and HSA, Atmos Energy may make an additional contribution to your HSA. Additional information regarding any Employer contributions will be distributed during the Annual Enrollment Period. If you enroll mid-year, regardless of whether or not you are a new Employee, any annual employer contribution will be pro-rated.

## REIMBURSEMENT FROM YOUR HSA

Expenses reimbursable from your HSA include the payment of Deductibles and Co-Share Amounts attributable to medical, dental or vision coverage, prescription drug expenses, prescribed over-the-counter medications, dental expenses, orthodontia, eyeglasses, contact lenses, and certain fertility treatments including in-vitro fertilization (subject to IRS guidelines). Please see IRS Publication 502 for a representative listing of eligible expenses but note that insurance premiums may not generally be reimbursed from an HSA with limited exceptions. Please consult your tax advisor for more information. Please note, unlike a traditional medical flexible spending account, expenses will not be reimbursed until the balance of the HSA is greater than or equal to the amount requested for reimbursement.

## SPECIAL CONSIDERATIONS

Information regarding the balance of your HSA and any activity with respect to your HSA can be obtained from the HSA Administrator, as indicated in the Section entitled “ERISA PLAN ADMINISTRATION INFORMATION.”

## **INTRODUCTION**

If you participate in an HSA, neither you nor your Spouse may contribute to a traditional health care flexible spending account, unless enrolled in the Atmos Energy Limited Purpose FSA for dental and vision expenses only.

The HSA you open serves as an individual savings account, set up by you, and you are the owner of the account. The HSA is not an employee benefit plan established or maintained by Atmos Energy.

## ELIGIBILITY AND PARTICIPATION

### ELIGIBILITY FOR EMPLOYEES

You are eligible to participate as an Employee if you are a Full-Time Employee of Atmos Energy. For purposes of this requirement, a Full-Time Employee is one who is regularly scheduled to work at least thirty (30) hours per week. Unpaid leave approved by Atmos Energy, including approved voluntary time-off, military leave, FMLA leave, workers' compensation leave, parental leave for in-vitro fertilization treatments, and adoption-related leave, will not impact your eligibility to participate in this Plan. However, you will not be eligible to participate in this Plan if you are an Employee who is covered by a collective bargaining agreement between a union and Atmos Energy that does not provide for coverage under this Plan.

New Full-Time Employees regularly scheduled to work at least thirty (30) hours per week are eligible to enroll on their date of hire. Individuals classified as independent contractors or leased employees are not eligible to participate in the Plan even if such individuals are determined to be common law employees of the Employer.

Please contact the Atmos Energy Corporation's Benefits Office at 972-855-9751 with questions regarding whether you are a Full-Time Employee and eligible for coverage.

### ELIGIBILITY FOR DEPENDENTS

Dependents are:

- Your Spouse (as further described below); and
- Your Children who are under age 26.

"Child" or "Children" include the following:

- Your biological child or stepchild;
- Your legally adopted child. A child is considered legally adopted upon your assumption and retention of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. A child's placement for adoption terminates upon the termination of the legal obligation for total or partial support.

A child who is immediately adopted by you without a preceding placement for adoption is considered to be placed for adoption on the date of adoption;

- Any other child who is a dependent for federal income tax purposes, and who is living with you, as a member of your household in a parent-child relationship. In the case of any such child you would be required to obtain legal guardianship prior to the child becoming a covered dependent; or
- Any child who is the subject of a Qualified Medical Child Support Order ("QMCSO") or a National Medical Support Notice (a "NMSN"). Refer to the subsection entitled "Qualified Medical Child Support Order," "under this **ELIGIBILITY AND PARTICIPATION**" Section for additional information.

Coverage for a Child who is mentally or physically incapacitated will not be denied due to age, and he or she will be considered a "Child" for purposes of dependent eligibility. Coverage for a mentally or physically incapacitated Child will be available as long as dependent **coverage under this Plan continues and the Child continues to meet all of the following conditions:**

- The Child is incapacitated and became incapacitated prior to attaining any limiting age;
- The Child is not capable of self-support; and
- The Child is a dependent of the Employee for federal income tax purposes.

For purposes of this provision, mentally or physically incapacitated means any medically determinable physical or mental condition that prevents the Child from engaging in self-sustaining employment. The incapacity must begin before the Child attains the limiting age. If the Child is covered under this Plan immediately prior to attaining the limiting age, you must submit satisfactory proof of the incapacity and

## **ELIGIBILITY AND PARTICIPATION**

dependency through your Plan Administrator to the Claims Administrator within 31 days following the Child's attainment of the limiting age. As a condition to the coverage of any Child as an incapacitated dependent beyond the limiting age, the Claims Administrator may require periodic certification of the Child's physical or mental condition.

### **Spouse**

An individual will be considered your Spouse if he or she is a person of the same or opposite sex to whom you are lawfully married. The marriage must have been solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, and the marriage must be legally recognized as valid for purposes of applicable Federal law (including, but not limited to, the Code, ERISA, and the Affordable Care Act), and any regulations issued under such applicable Federal law. An individual also will be considered your Spouse if you reside in a state which recognizes common law marriages, and your common law marriage meets the legal requirements in your state. You must provide a notarized declaration of your common law marriage to the Plan Administrator. Your Spouse must be a legal resident of the United States in order to participate in the Plan. A person from whom you've been separated under a legal separation or divorce decree will not be considered your Spouse.

### **Proof of Dependent Status**

You must give the Claims Administrator and/or Plan Administrator proof that a Dependent meets these conditions when requested. You will not be asked to provide proof of a Child's disabled status more than once a year. If, upon request, you do not provide adequate proof that a Dependent meets the applicable requirements, coverage for the Dependent will be ended.

For information about the specific forms of proof required to prove Dependent status, please contact your local HR Partner at Atmos Energy.

### **WHEN COVERAGE STARTS**

#### **Your Coverage**

You must enroll for coverage under the Plan. Refer to the subsection entitled "**HOW TO ENROLL**" under this "**ELIGIBILITY AND PARTICIPATION**" Section of the Benefit Booklet for information on how to enroll.

Coverage starts on the date you enroll for coverage when you are first eligible to participate, during an Annual Enrollment Period or Special Enrollment Period, or when a Change in Status occurs.

#### **Your Dependent's Coverage**

You must enroll your Dependents for coverage under the Plan. Refer to the subsection entitled "**HOW TO ENROLL**" under this "**ELIGIBILITY AND PARTICIPATION**" Section of the Benefit Booklet for information on how to enroll.

Coverage starts on the latest of:

- The date you become covered;
- The date you acquire your first Dependent; or
- The date you enroll your Dependent for coverage.

Please see "**Special Enrollment Periods**" under this "**ELIGIBILITY AND PARTICIPATION**" Section for information about the effective date of coverage in the event of a birth, adoption, or placement for adoption.

#### **Qualified Medical Child Support Order**

If, as a result of a divorce or legal separation, your Child is not otherwise eligible to be covered by the Plan, it may be possible to obtain coverage through a Qualified Medical Child Support Order ("**QMCSO**") or a National Medical Support Notice (a "**NMSN**"). A QMCSO is any judgment, order or decree issued by a court of competent jurisdiction that includes certain information and relates to the medical plan or insurance coverage of a child of a Plan Participant. A NMSN is issued by a state or governmental agency and provides health benefit coverage for a child of a Plan Participant. A QMCSO or a NMSN cannot require a plan to provide any type or form of benefit or any option not already provided by the Plan. The QMCSO

## ELIGIBILITY AND PARTICIPATION

must specify the name and address of the Participant and each alternate recipient, describe the type of coverage to be provided and the period for which the coverage is to be provided, and specify the plan to which the QMCSO applies.

If you are required by a medical child support order or NMSN to provide health benefit coverage for any of your Children (an alternate recipient), you must submit that order or notice to Human Resources at Atmos Energy for a determination as to whether it is a QMCSO or a properly completed NMSN. The order or notice must be submitted within 31 days after the order becomes effective or, if later, within the time for initially enrolling your Dependents for coverage. Contact the Plan Administrator for additional information regarding QMCSOs.

If you are required by a QMCSO or NMSN to provide health benefit coverage for any of your Children, and you are not already enrolled in the Plan as an Employee, you must at the same time you would enroll your Child for coverage in order to comply with the terms of the QMCSO or NMSN.

### **Special Provision for Newborn Children**

You must enroll each of your Dependents for Dependent coverage if they are to be covered under the Plan. **If you currently have Dependent coverage, you must still notify Human Resources at Atmos Energy of the addition of a new Dependent within 31 days after you acquire a new Dependent (that is within 31 days of the Child's birth, adoption or placement for adoption). You must file a written request with your Employer to deduct the required contributions from your pay for Dependent coverage during the first 31 days in order for the Child to be a timely enrollee.**

### **HOW TO ENROLL**

You can enroll for coverage by enrolling online via Employee Self-Service. This process authorizes your Employer to deduct the required contributions from your pay. You will be able to enroll during the 31-day period following the date you first become eligible to participate, during an

Annual Enrollment Period, a Special Enrollment Period, or when a Change in Status occurs, as applicable.

You must enroll for Employee coverage in order to enroll for Dependent coverage. You must enroll each Dependent you want covered under the Plan.

Generally, you should enroll your Dependents when you enroll for coverage. However, there may be additional time periods during which you can enroll your Dependents. Refer to the subsections entitled "**Qualified Medical Child Support Order**," "**Special Provision for Newborn Children**" and "**Special Enrollment Periods**" under this "**ELIGIBILITY AND PARTICIPATION**" Section for information on other potential Dependent enrollment periods.

No person can be covered both as an Employee and as a Dependent. No person can be covered as a Dependent of more than one Employee under the Plan. For purposes of this Plan, a child born through in-vitro fertilization, surrogacy, or adoption shall be considered a Dependent of the Employee(s) who have legal custody and parental rights under applicable Texas law.

### **Annual Enrollment Period**

An Annual Enrollment Period is a period of time each year during which you may enroll in one of the Medical Benefit Options offered under the Plan. The Annual Enrollment Period is agreed on by Atmos Energy. This Annual Enrollment Period occurs once each Calendar Year and you will be notified as to when it is scheduled.

During the Annual Enrollment Period, you will have the right to change your election of the HDHP, PPO or EPO, provided, that you are eligible to participate in the Plan.

You and your eligible Dependents must enroll in the same Medical Benefit Option under the Plan.

### **Special Enrollment Periods**

Under certain circumstances, an Employee and/or Dependent may enroll under a Dependent Special Enrollment Period, a Loss of Coverage Special Enrollment Period, a Medicaid/CHIP

## ELIGIBILITY AND PARTICIPATION

Special Enrollment Period, or a Special Enrollment Period to comply with health care reform requirements.

A Loss of Coverage Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependent can enroll under a Loss of Coverage Special Enrollment Period if the Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Employee or Dependent; and
- The Employee's or Dependent's prior coverage was one of the following:
  - COBRA continuation which was exhausted; or
  - Non-COBRA coverage which was ended either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, separation of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were ended.

The Employee must request enrollment under this Plan not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of the employer contribution. You must provide any proof of the loss of coverage that is requested by the Plan Administrator and/or the Claims Administrator.

A Dependent Special Enrollment Period permits eligible Employees and their Dependents to take advantage of a Special Enrollment Period under certain circumstances if they request enrollment on a timely basis. A Dependent Special Enrollment Period is available to eligible Employees and their Dependents who are acquired through marriage, birth, adoption, placement for adoption, or in-vitro fertilization procedures resulting in a child. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent (i.e., the date of marriage, birth, adoption or placement for adoption). You must

request enrollment within that 31-day period and provide any proof of the new Dependent that is requested by the Plan Administrator and/or the Claims Administrator. If you timely enroll, the effective date for coverage in the event of a birth, adoption, or placement for adoption will be retroactive to the date of the event.

If a subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

A Medicaid/CHIP Special Enrollment Period will be available to eligible Employees and their Dependents who previously declined Plan coverage and who either (i) lose eligibility for coverage under Medicaid or the Children's Health Insurance Program ("**CHIP**"), or (ii) become eligible for state assistance through Medicaid or CHIP that helps pay for Plan coverage, provided that enrollment is timely requested. The Medicaid/CHIP Special Enrollment Period is the 60-day period following the date government provided coverage ends, or the date an individual is determined to be eligible for state assistance, as applicable. Enrollment must be requested within the 60-day period.

You should contact the Plan Administrator if you have any questions about the Loss of Coverage, Dependent, or Medicaid/CHIP Special Enrollment Periods.

**Proof of Dependent status must be submitted as supporting documentation with the enrollment request.**

### **CHANGE OF ELECTION**

## ELIGIBILITY AND PARTICIPATION

Additional midyear changes to your Plan elections are permitted only when there is a "Change in Status" or a Special Enrollment Period. You must provide proof of the Change in Status, as requested by your HR Partner or Plan Administrator. While a Change in Status will allow you to enroll or terminate coverage, in general, you cannot make mid-year changes to your Medical Benefit Option elections as a result of a Change in Status.

The following events constitute a Change in Status:

- A change in legal marital status. Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment;
- A change in the number of Dependents. Events that change an Employee's number of Dependents including birth, adoption, placement for adoption, or death of a Dependent;
  - An official birth certificate must be submitted as supporting documentation for adding a Dependent Child. The Hospital Vital Records should be submitted with enrollment of a newborn Child to ensure timely enrollment within 31 days of the event date.
- A change in employment status. A separation or commencement of employment by the Employee, Spouse, or Dependent;
- A change in work schedule. A reduction or increase in hours of employment by the Employee, Spouse, or Dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence;
- A change in Dependent status. An event that causes an Employee's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstance as provided in this Plan; or

- A change in residence or worksite. A change in the place of residence or work of the Employee, Spouse, or Dependent.

You may also be able to make mid-year changes under the following circumstances:

- Significant changes in the cost of your benefit;
- Significant changes in the coverage of your benefit;
- You, your Spouse, or your Dependent become eligible for COBRA continuation coverage or become eligible (or cease to be eligible) for Medicare or Medicaid; and
- You, your Spouse, or your Dependent have either a Loss of Coverage or Medicaid/CHIP Special Enrollment Period as described earlier.

A Dependent pregnancy is not classified as a Change in Status. This means if you were not enrolled in the Plan or your Dependent was not already covered by the Plan, your Dependent's pregnancy would not permit you to add coverage or change coverage levels mid-year to add your Dependent.

There may be other circumstances that result in a mid-year election change to your benefits. Please contact the Plan Administrator for additional information.

For information about the specific forms of proof required to prove Dependent status, please contact your local HR Partner at Atmos Energy.

### **Consistency Rule**

Your revocation of a Plan election during a period of coverage and new election for the remaining portion of the period (referred to below as an "election change") must be consistent with the Change in Status. An election change is consistent with a Change in Status if, and only if:

- The Change in Status results in the Employee, Spouse, or Dependent gaining or losing eligibility for coverage under this Plan

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or a medical plan of the Spouse's or Dependent's employer; and

- The election change corresponds with that gain or loss of coverage.

**An election change during a Plan Year because of a Change in Status can only be accepted within the first 31 days following the Change in Status (unless the Change in Status gives rise to a Medicaid/CHIP Special Enrollment Period, in which case the enrollment period will be 60 days). Your election must follow the Consistency Rule for a Change in Status.**

### **WHEN COVERAGE STOPS**

Coverage will stop on the earliest of the following:

- When you stop being an eligible Employee (as defined above);
- When you stop making contributions; or
- When the Plan is terminated.

Your Dependent's coverage will stop when he or she is no longer an eligible Dependent, or when your coverage stops, whichever occurs first, subject to any applicable continuation coverage rights under federal or state law.

## HOW TO RECEIVE HEALTHCARE BENEFITS

### **CONTRACTING/NON-CONTRACTING FACILITIES**

The Claims Administrator has written contracts with many (but not all) Hospitals and Facility Other Providers. Those institutions are Contracting Facilities. An institution without a written contract with the Claims Administrator is a Non-Contracting Facility.

In an emergency situation, the immediate, initial treatment necessary to stabilize the Participant furnished by any Hospital is subject to the benefits provided by the Plan.

### **PARPLAN**

*For Employees residing in the state of Texas*

When you consult a Physician or Professional Other Provider, you should inquire if he participates in the Claims Administrator's *ParPlan*, a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for you;
- Accept the Claims Administrator's Allowable Amount determination as payment for Medically Necessary services; and
- Not bill you for services over the Allowable Amount determination.

You will be responsible for any applicable Deductibles, Co-Share Amounts, or services that are limited or not covered under the Plan.

If your Physician or Professional Other Provider does not participate in the *ParPlan*, you will be responsible for filing the claims, and you may be billed for charges above the Claims Administrator's Allowable Amount determination. Information on how to file claims is included in the subsection of this Benefit Booklet entitled "**Benefit Determinations**" in the "**HOW TO RECEIVE HEALTHCARE BENEFITS**" section of this Benefit Booklet.

**Note:** For Employees residing outside the state of Texas, check with your Physician or Professional Other Provider to determine if he

participates as a contracting provider with Blue Cross and Blue Shield.

### **BLUE CROSS AND BLUE SHIELDS' OTHER SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS**

#### **BLUE CARD**

Other Blue Cross and Blue Shield Plans outside of Texas ("**Host Blue**") may have contracts similar to the *ParPlan* contracts described above with certain Providers ("**Host Blue Providers**") in their service area.

When you receive health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services; or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a

## HOW TO RECEIVE HEALTHCARE BENEFITS

surcharge, Blue Cross and Blue Shield would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

### **SPECIALTY CARE PROVIDERS**

*Applies to In-Network and Out-of-Network*

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If specialty care by an Out-of-Network Provider is needed, In-Network Benefits may still be available if a Network Physician notifies the Claims Administrator, and the Claims Administrator authorizes your visit to an Out-of-Network Provider prior to the visit; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate. **For Participants who elect the EPO Medical Benefit Option, no benefits will be paid by the Plan for specialty care by an Out-of-Network Provider without prior authorization;** or
- If the services you require are covered by this Plan, but not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers, if prior authorization is received. For more information on prior authorization, refer to the **"PREAUTHORIZATION REQUIREMENTS"** subsection in this **"HOW TO RECEIVE HEALTHCARE BENEFITS"** Section of the Benefit Booklet.

### **Participants electing the PPO or HDHP Medical Benefit Options**

If you elect to see an Out-of-Network Provider and if the services could have been provided by

a Network Provider, only Out-of-Network Benefits will be available.

### **Participants electing the EPO Medical Benefit Option**

Network Benefits for authorized Out-of-Network services will be paid based on the Allowable Amount for Hospitals and Facility Other Providers, and Physicians or Professional Other Providers **not** contracting with BCBSTX (or any other Blue Cross and Blue Shield Plan outside of Texas.) If the Allowable Amount is less than the amount charged by the Provider, you may be billed for the balance. (See Allowable Amount definition.) If you **choose** to see an Out-of-Network Provider without prior authorization, **no benefits will be paid by the Plan.** For more information on prior authorization, refer to the subsection entitled **"PREAUTHORIZATION REQUIREMENTS"** in this **"HOW TO RECEIVE HEALTHCARE BENEFITS"** Section of the Benefit Booklet.

### **MEDICAL NECESSITY**

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claims Administrator.

Charges for services and supplies which the Claims Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Out-of-Pocket Maximum.

The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only treatment for a particular injury, sickness, mental illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined by the Plan. See the "Medically Necessary" definition in the Section of this Benefit Booklet entitled "DEFINITIONS."

### **UTILIZATION MANAGEMENT**

Utilization management may be referred to as Medical Necessity reviews, utilization review ("UR") or medical management reviews. Medical Necessity reviews occur when a Provider requests an authorization before services are received, during a course of care or after the care

## HOW TO RECEIVE HEALTHCARE BENEFITS

has been completed for a Post-Service Medical Necessity Review. In addition, certain procedures require prior authorization.

The types of Utilization Management include:

- Preauthorization or prior authorization;
- Predetermination; and
- Post-Service Medical Necessity Review.

Refer to the “Medically Necessary” definition in the Section of this Benefit Booklet entitled “DEFINITIONS” for additional information.

### **PREAUTHORIZATION REQUIREMENTS**

Preauthorization establishes in advance the Medical Necessity of certain care and services covered under this Plan. It ensures that the preauthorized care and services described below will not be denied on the basis of Medical Necessity. **However, preauthorization does not guarantee payment of benefits. Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.**

Preauthorization is simple. You, your Physician, Provider of services, or a family member calls one of the toll-free numbers listed on the back of your Identification Card. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider’s office. In most cases, preauthorization is made within minutes on the telephone with your Provider’s office.

**The following types of services require preauthorization:**

- All inpatient admissions;
- Expanded Outpatient services;
- Extended Care Expense;
- Home Infusion Therapy;
- All inpatient treatment of Chemical Dependency;

- All inpatient treatment of Mental Health Care (including Serious Mental Illness);
- If you transfer to another facility or to or from a specialty unit within the facility; and
- Psychological testing
- Neuropsychological testing
- Outpatient Electroconvulsive therapy
- Intensive Outpatient program
- Repetitive Transcranial Magnetic Stimulation

Preauthorization does not apply to Emergency Care.

### **Participants electing the PPO or High Deductible Medical Benefit Options**

***In-Network:*** In-Network Benefits will be available if you use a Network Provider or Specialty Care Provider. In-Network Providers will preauthorize services for you, when required.

***Out-of-Network:*** If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. Failure to preauthorize services will be subject to guidelines described below.

However, if care is not available from Network Providers as determined by the Claims Administrator, and the Claims Administrator authorizes your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits may be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

### **Participants electing the EPO Medical Benefit Option**

***In-Network:*** Network Providers will preauthorize services for you, when required.

***Out-of-Network:*** If you **choose** to use Out-of-Network Providers for services and supplies available in the Network, **no benefits will be paid under this Plan**, except as required by law for Emergency Care or as otherwise specified in this Plan.

## HOW TO RECEIVE HEALTHCARE BENEFITS

However, if care is not available from Network Providers, you must seek preauthorization from the Claims Administrator to use an Out-of-Network Provider. You or your Network Provider must contact the Claims Administrator to receive a referral authorization **prior** to use of the Out-of-Network Provider. If you receive the referral authorization from the Claims Administrator, Network Benefits will be paid based on the Allowable Amount for Out-of-Network Providers. You may be billed for any difference between the Allowable Amount and the amount charged by the Provider. If you fail to request preauthorization for Out-of-Network benefits, **no benefits will be paid by the Plan**, except in cases of Emergency Care or other circumstances where prior authorization was not reasonably possible.

To request authorization, ask your Network Provider to contact the Claims Administrator, or you may contact Customer Service at the number shown on your Identification Card.

### ***Inpatient Admissions***

In the case of an elective inpatient admission, the call for preauthorization should be made at least two working days before you are admitted, unless it would delay Emergency Care. Emergency Care never requires preauthorization. Preauthorization is required regardless of whether treatment is provided by a Network or Out-of-Network Provider.

When an inpatient admission is preauthorized, a length-of-stay is assigned. The Plan is required to provide a minimum length of stay in a Hospital facility for the following:

- Maternity Care:
  - 48 hours following an uncomplicated vaginal delivery; or
  - 96 hours following an uncomplicated delivery by caesarean section.
- Treatment of Breast Cancer:
  - 48 hours following a mastectomy; or
  - 24 hours following a lymph node dissection.

If you require a longer stay than was first preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for days determined not to be Medically Necessary in accordance with the Plan's Medical Necessity criteria and review procedures described in this Plan.

### ***Extended Care Expense and Home Infusion Therapy***

Preauthorization for Extended Care Expense and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claims Administrator to request preauthorization. The request should be made:

- Prior to initiating Extended Care Expense or Home Infusion Therapy;
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

The Claims Administrator will review the information submitted prior to the start of Extended Care Expense or Home Infusion Therapy. The Claims Administrator will send a letter to you and the agency or facility confirming preauthorization or denying benefits.

If Extended Care Expense or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Medical Preauthorization Helpline.

If the Claims Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

**To satisfy all medical preauthorization requirements for Inpatient Hospital Expense, Extended Care Expense, or Home Infusion Therapy, call:**

**Toll-free: 1-800-441-9188**

***Inpatient Chemical Dependency, Mental Health Care (including Serious Mental Illness)***

## **HOW TO RECEIVE HEALTHCARE BENEFITS**

All **inpatient** treatment of Chemical Dependency and Mental Health Care (including Serious Mental Illness) should be preauthorized, regardless of whether the treatment is provided In-Network or Out-of-Network.

You or your Provider should contact the Mental Health Helpline for a referral to Network Providers who have entered into a managed care arrangement with BCBSTX to furnish services and supplies for Mental Health Care (including Serious Mental Illness) or treatment of Chemical Dependency. When your services have been preauthorized and are provided by the Network Provider, In-Network Benefits will be available.

**To satisfy preauthorization requirements for Mental Health Care (including Serious Mental Illness) or Chemical Dependency, call BCBSTX  
Toll-free: 1-800-528-7264**

### ***Length of Stay/Service Review***

**Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under the Plan.**

Upon completion of a preadmission or emergency admission review, BCBSTX will send you a letter confirming that you or your representative called BCBSTX. A letter authorizing the length of service or length of stay will be sent to you, your Physician, Provider and/or the Hospital or Facility.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described under “**Benefit Determinations**” in the **HOW TO RECEIVE HEALTHCARE BENEFITS**” section of this Benefit Booklet.

A length of stay/service review, also known as concurrent Medical Necessity review, is when you, your Provider or other authorized representative may submit a request to BCBSTX for continued services. If you, your Provider, or

authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing course of treatment, BCBSTX will make a determination of the request as soon as possible (taking into account medical exigencies), but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information, if the initial request is incomplete.

### **PREDETERMINATION**

Predetermination means an optional voluntary review of a Provider’s recommended medical procedure, treatment or test that does not require prior authorization, to make sure it meets Medical Necessity requirements.

### **POST-SERVICE MEDICAL NECESSITY REVIEW**

A Post-Service Medical Necessity Review, sometimes referred to a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms your eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be available when preauthorization or predetermination was not obtained before the services were provided.

A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions and limitations of this Plan. A Post-Service Medical Necessity Review does not guarantee payment of benefits by the Plan, for instance you may have been ineligible as of the date of service or your benefits may have changed as of the date of service.

The Post-Service Medical Necessity Review may require additional documentation from your Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the Provider or pharmacist may be required to include pertinent documentation

## HOW TO RECEIVE HEALTHCARE BENEFITS

explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSTX to make a determination under the terms and conditions of the Plan.

### **CASE MANAGEMENT**

Under certain circumstances, the Plan allows the Claims Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible or Covered Expenses. The Claims Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claims Administrator anticipates future expenditures for Eligible or Covered Expenses that may be reduced by such benefits.

Any decision by the Claims Administrator to provide such benefits will be made on a case-by-case basis. The case coordinator for the Claims Administrator will initiate case management in appropriate situations.

### **CLINICAL TRIALS**

The Plan will not:

- Deny your participation in a clinical trial;
- Deny (or limit or impose additional conditions on) the coverage of “routine patient costs” (see below) for items and services furnished in connection with participation in a clinical trial; or
- Discriminate against you on the basis of your participation in a clinical trial, provided that you meet the following requirements:
- You are eligible to participate in a clinical trial according to the clinical trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

- Your participation in such clinical trial would be appropriate based upon your eligibility to participate according to the clinical trial protocol (i) as concluded by the referring health care professional who is a participating health care provider in the clinical trial; or (ii) as established by medical and scientific information provided by you.

For purposes of this section, “**routine patient costs**” include all services and supplies consistent with the coverage provided under the Plan that are typically covered for someone who is not enrolled in a clinical trial, but do not include the investigational item, device or service itself, services and supplies that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

For purposes of this section, “**clinical trial**” means an “approved clinical trial” as defined in Section 2709 of the Public Health Service Act.

### **INTERNAL CLAIM PROCEDURES**

#### **Filing of Claims Required**

##### ***Notice of Claim***

You must give written notice to the Claims Administrator within 12 months after any Participant receives services for which benefits are provided under the Plan, or as soon as reasonably possible if circumstances prevent timely filing.

##### ***Claim Forms***

Claim forms for filing Proof of Loss are available on the Atmos Energy intranet and may also be obtained by calling customer service at 1-866-314-0266.

The Claims Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

#### **Who Files Claims**

#### ***Contracting Providers***

## **HOW TO RECEIVE HEALTHCARE BENEFITS**

When you receive treatment or care from a Provider or Covered Drugs dispensed from a Pharmacy that contracts with the Claims Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

### ***Non-Contracting Providers***

When you receive treatment or care from a health care Provider or Covered Drugs dispensed from a Pharmacy that does not contract with the Claims Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection of this Benefit Booklet entitled “**Participant-Filed Claims**” in this “**HOW TO RECEIVE HEALTHCARE BENEFITS**” Section for instruction on how to file your own claim forms.

### ***Mail Service Prescription Drug Program***

When you receive Covered Drugs dispensed through the Mail Service Prescription Drug Program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from Human Resources at Atmos Energy, from the Prime Therapeutics website, [www.myprime.com](http://www.myprime.com), or by calling the Customer Service Helpline at 1-833-715-0942.

### ***Participant-Filed Claims***

#### **Medical Claims**

If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a subscriber-filed claim form provided by the Plan. You can obtain copies of the claim form from Human Resources at Atmos Energy, from the BCBSTX website ([www.bcbstx.com](http://www.bcbstx.com)) or by calling the Customer Service Helpline at 1-866-314-0266.

Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant’s expenses separately because any Deductibles and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the

services performed, dates of service, charges, and name of the Participant involved.

#### **Prescription Drug Claims**

When you receive Covered Drugs dispensed from a Non-Participating Pharmacy, a Prescription Reimbursement Claim Form must be submitted. This form can be obtained from Human Resources at Atmos Energy, from the Prime Therapeutics website, [www.myprime.com](http://www.myprime.com) or by calling the Customer Service Helpline at 1-800-423-1973.

This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

Instructions for completing the claim form are provided on the back of the form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

Bills for Covered Drugs should show the name, address and telephone number of the Pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and, the name of the Participant using the drug.

Visit the BCBSTX Website for subscriber-filed claim forms and other useful information  
[www.bcbstx.com](http://www.bcbstx.com)

### ***Where to Mail Completed Claim Forms***

#### ***Medical Claims***

Blue Cross and Blue Shield of Texas  
Claims Division  
P. O. Box 660044  
Dallas, Texas 75266-0044

#### ***Prescription Drug Claims***

**Prime Therapeutics**  
**Mail route Commercial**  
**P. O. Box 25136**  
**Lehigh Valley, PA 18002-5136**

### ***Who Receives Payment***

## **HOW TO RECEIVE HEALTHCARE BENEFITS**

Benefit payments will be made directly to contracting Providers when they bill the Claims Administrator. Written agreements between the Claims Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving Spouse, as beneficiary. If there is no surviving Spouse, then the benefits will be paid to your estate.

Except as provided in the subsection entitled **“ASSIGNMENT AND PAYMENT OF BENEFITS”** in the **“GENERAL INFORMATION”** Section of this Benefit Booklet, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

### ***Benefit Payments to a Managing Conservator***

Benefits for services provided to your minor Dependent Child may be paid to a third party if:

- The third party is named in a court order as managing or possessory conservator of the Child; and
- The Claims Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a Child, the managing or possessory conservator must submit to the Claims Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claims Administrator for the Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment, provided that such deduction is permitted under applicable law and does not violate any anti-assignment provisions. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it will be considered in satisfaction of its obligations to you under the Plan.

An explanation of benefits summary is sent to the Participant, showing what has been paid.

### **When to Submit Claims**

All claims for benefits under the Plan must be properly submitted to the Claims Administrator

within twelve (12) months of the date that services or supplies are received. Claims not submitted and received by the Claims Administrator within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity or as otherwise required by applicable law.

### **Receipt of Claims by the Claims Administrator**

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the administrative office of the Claims Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claims Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claims Administrator will notify the Participant by way of an explanation of benefits summary.

## **BENEFIT DETERMINATIONS**

### **Urgent Claims that Require Immediate Action**

Urgent care claims or appeals are those claims or appeals that require notification or approval prior to receiving medical care, where a delay in treatment as a result of the application of the time periods for making non-urgent care determinations could seriously jeopardize you or your Dependent's life or health or ability to regain maximum function or, in the opinion of a physician with knowledge of you or your Dependent's medical condition, could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the case of an urgent care claim, the Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be given a reasonable amount of time, taking

## **HOW TO RECEIVE HEALTHCARE BENEFITS**

into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, but in no case later than 48 hours after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period given you to provide the specified additional information.

A denial notice will comply with the requirements set forth below.

### **Pre-Service Claims**

Pre-service claims or appeals are those claims or appeals that require notification or approval prior to receiving medical care.

In the case of a pre-service claim, the Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from receipt of the notice within which to provide the specified information. In the case of your failure to follow the Plan's procedures for filing a pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral unless you request written notification. This paragraph applies only in the case of a failure by you to file a claim with the Claims Administrator that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

A denial notice will comply with the requirements set forth below.

### **Post-Service Claims**

Post-service claims or appeals are those claims or appeals that are not pre-service claims or appeals and are filed for payment of benefits after medical care has been received.

In the case of a post-service claim, the Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the Plan's control and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from receipt of the notice within which to provide the specified information.

A denial notice will comply with the requirements set forth below.

### **Concurrent Care Claims**

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Claims Administrator will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the course of treatment is reduced or terminated. Any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify you of the benefit determination (whether

## HOW TO RECEIVE HEALTHCARE BENEFITS

adverse or not) within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Any request to extend the course of treatment beyond the period of time or number of treatments that is not or is no longer a claim involving urgent care will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

### Denial Notification Requirements

In the event a claim for benefits is denied or the Claims Administrator otherwise makes an adverse benefit determination as defined in the U.S. Department of Labor regulations regarding claims procedures, the Claims Administrator will provide you with written or electronic notification of such adverse benefit determination. The notification will be written in a manner calculated to be understood by you and will include the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provision on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures, and as applicable, a description of the Plan's expedited review process for claims involving urgent care, and the time limits applicable to such procedures;
- A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review, and contact information for the office of health insurance consumer assistance or ombudsman, as applicable, established to assist individuals with internal claims and appeals and external review procedures;
- Any specific internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar

criterion was relied upon and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request;
- Information necessary to identify the claim, (including the date of service, healthcare provider, claim amount (if applicable), and a statement describing availability upon request, of the diagnosis code and its meaning and treatment code and its meaning);
- The reason or reasons for the adverse benefit determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that used in denying the claim; and
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

In the case of an adverse benefit determination concerning a claim involving urgent care, the notice described in the preceding paragraph may be provided to you orally within the time frame described above, provided that a written or electronic notification is furnished to you not later than 3 days after the oral notification.

If your claim has been denied and you do not agree with the denial, you must submit your claim for review (i.e., appeal) by following the Claims Review Procedure described below.

### **INTERNAL CLAIMS REVIEW PROCEDURES**

Upon the denial of your claim for benefits, if you disagree with the denial, in order to preserve legal remedies that may be available to you, you or your duly authorized representative acting on your behalf must file an appeal in writing with the Claims Administrator (all references to you will

## **HOW TO RECEIVE HEALTHCARE BENEFITS**

include your duly authorized representative for the remainder of this section). You must file an appeal not later than 180 days following receipt of a notification of an adverse benefit determination. You may submit written comments, documents, records and other information relating to the claim for benefits in connection with the appeal, and the review of your appeal will take into account all such comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, you may submit additional evidence and testimony in support of your appeal and if any new evidence is provided by the Plan or any new rationale is considered by the Claims Administrator in making the decision, you must receive notice of such new evidence and new rationale and have an opportunity to respond. You must respond within the time period during which the Claims Administrator is considering your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.

In conducting its review of your appeal, the Claims Administrator will not afford deference to the initial adverse benefit determination, and the review will be conducted by an appropriate individual who is neither the individual who made the adverse benefit determination nor the subordinate of such individual. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental/Investigational or not Medically Necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. Any such health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. The Claims Administrator will provide you with the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit

determination, without regard to whether the advice was relied upon in making the benefit determination. Further, in the case of a claim involving urgent care (whether an appeal on a claim involves urgent care requiring the expedited handling procedures is determined by the nature of the claim at the time of the appeal), the Claims Administrator will provide for an expedited review process pursuant to which your request for an expedited review may be submitted orally or in writing, and all necessary information, including the Plan's benefit determination, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

The Claims Administrator will notify you of the Plan's benefit determination on review as follows: (i) for urgent care appeals, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review, (ii) for pre-service appeals, not later than 30 days after receipt by the Plan of your request for review and (iii) for post-service appeals, not later than 60 days after receipt by the Plan of the claimant's appeal.

The Plan Administrator will provide you with written or electronic notification of the Plan's benefit determination on your appeal. In the event of an adverse benefit determination on your appeal, the notification will be written in a manner calculated to be understood by you and will include the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan, including information on how to initiate a voluntary appeal, and the claimant's right to obtain the information about such procedures,

## HOW TO RECEIVE HEALTHCARE BENEFITS

- A description of the external review processes, including information on how to initiate an external review;
- A statement of the claimant's right to bring an action under ERISA Section 502(a) following an adverse benefit determination on appeal and a description of any limitations period applicable to filing such action;
- Contact information for the office of health insurance consumer assistance or ombudsman, as applicable, established to assist individuals with internal claims and appeals and external review procedures;
- Any specific internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request;
- Information necessary to identify the claim (including the date of service, healthcare provider, claim amount, and a statement describing availability upon request, of the diagnosis code and its meaning and treatment code and its meaning);
- The reason or reasons for the adverse benefit determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that used in denying the claim, including a discussion of the decision;
- A statement that reads as follows: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S.

Department of Labor Office and your State insurance regulatory agency."

A claimant is not required to file more than one appeal of an adverse benefit determination prior to bringing a civil action under ERISA Section 502(a). However, before doing so, a claimant may elect to invoke the Plan's Voluntary Review Procedures, described below.

### **EXTERNAL CLAIM PROCEDURES**

#### Request for Standard External Review

If you disagree with the final adverse benefit determination on your claim for review, your next step in having such decision reviewed requires you to request an external independent review from the Plan.

External review will be available with respect to claims for medical benefits. However, a reduction, termination, or failure to provide for a benefit based on a determination that you fail to meet eligibility requirements under the Plan is not eligible for external review. In addition, unless and until the issuance of official guidance to the contrary, external review only applies to (1) an adverse benefit determination that involves medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational), as determined by the external reviewer; and (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

You may only file a request for external review if you file such request within four months of the date you received the Plan's final adverse benefit determination on your claim for review. Your request for an external review must be filed with:

Blue Cross and Blue Shield of Texas  
Claims Division  
P.O. Box 660044  
Dallas, TX 75266-0044

#### Review and Preliminary Determination of Eligibility for External Review for a Standard External Review

## HOW TO RECEIVE HEALTHCARE BENEFITS

The Claims Administrator must review such request and respond to you within five (5) business days of receipt of such request for a standard review with a determination of whether your request for external review is eligible for external review. A request is eligible for external review if it meets all of the following four requirements during the preliminary review.

- (1) the claimant is or was covered by the Plan at the time the health care item or service in question was provided;
- (2) the adverse benefit determination or final adverse benefit determination does not relate to whether the claimant satisfied the Plan's eligibility requirements;
- (3) the claimant has exhausted or is deemed to have exhausted, as described in 29 CFR § 2590.715-2719, the Plan's internal appeal process; and
- (4) the claimant has provided all the information and forms required to process an external review.

### Preliminary Notice Regarding Eligibility for Standard External Review

Within one business day after the Claims Administrator completes the preliminary review, the Plan must issue a written notice to the claimant and such notice must include the reasons the requested appeal is not eligible for external review if the request was complete but not eligible for external review and must also provide contact information for the Employee Benefit Security Administration (toll-free number 866-444-EBSA (3272)). If the request for external review was not eligible because it was not complete, the notice must include a description of the information necessary to complete the request for external review and permit the claimant to submit such information by the later of 48 hours after the claimant receives the notice or by the end of the four-month period during which external review must be requested.

### Standard External Review

The Plan must rotate its assignment of claims for external review to an independent review organization that is one of the at least three independent review organizations retained by the

Plan to conduct external reviews and which is due to receive the claim on the Plan's rotational basis established to ensure independence. The external independent review organization must conduct a full review of the file, applicable plan provisions and any material submitted as required by applicable guidance and in compliance with the independent review organization's contract with the Plan. The independent review organization will conduct such review on a de novo basis without deference to the plan's decision.

Within four business days after the independent review organization is assigned, the Plan will provide to the independent review organization all documents and information considered by the Plan in making its adverse benefit determination. If the independent review organization receives any new evidence or information, it will provide such information to the Plan and the Plan may reconsider its decision. If the Plan changes its decision upon reconsideration, it must notify the claimant and the independent review organization of its new decision within one business day of making such decision. The independent review organization must then terminate its review.

The independent review organization will provide the claimant and Plan with a written notice of its decision within 45 calendar days of the date on which the independent review organization received the request for external review. Such notice will include all information required by applicable guidance.

Upon the Plan's receipt of an independent review organization's final external review determination reversing the Plan's adverse benefit determination, the Plan will immediately provide coverage or payment for the claim in accordance with applicable law.

### Request for Expedited External Review

An expedited external review will be provided:

- (1) If a claimant receives an adverse benefit determination on a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant

## **HOW TO RECEIVE HEALTHCARE BENEFITS**

has filed a request for an expedited internal appeal, or

- (2) If the claimant received a final internal adverse benefit determination and the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or
- (3) If the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged since receiving such emergency services.

Upon receipt of a request for expedited external review, the Plan will determine if the request satisfies the requirements to be eligible for a standard external review (under Review and Preliminary Determination of Eligibility for External Review for a Standard External Review above) and must immediately send the claimant a notice of such preliminary determination of eligibility.

If the request for expedited external review is approved, the Plan will assign the claim to an independent review organization in accordance with its standard procedures for assigning claims to external reviewers (see "Standard External Review" above) and must transmit all necessary documents and information considered by the Plan in making its final internal adverse benefit determination or adverse benefit determination to the assigned independent review organization electronically, by telephone, facsimile or any other available expeditious method. The assigned independent review organization must consider the expedited request under its standard review procedures on a de novo basis. The independent review organization must provide the Plan and claimant notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the independent review organization received the request for expedited external review. If such notice is not in writing, within 48 hours of the date the notice is provided, the independent review organization must provide a written confirmation of its decision to the claimant and the Plan.

### **Voluntary Plan Administrator Review**

If your claim is denied on internal appeal or External Review (if you have requested External Review), you may choose to file a request for Voluntary Review by the Plan Administrator. Your request for Voluntary Plan Administrator Review should be made no later than four months after you receive the notice of denial on internal appeal, or, if you have requested External Review, 60 days after the date you receive notice of the final external review decision.

Requests for Voluntary Plan Administrator Review should be submitted to the Plan Administrator in writing (or orally, but only if your claim is an urgent care claim), and you should provide your name, the patient's name, the date of service, and the amount of the charge. You may not request Voluntary Plan Administrator Review unless you have completed the applicable internal appeals process.

The Plan Administrator will provide you with a notice of its decision upon Voluntary Plan Administrator Review within: (i) 72 hours after receiving the request, in the case of an urgent care claim, or (ii) 60 days after receiving your request, in the case of a pre-service claim or post-service claim.

If your claim is denied in whole or in part upon Voluntary Plan Administrator Review, the notice of denial will include a discussion of the decision to deny the claim on Voluntary Plan Administrator Review and a statement of any other dispute resolution rights you may have, such as voluntary mediation or arbitration, or the right to file suit under federal law.

### **Legal Actions**

If you want to bring legal action against the Plan or Claims Administrator, there is a set time frame to do so. Exhaustion of the claims procedure is a mandatory precondition to filing a legal or equitable action under section 502(a) of ERISA. If you want to bring legal action against Atmos Energy, the Plan, the Plan Administrator, or the Claims administrator, you must do so within 3 years from the date you are notified of the final decision on appeal or lose any rights to bring such action.

## **HOW TO RECEIVE HEALTHCARE BENEFITS**

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator, you must do so within three years of the date you are notified of the final decision on the appeal, or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

## **MEDICAL BENEFITS PROVIDED**

### **ELIGIBLE OR COVERED EXPENSES**

This portion of the Plan provides benefits for three major categories of Eligible or Covered Expenses:

- *Inpatient Hospital Expenses*;
- *Medical-Surgical Expenses*; and
- *Extended Care Expenses*.

This “**MEDICAL BENEFITS PROVIDED**” Section generally explains the medical benefits that are available under the Plan. Please remember to refer to the “**DEFINITIONS**” Section of this Benefit Booklet for a description of terms such as *Inpatient Hospital Expense*, *Medical-Surgical Expense*, and *Extended Care Expense*.

Refer to the “**MEDICAL LIMITATIONS AND EXCLUSIONS**” Section of this Benefit Booklet for a description of limitations and exclusions under the Plan, including limitations and exclusions that may apply to otherwise Eligible or Covered Expenses.

Wherever Schedule of Coverage is mentioned, please refer to the Schedule at the beginning of this Benefit Booklet.

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

### **CHANGES IN BENEFITS**

Changes to covered benefits will apply to all services provided to each Participant under the Plan.

Benefits for Eligible or Covered Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

### **BENEFITS FOR INPATIENT HOSPITAL EXPENSE**

Among those expenses normally included under *Inpatient Hospital Expense* as defined in this Benefit Booklet are intensive and coronary care units, operating room, lab and x-ray, and blood. Please note that if you are confined in a private room, only the Hospital’s average semiprivate room rate is allowed as *Inpatient Hospital Expense*.

Remember, each Hospital Admission requires preauthorization.

The benefit percentage of your total eligible *Inpatient Hospital Expense* in excess of any Deductible indicated on your Schedule of Coverage is the Plan’s obligation. The remaining unpaid *Inpatient Hospital Expense* including any Deductible is your obligation to pay. This amount will be applied to the Co-Share Amount.

### **BENEFITS FOR MEDICAL-SURGICAL EXPENSE**

The following services are included under *Medical-Surgical Expense* as defined in this Benefit Booklet:

- Physician services;
- Services of Professional Other Providers;
- Speech and hearing services;
- Diagnostic x-ray and laboratory examinations;
- Prosthetic Appliances; and
- Home Infusion Therapy.

Remember that certain services require preauthorization, and any Deductibles and Co-Share Amounts shown on your Schedule of Coverage will also apply.

The benefit percentages of your total eligible *Medical-Surgical Expense* shown on your Schedule of Coverage in excess of your Co-Share Amount and any Deductible shown are the Plan’s obligation. The remaining unpaid *Medical-Surgical Expense* in excess of the Co-Share Amount and any Deductible is your obligation to pay.

To calculate your benefits, subtract any Deductibles from your total eligible *Medical-Surgical Expense* and then multiply the difference by the benefit percentage shown on your Schedule of Coverage. Most remaining unpaid *Medical-Surgical Expense* including the Deductible is your Co-Share Amount.

### **BENEFITS FOR EXTENDED CARE EXPENSE**

When *Extended Care Expense* has been preauthorized, the Plan’s benefit obligation as

## **MEDICAL BENEFITS PROVIDED**

shown on your Schedule of Coverage will be:

- At the benefit percentage under “**Extended Care Expense Benefits**,” and
- Up to the amount of the combined benefit maximums shown for each category of Extended Care Expense on your Schedule of Coverage.

*Remember...* Out-of-Area Benefits are not available unless services are rendered by a Contracting Facility and have been preauthorized and approved by the Claims Administrator.

If shown on your Schedule of Coverage, the Deductible will apply. Any unpaid *Extended Care Expense* in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co-Share Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be *Extended Care Expense* but will be considered *Medical-Surgical Expense*.

Services and supplies for *Extended Care Expense*:

1. For Skilled Nursing Facility:

- All usual nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
- Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility; and
- Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
- Part-time or intermittent home health aide services which consist primarily of caring for the patient;

- Physical, occupational, speech, and respiratory therapy services by licensed therapists; and
- Supplies and equipment routinely provided by the Home Health Agency.

Benefits will **not** be provided for Home Health Care for the following:

- Food or home delivered meals;
- Social case work or homemaker services;
- Services provided primarily for Custodial Care;
- Transportation services;
- Home Infusion Therapy; or
- Durable medical equipment.

3. For Home Hospice Care:

- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
- Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- Physical, speech, and respiratory therapy services by licensed therapists; and
- Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

4. For Facility Hospice Care:

- All usual nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
- Room and board and all routine services, supplies, and equipment provided by the Hospice facility; and
- Physical, speech, and respiratory therapy services by licensed therapists.

## MEDICAL BENEFITS PROVIDED

### OTHER BENEFIT PROVISIONS

Benefits available under this “**OTHER BENEFIT PROVISIONS**” subsection are generally determined on the same basis as for other *Inpatient Hospital Expense*, *Medical-Surgical Expense*, and *Extended Care Expense*, except to the extent described in this subsection. Benefits will be determined as indicated on your Schedule of Coverage. Remember that certain services require preauthorization and that any Co-Share Amounts and Deductibles shown on your Schedule of Coverage will also apply.

#### 1. **Benefits for Treatment of Complications of Pregnancy**

Benefits for Eligible or Covered Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for benefits for treatment of Complications of Pregnancy.

#### 2. **Benefits for Maternity Care**

Benefits for Eligible or Covered Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness, except to the extent covered as preventive care. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child will be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

*Inpatient Hospital Expense* incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother’s Hospital Admission for the delivery. These charges will be considered *Inpatient Hospital Expense* of the child and will be subject to the benefits

provisions and benefit maximums as described elsewhere in this “**MEDICAL BENEFITS PROVIDED**” Section.

#### **Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act**

Under federal law, the Plan generally may not 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 delivery by caesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, the Plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain a preauthorization for benefits. For information on preauthorization, refer to the subsection entitled “**PREAUTHORIZATION REQUIREMENTS**” in the “**HOW TO RECEIVE HEALTHCARE BENEFITS**” Section of this Benefit Booklet.

#### 3. **Benefits for Mental Health Care (including Serious Mental Illness) and Chemical Dependency Treatment**

Benefits for *Inpatient Hospital Expense* and *Medical-Surgical Expense* for Mental Health Care (including Serious Mental Illness) and for treatment of Chemical Dependency are available as indicated.

**NOTE:** Refer to the subsection entitled “**PREAUTHORIZATION REQUIREMENTS**” in the “**HOW TO RECEIVE HEALTHCARE BENEFITS**” Section of this Benefit Booklet to

## MEDICAL BENEFITS PROVIDED

determine what services require preauthorization.

The Plan may use state guidelines to administer benefits for treatment of Chemical Dependency.

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under the “**BENEFITS FOR INPATIENT HOSPITAL EXPENSE**” subsection in this “**MEDICAL BENEFITS PROVIDED**” Section of this Benefit Booklet.

Medically Necessary treatment of Chemical Dependency and/or Mental Health Care (including Serious Mental Illness) in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of Hospitalization will be considered *Inpatient Hospital Expense*. *Inpatient Hospital Expense* benefit percentages for this Plan as shown on your Schedule of Coverage will apply.

Mental health benefits include, but are not limited to: assessment, diagnosis, treatment planning, medication management, individual, family and group psychotherapy, psychological education, and psychological testing.

Additional Eligible or Covered Expenses specific to mental disorder treatment are listed below. These additional Eligible or Covered Expenses are subject to the same requirements as Eligible or Covered Expenses described above.

### **Additional Eligible or Covered Expenses**

- Licensed counselor services of a licensed counselor for mental disorder treatments.
- Any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.

- Treatment Center Services, including:
  - Room and board; and
  - Other services and supplies.

Exclusions and limitations that apply to this benefit are described in the “**MEDICAL LIMITATIONS AND EXCLUSIONS**” Section of this Benefit Booklet.

#### 4. ***Benefits for Emergency Care and Treatment of Accidental Injury***

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician before going to the Hospital emergency room. He can help you determine if you need Emergency Care and recommend that care. If not reasonably possible to contact your Network Physician, go to the nearest emergency facility, whether or not the facility is in the Network. A Co-payment may be required if you go to a Hospital emergency room.

Whether you require Hospitalization or not, you should notify your Network Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In-Network Benefits. After 48 hours, In-Network Benefits will be available only if you use Network Providers or you are receiving Emergency Care. If after the first 48 hours of treatment following the onset of a medical emergency you are no longer receiving Emergency Care and can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits, if any, will be available.

## MEDICAL BENEFITS PROVIDED

Benefits for Eligible or Covered Expenses incurred for treatment of an Accidental Injury will be considered on the same basis as any other sickness.

### 5. **Benefits for Preventive Care**

Without limiting any other benefits described in this “**OTHER BENEFIT PROVISIONS**” subsection, benefits are available for *Medical-Surgical Expense* incurred for:

- Well-baby care;
- Routine physical examinations;
- Hearing examinations, including benefits as provided under **Benefits for Screening Test for Hearing Impairment**;
- Preventive supplies or services with a rating of A or B as recommended by the United States Preventive Services Task Force;
- Routine immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and adopted by the Director of the Centers for Disease Control and Prevention, including benefits as provided under **Benefits for Childhood Immunizations**;
- With respect to infants, children, and adolescents, preventive care and screenings recommended by the Health Resources and Services Administration (HRSA);
- Immunizations for Participants age six and over, as described under **Benefits for Childhood Immunizations** below; and
- With respect to women, preventive care and screening recommended by HRSA, including:
  - Well-woman visits;
  - Screening for gestational diabetes;
  - HPV testing;
  - Counseling for sexually transmitted infections;

- Counseling and screening for HIV;
- Breastfeeding support, supplies, and counseling; and
- Screening and counseling for interpersonal and domestic violence.

The complete list of preventive care covered under the Plan can be found at <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/index.html>.

Benefits are not available for *Inpatient Hospital Expense* or *Medical-Surgical Expense* for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Benefits for preventive care services will be determined for Physician office visits, diagnostic lab and x-rays.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for preventive care are not subject to any Co-payment or Deductible.

### 6. **Benefits for Screening Test for Hearing Impairment**

Benefits are available for Eligible or Covered Expenses incurred by a Dependent Child:

- For a screening test for hearing loss from birth through the date the Child is 30 days old; and
- Necessary diagnostic follow-up care related to the screening test from birth through the date the Child is 24 months.

### 7. **Benefits for Childhood Immunizations**

Benefits for *Medical-Surgical Expense* incurred by a Dependent Child for childhood immunizations from birth through the date the Child turns six years of age will be determined at 100% of the Allowable Amount. Benefits are available for:

- Diphtheria;
- Hemophilus influenza type b;
- Hepatitis B;
- Measles;

## **MEDICAL BENEFITS PROVIDED**

- Mumps;
- Pertussis;
- Polio;
- Rubella;
- Tetanus;
- Varicella; and
- Any other immunization that is required by law for the Child.

Injections for allergies are not considered immunizations under this benefit provision.

### **8. *Benefits for Mammography Screening***

If a Participant incurs a *Medical-Surgical Expense* for a screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other *Medical-Surgical Expense*, except to the extent covered as preventive care. Preventive and diagnostic mammograms will be covered at 100% under the PPO and EPO Medical Benefit Options.

### **9. *Benefits for Cosmetic, Reconstructive, or Plastic Surgery***

Eligible or Covered Expenses for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness for the following services only:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant, but only if initial treatment is sought within 24 hours of the Accidental Injury;
- Treatment provided for reconstructive surgery following cancer surgery;
- Surgery performed on a newborn Child for the treatment or correction of a congenital defect;
- Surgery performed on a Dependent Child (other than a newborn Child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast;
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; and

- Reconstructive surgery performed on a Dependent Child under the age of 19 due to craniofacial abnormalities to improve the function of or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

### **10. *Benefits for Gender Transition and Gender Identity Medical Care Services***

Eligible or Covered Expenses include Medically Necessary charges for the diagnosis, treatment, and procedures associated with gender transition and gender identity services for Plan Participants who are at least 18 years old. For more information about Eligible or Covered Expenses for gender transition and gender identity services, please call the Customer Service Helpline at 1-866-314-0266 or Atmos Energy's Benefits Office at 972-855-4032.

### **11. Benefits for In Vitro Fertilization Services**

Benefits for Medical-Surgical Expenses incurred for in vitro fertilization services will be the same as for Maternity Care provided all the following requirements are met:

Coverage is subject to a lifetime maximum benefit of \$15,000 for medical expenses related to infertility, and \$15,000 for fertility-related prescriptions and specialty drugs per covered Participant.

(1) The following services related to in vitro fertilization are not covered:

- Costs associated with a donor egg, donor sperm, or donor embryo;
- Storage fees for cryopreserved eggs or embryos beyond twelve (12) months from the date of cryopreservation;
- Elective or experimental procedures not deemed medically necessary;
- Services provided to a surrogate; and
- Reversal of voluntary sterilization procedures.

## **MEDICAL BENEFITS PROVIDED**

(2) The in vitro fertilization procedures must be performed in a facility that conforms to the American Society for Reproductive Medicine guidelines and is licensed and approved to provide in vitro fertilization services under the appropriate state authority. No benefits for in vitro fertilization services are available if:

- Any condition contained in items (1) through (2) indicated above is not complied with;
- The services or supplies are for Inpatient Hospital Expense; or
- The Participant has exhausted the applicable lifetime or annual maximum benefit for in vitro fertilization services under this Plan.

### 12. Benefits for Adoption Assistance

Atmos Energy offers adoption assistance with a lifetime maximum benefit of \$30,000 per employee to all eligible employees covered by the Atmos Energy Medical Plan. Eligible adoption expenses are reasonable and necessary expenses directly related to, and for the principal purpose of, the legal adoption of an eligible child, including the following:

- Adoption agency fees and charges paid to a licensed adoption agency
- Reasonable legal fees and court costs paid to attorneys licensed to practice law in the jurisdiction where the adoption is finalized
- Court costs
- Reasonable and necessary travel expenses directly related to the adoption, including transportation, lodging, and meals for the adoptive parent(s) when required to travel [more than 50 miles] from their primary residence for adoption-related proceedings or to take custody of the child
- Medical examination fees for the child that are required as part of the adoption process and that are not reimbursed or reimbursable by any other medical benefits program or insurance coverage
- Temporary foster care expenses
- The Adoption Assistance Program provides reimbursement for approved adoption expenses; the reimbursed funds are considered a taxable benefit income to the employee and will be reported on the employee's Form W-2. Employees should

consult with a tax advisor regarding the potential availability of the federal adoption tax credit under Internal Revenue Code Section 23.

Exclusions: The following expenses are not eligible for reimbursement under the Adoption Assistance Program:

- [Expenses reimbursed or reimbursable under any other benefit plan or insurance program;
- Expenses related to a surrogate parenting arrangement;
- Expenses paid or reimbursed by any government agency, court, or other third party;
- Expenses incurred prior to the employee's eligibility date under the Plan;
- Expenses incurred after the employee's coverage terminates; or
- Any expenses that are illegal under applicable federal or state law.]

### 13. **Benefits for Dental Services**

If a Participant incurs Eligible or Covered Expenses for dental services, benefits will be the same as for treatment of any other sickness.

Benefits are provided only for:

- Covered Oral Surgery;
- Services provided to a newborn Child which are necessary for treatment or correction of a congenital defect; and
- The correction of damage caused solely by external, violent Accidental Injury to healthy, unrestored natural teeth and supporting tissues but only if initial treatment is sought within 24 hours of the Accidental Injury and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing will not be considered an Accidental Injury.

Except as excluded in the "**MEDICAL LIMITATIONS AND EXCLUSIONS**" Section of this Benefit Booklet, any other expenses for

## **MEDICAL BENEFITS PROVIDED**

dental services for which a Participant incurs *Inpatient Hospital Expense* for a Medically Necessary Hospital Admission, will be determined as described in the subsection entitled “**BENEFITS FOR INPATIENT HOSPITAL EXPENSE**” in this “**MEDICAL BENEFITS PROVIDED**” Section of this Benefit Booklet.

### 14. ***Benefits for Organ and Tissue Transplants***

Subject to the conditions described below, benefits for covered services and supplies provided to a Participant (donor and/or recipient) by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if:

- The transplant procedure is not Experimental/Investigational in nature;
- Donated human organs or tissue are used;
- The recipient is a Participant under the Plan (benefits are also available to the donor who is a Participant under the Plan);
- The transplant procedure is preauthorized as provided below;
- The Participant meets all of the criteria established by the Claims Administrator; and
- The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory, chemotherapy, radiation therapy, prescription drugs, and complications arising from such transplant.

Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is for the following:

- Liver;
- Heart;
- Heart - Lung (heart and one lung or heart and both lungs);
- Kidney;
- Cornea;

- Lung; and
- Bone Marrow.

Covered services and supplies include services and supplies provided for the:

- Evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
  - Removal of organs or tissues from deceased donors;
- Transportation and storage of donated organs or tissues; and
- Donor search and acceptability testing of potential living donors.

No benefits are available for a Participant for the following services or supplies:

- Living and/or travel expenses of the live donor or recipient;
- Expenses related to maintenance of life for purposes of organ or tissue donation; or
- Purchase of the organ or tissue.

Preauthorization is required for any organ or tissue transplant and is the process by which the Medical Necessity of the transplant and the length of stay of the admission is approved or denied. Preauthorization does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the preauthorized length of stay will not be denied on the basis of Medical Necessity.

At the time of preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary.

No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such procedure) which the Claims Administrator considers to be Experimental/Investigational.

## **MEDICAL BENEFITS PROVIDED**

### 15. **Benefits for Detection and Prevention of Osteoporosis**

If a Participant is a *Qualified Individual*, benefits will be determined on the same basis as any other sickness, except to the extent covered as preventive care, for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

*Qualified Individual* means:

- A postmenopausal woman not receiving estrogen replacement therapy;
- An individual with:
  - Vertebral abnormalities;
  - Primary hyperparathyroidism; or
  - A history of bone fractures; or
- An individual who is:
  - Receiving long-term glucocorticoid therapy; or
  - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

### 16. **Benefits for Certain Tests for Detection of Prostate Cancer**

If a male Participant incurs *Medical-Surgical Expense* for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided only for a:

- Physical examination for the detection of prostate cancer; and
- Prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan.

### 17. **Benefits for Speech and Hearing Services**

Benefits are available for the services of a Physician or Professional Other Provider to

restore loss of or correct an impaired speech or hearing function. Benefits for Eligible Medically Necessary Covered Expenses incurred for hearing aids is limited to one basic model hearing aid per ear per thirty-six (36) month period up to the allowable amount. Additional out-of-pocket costs may be incurred by members who elect to purchase a Hearing Aid that is enhanced or is not a basic model.

### 18. **Benefits for Treatment of Acquired Brain Injury**

Benefits for Eligible or Covered Expenses incurred for Medically Necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition.

Eligible or Covered Expenses include the following services as a result of and related to an acquired brain injury:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neurophysiological, neuro-psychological, and psychophysiological testing or treatment;
- Neurofeedback therapy;
- Remediation;
- Post-acute transition services; and
- Community reintegration services.

### 19. **Benefits for Tests for Detection of Colorectal Cancer**

Except to the extent covered as preventive care, benefits for *Medical-Surgical Expense* incurred for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, including:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy.

Preventive and diagnostic colonoscopies will be covered at 100% under the EPO and PPO Medical Benefit Options.

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### 20. **Benefits for Treatment of Diabetes**

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, will include but not be limited to the following:

#### a. *Diabetes Equipment*

- (1) Blood glucose monitors (including noninvasive glucose monitors and monitors designed to be used by blind individuals);
- (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:
  - Insulin infusion devices;
  - Batteries;
  - Skin preparation items;
  - Adhesive supplies;
  - Infusion sets;
  - Infusion cartridges;
  - Durable and disposable devices to assist in the injection of insulin; and
  - Other required disposable supplies;
- (3) Insulin infusion devices; and
- (4) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

#### b. *Diabetes Supplies*

- (1) Test strips for blood glucose monitors;
- (2) Visual reading and urine test strips and tablets for glucose, ketones and protein;
- (3) Lancets and lancet devices;
- (4) Insulin and insulin analog preparations;

- (5) Injection aids, including devices used to assist with insulin injection and needleless systems;
- (6) Biohazard disposable containers;
- (7) Insulin syringes;
- (8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- (9) Glucagon emergency kits.

NOTE: *Insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents will be covered under the Prescription Drug Program.*

Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which will exceed the purchase price of a similar replacement pump.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the FDA, such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

*Medical-Surgical Expense* provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant are limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning:

- (1) The physical cause and process of diabetes;
- (2) Nutrition, exercise, medications, monitoring of laboratory values and the

## **MEDICAL BENEFITS PROVIDED**

interaction of these in the effective self-management of diabetes;

- (3) Prevention and treatment of special health problems for the diabetic patient;
- (4) Adjustment to lifestyle modifications; and
- (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

*Diabetes Self-Management Training* for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family or caretaker) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

### **21. Benefits for Early Detection of Cardiovascular Disease**

Benefits will be determined on the same basis as any other sickness for a *Medical-Surgical Expense* incurred for one of the following Medically Necessary noninvasive screening tests for atherosclerosis and abnormal artery structure and function:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque, covered once every 5 years.

This benefit is available to each Participant who is either (i) a male older than forty-five (45) years of age and younger than seventy-six (76)

years of age, or (ii) a female older than fifty-five (55) years of age and younger than seventy-six (76) years of age. The Participant must be diabetic or have a risk of developing coronary heart disease based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

### **22. Benefits for Autism Spectrum Disorder**

Benefits will be determined on the same basis as any other sickness for a *Medical-Surgical Expense* incurred for generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or qualifying behavioral health practitioner in a treatment plan recommended by such Physician or behavioral health practitioner. For purposes of this provision, generally recognized services may include services such as:

- Evaluation and assessment services;
- Applied behavioral analysis;
- Behavioral training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

### **Employee Assistance Program**

The Plan Administrator has contracted with Magellan to coordinate care for personal problems under the Employee Assistance Program (EAP). Magellan works to ensure treatment is provided by qualified providers at the proper level of care. By doing so, Magellan helps to keep out-of-pocket expenses as low as possible. Magellan contracts with licensed counselors, certified social workers, clinical psychologists, psychiatrists, and psychiatric facilities.

### **Employee Assistance Program Benefits**

EAP is a benefit offered to Employees and their Dependents to help them address personal problems.

## **MEDICAL BENEFITS PROVIDED**

During your assessment visit, the counselor will try to determine the underlying reasons for your problem and develop a treatment plan. If the problem cannot be adequately resolved with the additional EAP visits, the EAP counselor may recommend other qualified specialists to help you. You are allowed up to eight (8) visits per Calendar Year when you contact Magellan. Depending on your needs, you may be referred to the mental health network prior to the completion of eight (8) visits. Therefore, when you need more assistance than is available through the EAP, your mental health benefits are there to help resolve Medically Necessary, longer-term chronic or acute mental health or chemical dependency problems.

If you or a Dependent has a psychiatric problem, you can call Magellan at 800-424-1768. Magellan is available to take calls 24 hours a day.

If Children under age 18 call Magellan, the procedures involved in accessing a counselor will be explained. However, without a signed release of parental consent, Magellan will not discuss educational needs or enter into any problem resolution. Magellan will, however, give Children suggestions on how to approach their parents and encourage them to do so.

Magellan's telephone is answered by trained intake specialists under the direction of a full-time psychiatric medical director.

These specialists will listen to your problem and ask a few questions so they can match you with an EAP counselor. Then they will give you all the information you need to discuss your situation in person. If your symptoms require Hospitalization, Magellan will arrange for an emergency evaluation or Hospital Admission.

By providing prepaid professional assessment and short-term counseling, the EAP helps address almost any type of crisis or concern, including:

- |                      |                             |
|----------------------|-----------------------------|
| Personal Problems    | Emotional Problems          |
| Depression           | Aging                       |
| Family               | Terminal Illness            |
| Children             | Legal                       |
| Adolescent           | Persistent Anxiety, Stress, |
| Emotional/Drug Abuse | Worries or Fears            |
| Alcohol              | Marriage/Divorce            |

- |                         |                          |
|-------------------------|--------------------------|
| Drugs                   | Premarital               |
| Codependency            | Disabilities in Children |
| Sexual Addiction        | Work-related Problems    |
| Eating Disorders        | Gambling                 |
| Bed-wetting             | Learning Disabilities    |
| Loneliness              | Budget/Credit            |
| Sleep Problems          | Smoking/Nicotine         |
| Rape or Battered Spouse | Grief/Loss               |

### **Confidentiality**

Magellan's services are completely confidential. Magellan is bound by the same laws of confidentiality as physicians.

### **Cost of EAP**

Atmos Energy pays the full cost of the EAP as a benefit to you; therefore, there is no charge to you for EAP evaluation, and up to eight (8) counseling visits with a Magellan EAP counselor.

## **MEDICAL LIMITATIONS AND EXCLUSIONS**

### **WHAT IS NOT COVERED UNDER THE MEDICAL BENEFIT**

The Plan does not provide medical benefits for any of the treatments, services or supplies described below, except as otherwise required by applicable law. However, some of the exclusions described below may be covered as a prescription drug benefit available under the Plan.

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction; or any Experimental/ Investigational services and supplies.
2. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claims Administrator.
3. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
4. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality; provided, however, that this exclusion will not be applicable to any coverage held by the Participant for Hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
5. Any services or supplies provided for reduction mammoplasty, except when Medically Necessary.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or intellectual disabilities provided by a tax supported institution.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
  - As a result of war, declared or undeclared, or any act of war; or
  - While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges:
  - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider;
  - For completion of any insurance forms; or
  - For acquisition of medical records.
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Any services or supplies provided for Custodial Care.
13. Any services or supplies provided for orthognathic surgery except when medically necessary after the Participant's 19<sup>th</sup> birthday. Orthognathic surgery includes, but is not limited to, correction of congenital, developmental or acquired maxillofacial skeletal deformities of the mandible and maxilla.
14. Any items of Medical-Surgical Expense incurred for dental care and treatments, dental surgery, or dental appliances, except as

## MEDICAL LIMITATIONS AND EXCLUSIONS

provided for in the subsection entitled “**OTHER BENEFIT PROVISIONS**” in the “**MEDICAL BENEFITS PROVIDED**” Section of this Benefit Booklet.

15. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the subsection entitled “**OTHER BENEFIT PROVISIONS**” in the “**MEDICAL BENEFITS PROVIDED**” Section of this Benefit Booklet.
16. Any services or supplies provided for:
  - Treatment of myopia and other errors of refraction, including refractive surgery;
  - Orthoptics or visual training;
  - Eyeglasses or contact lenses, provided that intraocular lenses will be specific exceptions to this exclusion; or
  - Examinations for the prescription or fitting of eyeglasses or contact lenses.
17. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.
18. Travel, whether or not recommended by a Physician or Professional Other Provider, except for local ground ambulance service or air ambulance service otherwise covered under the Plan, except treatment as determined Medically Necessary by the Claims Administrator’s case management.
19. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except:
  - As determined Medically Necessary; or
  - Obesity counseling covered under the Plan as preventive care.
20. Any services or supplies provided primarily for:
  - Environmental Sensitivity;
  - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
  - Inpatient allergy testing or treatment.
21. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
22. Any services or supplies provided for, in preparation for, or in conjunction with (except as otherwise required by applicable law):
  - Sterilization reversal (male or female), except as required by applicable law;
  - Gender transition or Gender identity services for Plan Participants who have not attained 18 years of age, except as required by applicable law or when determined to be Medically Necessary by the treating Physician;
  - Gender transition or Gender identity services that are not Medically Necessary for Plan Participants of any age, as determined by the Claims Administrator in consultation with the treating Physician;
  - Sexual dysfunction, except when Medically Necessary;
23. Any services or supplies for routine foot care, such as:
  - The cutting or removal of corns or callouses, the trimming of nails (including mycotic nails) and other hygienic and preventive care maintenance in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory or bedfast patients;
  - Any services performed in the absence of localized illness, injury, or symptoms involving the foot;

## MEDICAL LIMITATIONS AND EXCLUSIONS

- Any treatment of a fungal (mycotic) infection of the toenail in the absence of:
    - (1) Clinical evidence of mycosis of the toenail;
    - (2) Compelling medical evidence that documents the patient either:
      - (a) Has a marked limitation of ambulation requiring active treatment of the foot; or
      - (b) In the case of a non-ambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment; and
  - Excision of a nail without using an injectable or general anesthetic.
24. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations; any Retin-A or pharmacologically similar topical drugs.
25. Any smoking cessation products available without a prescription, including, but not limited to, nicotine gum and nicotine patches above the limits described in the “**MEDICAL BENEFITS PROVIDED**” Section of this Booklet.
26. Any services or supplies not specifically defined as Eligible or Covered Expenses in this Plan.
27. Any services or supplies provided for the following treatment modalities:
- Acupuncture;
  - Video fluoroscopy;
  - Intersegmental traction;
  - Surface EMGs;
  - Manipulation under anesthesia; and
  - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
28. Any benefits in excess of any specified maximums.

# **PRESCRIPTION DRUG PROGRAM**

## **PRESCRIPTION DRUG BENEFITS**

Benefits are payable for Covered Drugs under all Medical Benefit Options. Certain Covered Drugs require prior authorization by a pharmacist or Physician from the Claims Administrator or its designee.

The eligible Employee or covered Dependent must be covered under this Prescription Drug Benefit when the prescription is filled.

Prescription drugs are covered through Prime Therapeutics. To find pharmacies in your area, log on to [www.myprime.com](http://www.myprime.com).

## **HDHP MEDICAL BENEFIT OPTION**

Participants enrolled in the HDHP Medical Benefit Option will be responsible for paying 100% of the cost of Prescription Drugs (other than toward preventative maintenance Prescription Drugs) until the Deductible is met. Amounts paid for Prescription Drugs will count toward the Participant's Deductible and Out-of-Pocket Maximum. Preventive maintenance Prescription Drugs (as determined by the Claims Administrator) will be covered the same as Prescription Drugs available under the other Medical Benefit Options. Amounts a Participant pays toward preventative maintenance Prescription Drugs will count toward the Out-of-Pocket Maximum. Once the Out-of-Pocket Maximum has been met, both preventative maintenance Prescription Drugs and non-preventative maintenance Prescription Drugs will be covered at 100%.

## **MEDICAL BENEFIT OPTION OTHER THAN THE HDHP MEDICAL BENEFIT OPTION**

### **How Co-payment Amounts Apply**

Retail Pharmacy: 25% Co-payment for all medical plans for a **30-Day Supply** of Generic and Preferred Brand Name Prescription Drugs and 35% Co-payment for all medical plans for a **30-Day Supply** of Non-Preferred Brand Name Prescription Drugs.

Mail Service Pharmacy: 25% Co-payment for all medical plans for a **90-Day Supply** of Generic and Preferred Brand Name Prescription Drugs and 35% Co-payment for all medical plans for a

**90-Day Supply** of Non-Preferred Brand Name Prescription Drugs.

Extended Supply Network: 25% Co-payment for all medical plans for a **90-Day Supply** of Generic and Preferred Brand Name Prescription Drugs and 35% Co-payment for all medical plans for a **90-Day Supply** of Non-Preferred Brand Name Prescription Drugs. The mail service coinsurance applies.

## **Per-Prescription Minimum and Maximum Co-payment Amounts**

There is a Per-Prescription Maximum Co-payment Amount imposed on each Covered Drug. Furthermore, for Preferred Brand Name Prescription Drugs and Non-Preferred Name Brand Prescription Drugs there is also a Per-Prescription Minimum Co-payment Amount imposed. The applicable Per-Prescription Minimum and Maximum Co-payments are specified in the Schedule of Coverage at the beginning of this Booklet.

## **Network Pharmacy**

When a Network Pharmacy is used, you pay the Co-payment up to the Per-Prescription Maximum Co-payment Amount for the type of drug, as set forth in the applicable chart (i.e., 30-Day or 90-Day Supply).

For example, if a covered person orders a 30-Day Supply of a Preferred Brand Name Covered Drug which costs \$100, since the 25% Co-payment (\$25) is less than the Per-Prescription Maximum Co-payment Amount (\$75), the covered person pays the \$25 Co-payment. On the other hand, if the cost of the Preferred Brand Name Covered Drug had been \$320, the 25% Co-payment (\$80) is more than the Per-Prescription Maximum Co-payment Amount, so the covered person would only have to pay \$75 (the amount of the Per-Prescription Maximum Co-payment Amount).

Extended Supply Network is a 90-day retail option that allows you to receive a 90-day supply of an approved prescription drug at one of the 54,000 participating retail pharmacies in the Extended Supply Network (ESN).

## **PRESCRIPTION DRUG PROGRAM**

### **Out-of-Network Pharmacy**

When an Out-of-Network Pharmacy is used, you must pay for the entire cost of each prescription at the time it is filled. Then you must submit a claim. Benefits are payable at the predominant contracted reimbursement rate (including any sales tax) for Network Pharmacies minus the applicable Co-payment amount.

### **Mail Service Network Pharmacy**

If the Mail Service Pharmacy is used, the covered person must pay the Co-payment amount.

There is no coverage for prescription drugs dispensed by an Out-of-Network Mail Service Pharmacy.

### **Supply Limits**

#### **Retail Pharmacy**

If the prescription drug is dispensed by a retail Pharmacy, the following limits apply:

- Up to a 30-Day Supply of a prescription drug, unless adjusted based on the drug manufacturer's packaging size. Some products may be subject to additional supply limits adopted by the Claims Administrator. A list of current additional supply limits may be obtained from the Claims Administrator.
- A one cycle supply of an oral contraceptive. Up to three cycles can be purchased at one time if a Co-payment (if not a Generic Covered Drug) is paid for each cycle supplied.

#### **Mail Service Pharmacy**

If the prescription drug is dispensed by the Mail Service Pharmacy, the supply limit is up to a 90 Day Supply of a prescription drug, unless adjusted based on the drug manufacturer's packaging size or any additional supply limits adopted by the Claims Administrator. A list of current supply limits may be obtained from the Claims Administrator.

### **How The Prescription Drug Program Works**

When you need a Prescription Order filled, you can elect to go to a Participating Pharmacy or a Non-Participating Pharmacy or use the Mail Service Prescription Drug Program.

#### ***Participating Pharmacy***

When you go to a Participating Pharmacy:

- Present your Identification Card to the pharmacist along with your Prescription Order;
- Provide the pharmacist with the birth date and relationship of the patient;
- Sign the insurance claim log; and
- Pay the appropriate Co-payment for each Covered Drug filled or refilled.

The Participating Pharmacy will take care of the rest.

Participating Pharmacies have agreed not to bill you for any Covered Drug expenses in excess of:

- The appropriate Co-payment amounts; and
- Any pricing differences that may apply.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card. **You must present your Identification Card to your Participating Pharmacy in order to receive full Plan benefits.**

#### ***Non-Participating Pharmacy***

If you have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit to the Claims Administrator a claim form and itemized receipt verifying that the prescription was filled. The Plan will reimburse you for Covered Drugs equal to:

- 80% of the Allowable Amount;

## PRESCRIPTION DRUG PROGRAM

- Less any applicable Pharmacy Deductible;
- Less the appropriate Co-payment amount; and
- Less any pricing differences that may apply.

### ***Mail Service Prescription Drug Program***

Your Employer has chosen to provide a Mail Service Prescription Program to you and your covered Dependents. Any pricing differences, as explained in the subsection “**How Co-Payment Amounts Apply**” in this “**PRESCRIPTION DRUG PROGRAM**” Section will also apply.

When you mail your Prescription Orders to the address provided on the *Mail Service Prescription Drug Program Claim Form*, you must send in your payment. If you need assistance in determining the amount of your payment, you may either contact the Customer Service Helpline for assistance or send the amount of payment you determine will be needed.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

### **YOUR IDENTIFICATION CARD**

The Identification Card you received is the key to your use of the Plan. It tells Participating Pharmacies that you are entitled to prescription drug benefits under the Prescription Drug Program. Participating Pharmacies are not permitted to file claims with the Claims Administrator unless you present the Identification Card with your Prescription Order.

You may print a temporary Identification Card as soon as your coverage is effective. To print an Identification Card, go to [www.BCBSTX.com](http://www.BCBSTX.com), and follow the instructions for logging in.

**Note:** If you do not have your Identification Card, you must pay your Participating Pharmacy directly for your prescription charges. You must then file a claim with the Claims Administrator. You will then be reimbursed for your payments less the appropriate Co-payment amount, and any applicable pricing difference.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you. (Refer to the subsections entitled “**CHANGE OF ELECTION**” and “**HOW TO ENROLL**” in the “**ELIGIBILITY AND PARTICIPATION**” Section of this Benefit Booklet for additional instructions when changes are made). Upon receipt of the change information, the Claims Administrator will issue a new Identification Card.

### ***Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards***

The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered family members will include, but not be limited to, the following actions, when intentional:

- Use of the Identification Card prior to your Effective Date;
- Use of the Identification Card after your date of termination of coverage under the Plan;
- Obtaining prescription drugs or other benefits for persons not covered under the Plan;
- Obtaining prescription drugs or other benefits which are not covered under the Plan;
- Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
- Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
- Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
- Obtaining prescription drugs using Prescription Orders for the same drugs

## **PRESCRIPTION DRUG PROGRAM**

from multiple Providers; and

- Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.

The fraudulent or intentionally unauthorized, improper, or abusive use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

- Denial of benefits;
- Cancellation of coverage under the Plan for all Participants under your coverage;
- Limitation on the use of Identification Card to one designated Participating Pharmacy of your choice;
- Recoupment from you or any of your covered family members of any benefit payments made;
- Pre-approval of drug purchases for all Participants receiving benefits under your coverage; and
- Notice to proper authorities of potential violations of law or professional ethics.

Other unauthorized, improper, or abusive use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

- Limitation on the use of Identification Card to one designated Participating Pharmacy of your choice;
- Recoupment from you or any of your covered family members of any benefit payments made; and
- Pre-approval of drug purchases for all Participants receiving benefits under your coverage.

### **WHAT THE PRESCRIPTION DRUG PROGRAM COVERS**

The Plan will provide benefits for those Covered Drugs prescribed for your use by your Provider which require a valid Prescription Order before they can be sold to you, and which are required by federal law to bear labeling stating "Caution: Federal law prohibits dispensing without prescription" or "Rx only." These drugs are commonly called Legend Drugs. As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits. Subject to applicable supply limitations, the Plan covers over-the-counter contraceptives and tobacco cessation medications, provided they are prescribed by your Provider.

#### ***Generic Covered Drugs***

You are encouraged to select Generic Covered Drugs when your prescribing Provider and pharmacist feel it is safe to do so and where state or federal laws permit.

#### ***Injectable Drugs***

Injectable drugs for subcutaneous self-administration are also covered under the Plan, including but not limited to fertility medications for in-vitro fertilization procedures. You are responsible for any Co-payment amounts, and pricing differences that may apply. Injectable drugs include, but are not limited to, insulin, Imitrex, and fertility medications such as gonadotropins and GnRH agonists/antagonists used in assisted reproductive technology.

The Day Supply of disposable syringes and needles you will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period, except that higher quantities may be authorized when Medically Necessary for fertility treatments or other conditions requiring more frequent injections as determined by the treating Provider.

#### ***Tobacco Cessation Medications***

The Plan covers without cost-sharing:

## **PRESCRIPTION DRUG PROGRAM**

- Screening for tobacco use; and
- For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
  - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
  - All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

### ***Prescribed Contraception***

The Plan covers prescribed contraceptive methods and counseling without cost-sharing. No cost sharing (including Co-Payment) for all medical plans for a 30-Day or 90-Day Supply of Generic Covered Drugs that are prescribed contraceptive methods. The Plan will cover Brand Name Drugs without cost sharing if a Generic Covered Drug is unavailable or the Participant's physician determines the Generic Covered Drug is not safe and effective for the Participant.

### ***Amount of Your Payment***

The amount of your payment under the Plan depends on whether:

- The Prescription Order is filled at a Participating Pharmacy, through the Mail Service Prescription Drug Program, or at a Non-Participating Pharmacy; and
- A Generic Covered Drug, a Preferred Brand Name Drug or Brand Name Covered Drug is dispensed.

If the Allowable Amount of the prescription drug is less than the Co-payment amount, the Participant will pay the lower cost.

### **LIMITATIONS ON QUANTITIES DISPENSED**

Benefits for Covered Drugs obtained from a Participating Pharmacy or a Non-Participating Pharmacy are provided for up to a maximum 30-Day Supply.

Benefits for Covered Drugs obtained from the Mail Service Prescription Drug Program are provided for up to a maximum of a 90-Day Supply.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Physician, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. To determine if a specific drug is subject to this limitation, contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

Payment for benefits covered under this Plan **may be denied** if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the 90-day maximum Day Supply limitation. (Refer to the subparagraph entitled **"Unauthorized, Fraudulent, Improper or Abusive Use of Identification Cards"** in this **"PRESCRIPTION DRUG PROGRAM"** Section of the Benefit Booklet for additional information).

## PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

### **WHAT IS NOT COVERED UNDER THE PRESCRIPTION DRUG PROGRAM**

The benefits of the Prescription Drug Program are not available for (note certain prescription and nonprescription drugs and devices, such as contraception, tobacco cessation, and fertility medications for in-vitro fertilization and adoption assistance, may be covered under the Medical Program Options):

1. Drugs which do not by law require a Prescription Order from a Provider (except injectable insulin and insulin pens); and drugs or covered devices for which no valid Prescription Order is obtained.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and except contraceptive devices covered without cost-sharing as required by applicable law).
3. Administration or injection of any drugs.
4. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
5. Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
7. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law.
8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
9. Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.
10. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
11. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
12. Drugs dispensed in quantities in excess of the Day Supply amounts stipulated in the subsection entitled "**LIMITATIONS ON QUANTITIES DISPENSED**" in the "**PRESCRIPTION DRUG PROGRAM**" Section of this Benefit Booklet.
13. Certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
14. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

## **PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS**

15. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
16. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
17. Drugs for the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
18. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
19. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.
20. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
21. Compounded drugs that do not meet the definition of Compound Drugs in this Benefit Booklet.
22. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
23. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s).
24. Athletic performance enhancement drugs.
25. Allergy serum and allergy testing materials.
26. Injectable drugs, except those self-administered subcutaneously, including fertility medications for in-vitro fertilization and other assisted reproductive technologies.

The exclusions described in this **"PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS"** Section of the Benefit Booklet will not apply to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

## DEFINITIONS

The definitions used in this Benefit Booklet apply to all Benefit Coverages unless otherwise indicated.

**Accidental Injury** means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider within 30 days after the occurrence.

**Allowable Amount** means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply or procedure.

1. ***For Hospitals and Facility Other Providers, Physicians and Professional Other Providers Contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan*** - The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts or other payment methodologies.
2. ***For procedures, services or supplies provided in Texas by Physicians and Professional Other Providers not contracting with the Claims Administrator*** – The Allowable Amount will be the lesser of the billed charge or the amount BCBSTX, the Claims Administrator, would have considered for payment for the same covered procedure, service, or supply if performed or provided by a Physician or Professional Other Provider with similar experience and/or skill.

If the Claims Administrator does not have sufficient data to calculate the Allowable Amount for a particular procedure, service or supply, the Claims Administrator will determine an Allowable Amount based on the complexity of the procedure, service, or supply and any unusual circumstances or medical complications specifically brought to its attention, which require additional experience, skill and/or time.

3. ***For procedures, services or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with the Claims Administrator or any other Blue Cross and Blue Shield Plan*** – The Claims Administrator will establish an Allowable Amount using, Texas regional or state allowable amounts applicable to procedures, services, or supplies of Physicians or Professional Other Providers with similar skills and experience.
4. ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day, will be the amount for the single procedure with the highest Allowable Amount *plus* one-half of the Allowable Amount *for each* of the other covered procedures performed.
5. ***For drugs administered by a Home Infusion Therapy Provider*** - The Allowable Amount will be the lesser of (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark-down from the AWP established by BCBSTX and updated on a periodic basis.
6. ***For procedures, services or supplies provided to Medicare recipients*** - The Allowable Amount will not exceed Medicare's limiting charge.
7. ***For Covered Drugs from a Participating Pharmacy or Mail Service Prescription Drug Program*** – The Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy/Mail Service Pharmacy in effect on the date of service.
8. ***For Covered Drugs from a Non-Participating Pharmacy*** – The Allowable Amount is based on the amount BCBSTX would have considered for payment for the same Covered Drug received at a Participating Pharmacy.

**Annual Enrollment Period** means the period preceding the next Plan Anniversary Date during which Employees and Dependents may change their coverage.

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**Average Wholesale Price** means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

**Brand Name Covered Drug** means a Covered Drug that is protected by trademark registration.

**Calendar Year** means the period commencing each January 1 and ending on the next succeeding December 31, inclusive.

**Chemical Dependency** means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

**Chemical Dependency Treatment Center** means a facility which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

- Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
- Accredited as such a facility by the Joint Commission on Accreditation of Hospitals;
- Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
- Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Any Chemical Dependency Treatment Center located outside the state of Texas will be licensed, certified, or approved as a Chemical Dependency Treatment Center by the appropriate agency of the state in which it is located and be accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations.

**Chiropractic Services** means any services or supplies provided by or under the direction of a Doctor of Chiropractic.

**Claims Administrator** means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

*Claims Administrator* may also mean any successor named by the Plan Administrator.

**Clinical Ecology** means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

- Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
- Urine auto injection (injecting one's own urine into the tissue of the body);
- Skin irritation by Rinkel method;
- Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
- Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

**Code** means the Internal Revenue Code of 1986, as amended

**Complications of Pregnancy** means:

- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but will not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
- Termination of pregnancy by nonelective

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cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

**Compound Drugs** means those drugs that meet the following requirements:

- The approved product must have an assigned National Drug Code (NDC);
- The drugs in the compounded product have to be FDA approved; and
- The primary active ingredient is a Covered Drug under the Prescription Drug Program.

**Contracting Facility** means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claims Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility will also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross and Blue Shield Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan will be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross and Blue Shield Plan.

**Co-payment** or **Co-pay** means the dollar amount that a Participant must pay toward an Eligible or Covered Expense at the time the service or supply is requested and/or received before any other amount of the charge will be considered by the Plan for payment.

**Co-Share Amount** means the percentage of Eligible or Covered Expenses that must be paid by the Participant.

**Cosmetic, Reconstructive, or Plastic Surgery** means surgery that:

- Can be expected or is intended to improve the physical appearance of a Participant;

- Is performed for psychological purposes; or
- Restores form but does not correct or materially restore a bodily function.

**Covered Drug** means any Legend Drug or injectable insulin, including disposable syringes and needles needed for self-administration:

- Which is Medically Necessary or for prevention of pregnancy and ordered by a Provider naming a Participant as the recipient;
- For which a written or verbal Prescription Order is prepared by a Provider;
- For which a separate charge is customarily made;
- Which is not entirely consumed at the time and place that the Prescription Order is written;
- For which the FDA has given approval for a particular use or purpose; and
- Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility.

**Covered Oral Surgery** means maxillofacial surgical procedures limited to:

- Excision of no dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and no dental related procedures of the accessory sinuses; and
- Surgical and diagnostic treatment of

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conditions affecting the temporomandibular joint as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology.

**Crisis Stabilization Unit or Facility** means an institution that is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and treatment of Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

**Custodial Care** means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care that is not a necessary part of medical treatment for recovery, and will include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

**Day Supply** means the number of units to be dispensed. The Claims Administrator has the right to determine the Day Supply at its sole discretion. A Day Supply of a given prescription drug is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Physician.

**Deductible** means the dollar amount of Eligible or Covered Expenses that must be incurred by a Participant before benefits under the Plan will be available.

**Dependent** means your Spouse or Dependent Children as described under subsections “**ELIGIBILITY FOR DEPENDENTS**” under the “**WHO GETS BENEFITS**” Section of this Benefits Booklet.

**Dietary and Nutritional Services** means the education, counseling, or training of a Participant (including printed material) regarding:

- Diet;

- Regulation or management of diet; or
- The assessment or management of nutrition.

**Durable Medical Equipment Provider** means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

**Effective Date** means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

**Eligibility Date** means the date the Participant satisfies the definition of either *Employee* or *Dependent* and is in a class eligible for coverage under the Plan as described in the subsections entitled “**ELIGIBILITY FOR EMPLOYEES**” and “**ELIGIBILITY FOR DEPENDENTS**” in the “**ELIGIBILITY AND PARTICIPATION**” Section of this Benefit Booklet.

**Eligible or Covered Expenses** means either *Inpatient Hospital Expense*, *Medical-Surgical Expense*, or *Extended Care Expense* or a *Covered Drug*, as specified in this Benefit Booklet, up to the Allowable Amount.

**Emergency Care** means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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**Employee** means an individual currently or formerly employed by the Employer as a common law employee.

**Employer** means Atmos Energy Corporation.

**Environmental Sensitivity** means the inpatient or outpatient treatment of allergic symptoms by:

- Controlled environment;
- Sanitizing the surroundings, removal of toxic materials; or
- Use of special nonorganic, nonrepetitive diet techniques.

**ERISA** means the Employee Retirement Income Security Act of 1974, as amended, a federal law that governs your rights under the Plan.

**Experimental/Investigational** means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

*Approval* by a Federal agency means that the treatment, procedure, facility, equipment, drug, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment. *Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- Are appropriate for the Hospital, Facility, or Other Provider in which they were performed; and
- The Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claims Administrator for the Plan will determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/ Investigational, and will consider the guidelines and practices of Medicare, Medicaid or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, such services, supplies, or treatment may still be considered to be Experimental/ Investigational within this definition. Except as provided in the subsection entitled "**CLINICAL TRIALS**," treatment provided as part of a clinical trial or a research study is Experimental/ Investigational.

**Extended Care Expense** means the services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the subsection entitled "**BENEFITS FOR EXTENDED CARE EXPENSE**" in the "**MEDICAL BENEFITS PROVIDED**" Section of this Benefit Booklet.

**Fertility Preservation Services** means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue, and does not include the storage of such unfertilized genetic materials.

**FDA** means the United States Food and Drug Administration.

**Generic Covered Drug** means a Covered Drug pharmaceutically and therapeutically equivalent to the Brand Name Covered Drug prescribed, and which usually costs less than the Brand Name Covered Drug.

**Home Health Agency** means a business that provides Home Health Care and is licensed by the Department of Health. A Home Health Agency located in another state must be licensed, approved, or certified by the appropriate agency of the state in which it is located and be certified by Medicare as a supplier of Home Health Care.

**Home Health Care** means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients

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confined at home due to a sickness or injury requiring skilled health care services on an intermittent, part-time basis.

**Home Infusion Therapy** means the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy will include:

- Drugs and IV solutions;
- Pharmacy compounding and dispensing services;
- All equipment and ancillary supplies necessitated by the defined therapy;
- Delivery services;
- Patient and family education; and
- Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

**Home Infusion Therapy Provider** means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

**Hospice** means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

- Licensed in accordance with state law (where the state law provides for such licensing); and
- Certified by Medicare as a supplier of Hospice Care.

**Hospice Care** means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

**Hospital** means a short-term acute care facility which:

- Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
- 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 for compensation from its patients;
- Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
- Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
- Has in effect a Hospital Utilization Review Plan; and
- Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

**Hospital Admission** means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, will be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time the Participant is confined in the Hospital, the

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admission will be considered a Hospital Admission by the Plan.

*Bed patient* means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed and operated to provide long-term institutional care on a residential basis.

**Identification Card** means the card issued to the Employee by the Claims Administrator of the Plan indicating pertinent information applicable to his coverage.

**Imaging Center** means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.

**Independent Laboratory** means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

**In-Network (Network) Benefits** means the benefits available under the Plan for services and supplies that are provided by or referred by a network Provider or referred through the Mental Health Helpline.

**Inpatient Hospital Expense** means charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant; provided that such items are:

- Furnished at the direction or prescription of a Physician or Professional Other Provider;
- Provided by a Hospital or a Chemical Dependency Treatment Center; and
- Furnished to and used by the Participant during a Hospital Admission.

An expense will be deemed to have been incurred on the date of provision of the service for

which the charge is made. *Inpatient Hospital Expense* will include:

- Room accommodation charges. *If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge is not an Eligible or Covered Expense.*
- All other usual Hospital services which are Medically Necessary and consistent with the condition of the Participant. *Personal items are not an Eligible or Covered Expense.*

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of Hospitalization, will be *Inpatient Hospital Expense*.

**Latrogenic Infertility** means an impairment of fertility caused directly or indirectly by surgery, chemotherapy radiation, or other medical treatment affecting reproductive organs or processes.

**Legend Drugs** means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

**Marriage and Family Therapy** means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

**Maternity Care** means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy, including in-vitro fertilization services as may be provided under the Plan.

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**Medical Benefit Option** will mean the different benefit options available under the Plan. The Medical Benefit Options are the PPO, EPO, High Deductible and Out-of-Area Medical Benefit Options. Not all Medical Benefit Options are available to all Participants.

**Medical Social Services** means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

- Social and emotional factors related to the Participant's sickness, need for care, response to treatment and adjustment to care; and
- Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

**Medical-Surgical Expense** means the Allowable Amount incurred for the items of service or supply listed below for the care of a Participant, provided such items are:

- Furnished by or at the direction or prescription of a Physician or Professional Other Provider; and
- Not included as an item of *Inpatient Hospital Expense* or *Extended Care Expense* in the Plan.

A service or supply is furnished at the direction of a Physician or Professional Other Provider if the listed service or supply is:

- Provided by a person employed by the directing Physician or Professional Other Provider;
- Provided at the usual place of business of the directing Physician or Professional Other Provider; and
- Billed to the patient by the directing Physician or Professional Other Provider.

An expense will have been incurred on the date of provision of the service for which the charge is made.

*Medical-Surgical Expense* will include:

1. Services of Physicians or Professional Other Providers, and in case of a professional counselor or licensed marriage and family therapist, a professional recommendation has been obtained from the Physician;
2. Services of a certified registered nurse-anesthetist;
3. Physical Medicine Services;
4. Chiropractic Services, as shown on your Schedule of Coverage;
5. Diagnostic x-ray and laboratory procedures;
6. Radiation therapy;
7. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases;
8. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan.

***The term "durable medical equipment" will not include:***

- Equipment primarily designed for alleviation of pain or provision of patient comfort; or
- Home air fluidized bed therapy.

Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment;

9. Professional local ground ambulance service or air ambulance service to the nearest Hospital or appropriate medical facility that is equipped and staffed to treat the Participant's condition, provided such transportation is Medically Necessary;
10. Anesthetics and its administration, when performed by someone other than the

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operating Physician or Professional Other Provider;

11. Oxygen and its administration provided the oxygen is actually used;
12. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant;
13. Prosthetic Appliances, excluding all replacements of such devices other than those necessitated by growth to maturity of the Participant;
14. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

Non-covered items include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-Hospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts. NOTE: This does not apply to podiatric appliances when provided as diabetic equipment.

15. Home Infusion Therapy when the treatment plan is preauthorized by the Home Infusions Therapy Provider in accordance with the Claims Administrator's established procedures. Any item of Home Infusion Therapy covered under this subsection will not be eligible for benefits under any other provision of the Plan;
16. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center;

17. Certain Diagnostic Procedures;

18. Injectable drugs that are Legend Drugs to be administered in the spine, joint, or muscle when given in the Physician's office. These medications may be purchased at a Pharmacy and charges submitted on subscriber-filed claim form for reimbursement of eligible benefits;

19. Bariatric Surgery when Medically Necessary and preauthorized by the Claims Administrator, provided it is performed at a qualifying Blue Cross Blue Shield Distinction Center or other facility approved by the Claims Administrator.

20. Reduction Mammoplasty when Medically Necessary; and

21. Reasonable and necessary transportation, lodging, meals, and expenses for the patient and a companion during the period of required Medically Necessary treatment, as determined by the Claims Administrator's case management, of the patient for travel to the nearest medical facility qualified to give the required treatment when it is Medically Necessary for the patient to receive special treatment or services. Benefits payable for up to a total of \$200 per day for both the patient and companion.

Transportation must be:

- To and from the site of the required treatment; and
- For the purposes of an evaluation, treatment or the necessary post-treatment follow up.

These services must be given within the United States, Puerto Rico or Canada. There is an overall lifetime maximum of \$10,000 per covered Participant for transportation, lodging and meal expenses incurred in connection with all covered treatment.

**Medically Necessary or Medical Necessity** means those services or supplies covered under the Plan that are:

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- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction;
  - Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States;
  - Not primarily for the convenience of the Participant, his Physician, the Hospital or the Other Provider; and
  - The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to Hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.
- The diagnosis or treatment of any symptom, condition, disease or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible or Covered Expense is:
    - Individual, group, family or conjoint psychotherapy;
    - Counseling;
    - Psychoanalysis;
    - Psychological testing and assessment;
    - The administration or monitoring of psychotropic drugs; or
    - Hospital visits or consultations in a Hospital, Facility Other Provider, or other licensed facility or unit providing such care;

The Claims Administrator for the Plan will determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

**Mental Health Care** means any one or more of the following:

- The diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system as used by the Claims Administrator, whether or not the cause of the disease, disorder or condition is physical, chemical, or mental in nature or origin;

- Electroconvulsive treatment;
- Psychotropic drugs; or
- Any of the services listed above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

**National Drug Code (NDC)** means a national classification system for the identification of drugs.

**Network** means identified Physicians, Professional Other Providers, Hospital, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

**Network Provider** means a Hospital, Physician, or Other Provider who has entered into an agreement with BCBSTX to participate as a managed care Provider.

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**Non-Preferred Brand Name Drug** means a brand name prescription drug that is covered under the Plan but that is not included on the Preferred Brand Name Drug list. Non-Preferred Brand Name Drugs have the highest Co-payment requirements of all the drug categories. Non-Preferred Brand Name Drugs may not offer clinical or cost advantages over other drugs in the same therapeutic categories.

**Non-Contracting Facility** means a Hospital, a Facility Other Provider, or any other facility or institution that has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility, Other Provider, facility, or institution with a written contract with BCBSTX that has expired or has been canceled is a Non-Contracting Facility.

**Non-Participating Pharmacy** means a Pharmacy that has not entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

**Other Provider** means a person or entity, other than a Hospital or Physician that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible or Covered Expenses. Other Provider will include:

1. **Facility Other Provider** - an institution or entity, only as listed:

- Birthing Center;
- Chemical Dependency Treatment Center;
- Crisis Stabilization Unit or Facility;
- Durable Medical Equipment Provider;
- Home Health Agency;
- Home Infusion Therapy Provider;
- Hospice;
- Imaging Center;
- Independent Laboratory;
- Prosthetics/Orthotics Provider;
- Psychiatric Day Treatment Facility;
- Renal Dialysis Center;
- Residential Treatment Center for Children and Adolescents;
- Skilled Nursing Facility; or

- Therapeutic Center.

2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:

- Advanced Practice Nurse;
- Doctor of Chiropractic;
- Doctor of Dentistry;
- Doctor of Optometry;
- Doctor of Podiatry;
- Doctor in Psychology;
- Licensed Audiologist;
- Licensed Chemical Dependency Counselor;
- Licensed Clinical Social Worker;
- Licensed Dietitian;
- Licensed Hearing Instrument Fitter and Dispenser;
- Licensed Marriage and Family Therapist;
- Licensed Midwives;
- Licensed Occupational Therapist;
- Licensed Physical Therapist;
- Licensed professional counselor;
- Licensed Speech-Language Pathologist;
- Licensed Surgical Assistant;
- Nurse First Assistant;
- Physician Assistant; and
- Psychological Associates who work under the supervision of a Doctor in Psychology.

In states where there is a licensure requirement, Other Providers must be licensed by the appropriate state administrative agency.

To the extent a service or supply is otherwise an Eligible or Covered Expense under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment, or setting for a service or supply, the Plan will not discriminate based on a Professional Other Provider's license or certification, to the extent the Professional Other Provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

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**Out-of-Network Benefits** means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

**Out-of-Network Provider** means a Hospital, Physician, or Other Provider, who has not entered into an agreement with BCBSTX as a managed care Provider. For the EPO Medical Benefit Option, **no benefits are paid to an Out-of-Network Provider** under this Plan unless use of such Provider is authorized by BCBSTX **prior** to the visit or for Emergency Care.

**Out-of-Pocket Maximum** means the maximum dollar amount that you will pay for Eligible or Covered Expenses, as specified in the Schedule of Coverage. The Out-of-Pocket Maximum will be calculated on a Plan Year basis. Only Co-Share Amounts, Deductibles and Co-payments apply to satisfaction of the Out-of-Pocket Maximum. After the Out-of-Pocket Maximum has been met for the Plan Year, Eligible or Covered Expenses, other than billed charges above the Claims Administrator's Allowable Amount, are payable at 100%.

Any amount that you pay toward a medical service or supply that is not an Eligible or Covered Expense will not count toward the Out-of-Pocket Maximum. The following amounts will not count toward the Out-of-Pocket Maximum:

- Services, supplies, or charges limited or excluded by the Plan;
- Billed charges above the Claims Administrator's Allowable Amount;
- Expenses not covered because a benefit maximum has been reached; and
- Penalties applied for failure to preauthorize.

Eligible or Covered Expenses for Out-of-Network Providers count toward the Network individual and Network family Out-of-Pocket Maximum. However, Eligible or Covered Expenses for Network Providers do not count toward the Out-of-Network individual and Out-of-Network family Out-of-Pocket Maximum.

**Participant** means an Employee whose coverage has become effective under this Plan.

**Participating Pharmacy** means an independent Pharmacy or chain of Pharmacies that have entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

**Per-Prescription Maximum Co-payment Amount** means the maximum amount that a Participant will have to pay toward a specified Day Supply of any Covered Drug.

**Pharmacy** means a state and federally licensed establishment where the practice of Pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which the pharmacist practices.

**Physical Medicine Services** means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010-97799), whether the service or supply is provided by a Physician or Professional Other Provider and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

**Physician** means a person, when acting within the scope of the person's license, who is a Doctor of Medicine or Doctor of Osteopathy. To the extent a service or supply is otherwise an Eligible or Covered Expense under the Plan, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment or setting for a service or supply, the Plan will not discriminate based on a Physician's license or certification, to the extent the Physician is acting within the scope of the Physician's license or certification under applicable state law. This provision does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

## DEFINITIONS

**Plan Administrator** means the named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

**Plan Anniversary Date** means the day, month, and year of the 12-month period following the Plan Effective Date and each 12-month period thereafter.

**Plan Effective Date** means the date on which coverage for the Employer's Plan begins with the Claims Administrator.

**Plan Service Area** means the geographical area designated by the Employer that determines eligibility for In-Network and Out-of-Network Benefits.

**Plan Year** means the Calendar Year.

**Preferred Brand Name Drug** means a prescription drug that is covered under the Plan and that is available at a price agreed upon by the Claims Administrator and is usually available at a lower cost than a Non-Preferred Brand Name Drug. Preferred Brand Name Drugs are sometimes referred to as formulary drugs.

**Prescription Order** means a written or verbal order from a Physician/Professional Other Provider to a pharmacist for a drug or device to be dispensed. Orders written by Physician/Professional Other Providers located outside the United States to be dispensed in the United States are not covered under the Plan.

**Proof of Loss** means written evidence of a claim including:

- The form on which the claim is made;
- Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim; and
- Correct diagnosis code(s) and procedure code(s) for the services and items.

**Prosthetic Appliances** means artificial devices including limbs or eyes, braces or similar

prosthetic or orthopedic devices, 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 and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

**Prosthetics/Orthotics Provider** means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

**Provider** means a Hospital, Physician, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible or Covered Expenses.

**Psychiatric Day Treatment Facility** means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and treatment of Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of Hospitalization.

**Renal Dialysis Center** means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

**Residential Treatment Center for Children and Adolescents** means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provision of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

**Serious Mental Illness** means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)*:

## DEFINITIONS

- Bipolar disorders (hypomanic, manic, depressive, and mixed);
- Depression in childhood and adolescence;
- Major depressive disorders (single episode or recurrent);
- Obsessive-compulsive disorders;
- Paranoid and other psychotic disorders;
- Pervasive developmental disorders;
- Schizo-affective disorders (bipolar or depressive); and
- Schizophrenia.

**Skilled Nursing Facility** means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

- Licensed in accordance with state law (where the state law provides for licensing of such facility); or
- Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

**Specialty Care Provider** means a Physician or Professional Other Provider who has entered into an agreement with BCBSTX to participate as a managed care Provider for specialty services.

**Therapeutic Center** means an institution that is appropriately licensed, certified, or approved by the state in which it is located and which is:

- An ambulatory (day) surgery facility;
- A freestanding radiation therapy center; or
- A freestanding birthing center.

## **GENERAL INFORMATION**

### **PARTICIPANT/PROVIDER RELATIONSHIP**

The choice of a health care Provider should be made solely by you or your Dependents. The Claims Administrator does not furnish services or supplies but only makes payment for an Eligible or Covered Expense incurred by Participants. The Claims Administrator is not liable for any act or omission by any health care Provider. The Claims Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claims Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claims Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claims Administrator does not furnish medical, surgical, Hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

### **ASSIGNMENT AND PAYMENT OF BENEFITS**

Coverage, and your rights, under a Medical Benefit Option under the Plan may not be assigned either before or after services or supplies are provided to you. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding. In the absence of a written agreement with a provider of services or supplies to a Participant under this Plan that is entered into, under, or on behalf of, the Plan (and not merely between a Participant and the provider), the Plan Administrator reserves the unilateral right and discretion to make benefit payments to the provider or to or on behalf of the Participant, as the Plan Administrator elects, in its complete discretion. A Participant's written direction to pay any such provider directly is subject to the Plan Administrator's discretion. Payment by this Plan to you, your covered Dependents, your beneficiary or a provider

discharges this Plan's responsibility to you or your covered Dependents for benefits under this Plan to the full extent of such payment.

In no event will any provider be considered a Participant or beneficiary under this Plan for any purpose, including, but not limited to, the right to use the claims and appeals procedures under this Plan. However, a Participant or beneficiary may designate a provider as his or her authorized representative.

Disclosures of information about a Participant can only be made to such Participant or such Participant's authorized representative and in accordance with applicable law, including HIPAA privacy requirements. Only a Participant or beneficiary, or a Participant's or beneficiary's authorized representative on the Participant's or beneficiary's behalf, is entitled to request and receive information regarding the Plan, including such information required under ERISA to be disclosed to the Participant or the Participant's beneficiary upon request. A Participant's designation of an authorized representative must be in writing and comply with applicable HIPAA authorization requirements.

### **AMENDMENTS**

The Plan may be amended or terminated at any time by the Employer with prior written notice to the Claims Administrator. No notice to or consent by any Participant is necessary to amend or terminate the Plan.

### **AGENT**

The Employer is not the agent of the Claims Administrator.

### **GENETIC INFORMATION NONDISCRIMINATION ACT**

To the extent applicable, the Plan will comply with the Genetic Information Nondiscrimination Act of 2008 as provided in Section 702 of ERISA and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

### **SUBROGATION**

## GENERAL INFORMATION

In the event you or your Dependents suffers an injury or sickness as a result of an allegedly negligent or wrongful act or omission of a third party, the Claims Administrator has the right to pursue subrogation where permitted by law.

Upon payment of the benefits under this Plan, the Claims Administrator as the Plan's third party administrator, will be subrogated to you or your Dependent's right to recovery from any third party alleged to be legally responsible to you or your Dependent. The Claims Administrator may use this right to the extent of the benefits paid under this Plan for your injury or sickness that was the result of the third party's allegedly negligent or wrongful act.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

You and your Dependent acknowledge that the Claims Administrator's subrogation rights under this "**SUBROGATION**" subsection will be considered as the first priority claims against any such third party and will extend to any amounts you or your Dependent receive from such third party. Such first priority claim will be paid before any other claims which may exist are paid, including claims for general damages by you or your Dependent. The Plan's recovery will be prior to and without regard to whether you or your Dependent has received a full recovery and will not be reduced by any expenses incurred by you or your Dependent in obtaining the recovery. The Plan's claim also will not be reduced for any "make whole," common fund or similar doctrine. You and your Dependent agree that as a condition of receiving benefits hereunder, you will hold any recovery you receive in a constructive trust for the benefit of the Plan and its subrogation right, regardless of whether you are fully compensated for your injuries or losses.

You or your Dependent will cooperate and assist the Claims Administrator in protecting the Claims Administrator's legal rights under these subrogation provisions and will do nothing to prejudice the Claims Administrator's rights under these provisions, either before or after the

request for services or receipt of benefits under this Plan. You or your Dependent agrees to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer. You, your Dependent or your attorney will notify the Plan before settling any claim or suit so as to enable the Claim Administrator to enforce the Plan's rights by participating in the settlement of the claim or suit.

The Claims Administrator may require an assignment from you or your Dependent of any right of recovery to the extent of the reasonable value of services and benefits provided by the Plan plus the Plan's reasonable costs of collection, including attorney's fees as described below. The Claims Administrator may require you or your Dependent to assign your rights to the first dollars received from third parties up to the full amount paid by the Plan. The Plan may require an escrow of funds to cover future claims arising from the same incident giving rise to the subrogation claim. Failure to execute a reasonable subrogation agreement or other assignment or reimbursement agreement may be grounds for denial of benefits related to the specific claim subject to subrogation, subject to applicable law and ERISA requirements.

The Plan Administrator and/or the Claims Administrator may, at its option, take such action as may be necessary and appropriate to preserve its rights under these subrogation provisions, including the right to bring suit on your or your Dependent's behalf. The Claims Administrator, may at its option, collect such amounts from the proceeds of any settlement or judgment that may be recovered by you or your Dependent or by any representative. Any such proceeds of settlement or judgment will be held in trust by you, your Dependent, or any representative, for the benefit of the Claims Administrator under these subrogation provisions. The Claims Administrator will be entitled to recover all amounts the Plan expended on behalf of you or your Dependent and also will be entitled to recover from the proceeds held by you or your Dependent, without reduction, the Plan's reasonable attorney fees which the Claims Administrator incurred in pursuing its claim under this "**SUBROGATION**" subsection.

### **REFUND OF BENEFIT PAYMENTS**

## GENERAL INFORMATION

If the Claims Administrator pays benefits for Eligible or Covered Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claims Administrator may deduct any refund due to it from any future benefit payment.

### **COORDINATION OF BENEFITS**

(This provision does not apply to Prescription Drug Benefits.)

This provision will coordinate the health benefits payable under the Plan with similar benefits payable under other plans.

You or any Dependent may be covered under another group health plan. It may be sponsored by another employer who makes contributions or payroll deductions for it. The other plan could also be a government or tax-supported program. This does not include Medicare or Medicaid. (See the subsection entitled “**EFFECT OF MEDICARE AND GOVERNMENT PLANS**” in this “**GENERAL INFORMATION**” Section of this Benefit Booklet to determine how this plan coordinates with Medicare.)

This provision applies when benefits for the same charges are payable under this Plan and another plan.

### **Which Plan is Primary**

One of the plans involved will pay the benefits first. (The plan that pays first is called “**Primary**”.) The other plans will pay benefits next. (These plans are called “**Secondary**”.)

In order to pay claims, the Claims Administrator must find out which plan is Primary and which plans are Secondary.

There are rules to find out which plan is Primary and which plans are Secondary. The rules are used until one is found that applies to the situation. They are always used in the following order:

- A plan which has no coordination of benefits provision will be Primary to a plan which does have a coordination of benefits provision.
- A plan which covers the person as an employee will be Primary to a plan which covers the same person as a dependent.
- A person may be covered as a dependent under two or more plans.
- The plan which covers that person as a dependent of the person whose birthday is earlier in the Calendar Year will be Primary to a plan which covers that person as a dependent of a person whose birthday is later in the Calendar Year.
- If both parents have the same birthday, the plan which covered one of the parents longer will be Primary to the plan which covered the other parent for a shorter period of time.
- The other plan may not have a rule based on birthdays similar to this rule. The rule in the other plan will determine which plan is Primary.

The person may be covered as a dependent under two or more plans of divorced or separated parents. The rules that are used to find out which plan is Primary and which plans are Secondary are as follows:

- The plan of the parent with custody will be Primary to a plan of the parent without custody. Further, the parent with custody may have remarried. In that case, the order of payment will be as follows:
  - The plan of the parent with custody will pay benefits first;
  - The plan of the stepparent with custody will pay benefits next; and
  - The plan of the parent without custody will pay benefits next.
- There may be a court decree which has specific terms giving one parent financial responsibility for the medical, dental or other health expenses of the dependent child. If the plan which covers the parent with financial

## GENERAL INFORMATION

responsibility knows the specific terms of the court decree, it is Primary to any other plan which covers that dependent child.

- A plan may cover a person as an employee who is not laid-off or retired, or as a dependent of that employee. The Plan will be Primary to any plan which covers the person as a laid-off or retired employee, or as a dependent of that employee. The other plan may not have a rule for laid-off or retired employees similar to this rule. In that case, this rule will not apply.
- If none of the above rules apply, the plan which has covered the person for the longest time will be Primary to all other plans.

You will have to give information about any other plans when you file a claim.

### **Out-of-Pocket Feature**

(Applicable to this “**COORDINATION OF BENEFITS**” subsection in this “**GENERAL INFORMATION**” Section only)

This subsection applies when the Plan is Secondary. You may still be required to pay for some charges after the Plan pays its benefits.

The amount of reasonable expenses will be determined first. Then the amount of benefits paid by plans Primary to the Plan will be subtracted from this amount. The Plan will pay you the difference but no more than the amount it would have paid without this provision.

### **How Coordination Works Under the High Deductible and PPO Medical Benefit Options**

If this Plan is Primary, it will pay benefits first. Benefits under the Plan will not be reduced due to benefits payable under other plans.

If the Plan is Secondary, it pays only the difference between the Plan’s normal benefit and any amount paid by the Primary plan. This is called “**Non-Duplication Coordination of Benefits.**” The covered individual is responsible for any remaining balance up to the allowable expense amount. The primary plan pays its normal benefits; the secondary plan calculates its normal benefits, then subtracts the amount paid by the primary plan and pays the difference (if any) between the two amounts. The

non-duplication method is designed to provide a certain level of cost sharing by imposing covered individual liability. Non-duplication plans do not have a reserve on secondary plan savings. See the example on the next page for more information on Non-Duplication Coordination of Benefits.

This Plan will pay no more than our normal plan benefit. (If this Plan’s benefit is less than or equal to the Primary plan’s payment, no payment is due by this Plan.)

### **How Coordination Works Under the EPO Medical Benefit Option**

The Primary plan will pay benefits first. The Primary plan’s rate will be the allowable expense. This is called “**Come Out Whole Coordination of Benefits.**” The Primary plan pays its normal benefit; the Secondary plan pays the difference between the allowable expense and the amount paid by the Primary plan, provided the difference does not exceed the normal plan benefit which would have been payable had no other coverage existed. Generally, the member does not incur out-of-pocket costs.

The computation of “Come out Whole Coordination of Benefits is based upon a Calendar Year accumulation period. Any unpaid benefits accumulated by the Secondary plan during a Calendar Year can be applied to a reserve. The reserve grows when the Secondary plan benefit is saved because the Primary Claims Administrator reimburses the member for eligible medical expenses in the Calendar Year that are not reimbursed in full between the two plans’ normal benefits. This benefit accumulation is even applied to allowable expenses that are not covered by the Secondary plan to the extent that they are covered in full or in part by the Primary plan. The reserve will decrease when the Secondary plan pays more than its normal benefit in order to reimburse the member in full for medical expenses.

## **EFFECT OF MEDICARE AND GOVERNMENT PLANS**

### **Medicare**

When you become eligible for Medicare, this Plan pays its benefits in accordance with the Medicare

## **GENERAL INFORMATION**

Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

### **When This Plan Pays Primary to Medicare**

This Plan pays primary to Medicare for covered persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has “current employment status” with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the disabled employee has “current employment status” with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

### **When Medicare Pays Primary to this Plan**

Medicare pays primary to this Plan for covered persons who are Medicare eligible if:

- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See “How this Plan Pays When Medicare is Primary.”

### **Important! - Medicare Enrollment Requirements**

When this Plan pays benefits first, without regard to Medicare, and the covered person wants Medicare to pay after this Plan, the covered person must enroll for Medicare Parts A and B. If the covered person does not enroll for Medicare when he or she is first eligible, the covered person must enroll during the Loss of Coverage Special Enrollment Period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the covered person should enroll for both Parts A and B of Medicare when that covered person is first eligible; otherwise, the expenses may not be covered by the Plan or Medicare.

### **How This Plan Pays When Medicare Is Primary**

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare-eligible individuals. It does not apply to any covered person unless that covered person becomes eligible under Medicare and Medicare is the Primary payer.

First, this Plan determines the amount of charges for Eligible or Covered Expenses according to the terms of the Plan. However, the amount of Eligible or Covered Expenses is based on the amount of charges allowed under Medicare rules instead of the Allowable Amount as defined by the Plan. This amount becomes the “Plan benefits”. Then, this Plan subtracts the amount payable under Medicare for the same expenses from the Plan benefits. This Plan pays only the difference (if any) between the Plan benefits and Medicare benefits.

The following examples will illustrate how the Plan coordinates with Medicare:

The Plan would pay \$489.60, because Medicare did not pay as much as the Plan would pay if you had not been covered by Medicare.

The amount payable under Medicare which is subtracted from this Plan’s benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Choice (Medicare Part C) plan and receives

## **GENERAL INFORMATION**

non-covered out-of-network services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.

- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

### **Government Plans (other than Medicare and Medicaid)**

If you are also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to you under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage other than Medicare or Medicaid which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

### **Refund of Overpayments**

If the Claims Administrator pays benefits for expenses incurred on account of you or your Dependent, you or any other person or organization that was paid must make a refund to the Claims Administrator if:

- All or some of the expenses were not paid by you or did not legally have to be paid by you or your Dependent;
- All or some of the payment made by the Claims Administrator exceeded the benefits under this Plan; or
- If all or some of the expenses were recovered from or paid by a source other than the Plan as a result of charges against a third party for negligence, wrongful acts or omissions.

If the refund is due from another person or organization, you or your Dependent agrees to help the Claims Administrator get the refund when requested.

If you or your Dependent, or any other person or organization that was paid, does not promptly refund the full amount, the Claims Administrator may reduce the amount of any future benefits that are payable under this Plan.

## TERMINATION OF COVERAGE

### TERMINATION OF COVERAGE

#### ***Termination of Individual Coverage***

Coverage under the Plan for you and/or your Dependents will terminate when:

- You terminate employment with Atmos Energy;
- Your contribution for coverage under the Plan is not received timely by the Plan Administrator;
- You elect to discontinue coverage; or
- A Dependent ceases to be a Dependent as defined in the Plan.

The Plan Administrator may terminate or refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a Child who is mentally or physically incapacitated will not be denied due to age, and he or she will be considered a "Child" for purposes of Dependent eligibility. Coverage for a mentally or physically incapacitated child will be available as long as Dependent coverage under this Plan continues and the Child continues to meet all of the following conditions:

- The Child is incapacitated and became incapacitated prior to attaining any limiting age;
- The Child is not capable of self-support; and
- The Child is a dependent of the Employee for federal income tax purposes.

For purposes of this provision, mentally or physically incapacitated means any medically determinable physical or mental condition that prevents the Child from engaging in self-sustaining employment. The incapacity must begin before the Child attains the limiting age. If the Child is covered under this Plan immediately prior to attaining the limiting age, you must submit satisfactory proof of the incapacity and dependency through your Plan Administrator to

the Claims Administrator within 31 days following the Child's attainment of the limiting age. As a condition to the coverage of any child as an incapacitated dependent beyond the limiting age, the Claims Administrator may require periodic certification of the Child's physical or mental condition.

#### ***Termination of the Group***

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan. However, see the subsection entitled "**CONTINUATION OF HEALTH COVERAGE UNDER COBRA**" in this "**TERMINATION OF COVERAGE**" Section of the Benefit Booklet.

### PROHIBITION AGAINST RESCISSION OF COVERAGE

The Plan Administrator is prohibited from rescinding or retroactively terminating the medical and prescription drug coverage under this Plan for you, your covered Spouse or covered Child unless you or the covered individual commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided, however, that the foregoing prohibition will not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; (ii) the Plan erroneously covers your ex-spouse because you failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate the Affordable Care Act.

The Plan Administrator will provide a covered individual with thirty (30) days' prior written notice of intent to rescind coverage. The covered individual may appeal the rescission of coverage as a denial of a Post-Service Claim under the Plan. In the event the Plan Administrator rescinds a covered individual's coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent, such rescission will not cause the individual to incur a "qualifying event" as provided under COBRA.

## **TERMINATION OF COVERAGE**

### **COVERAGE CONTINUATION DURING ACTIVE DUTY IN THE UNIFORMED SERVICES**

A “**USERRA Leave**” is a leave of absence taken by an Employee for a call to military duty that is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (“**USERRA**”). Unless otherwise provided by Atmos Energy’s Military Leave of Absence Policy, the following rules apply under USERRA:

If you return from a USERRA Leave, you may reenter the Plan immediately upon return, and you will receive the same benefits as existed before your USERRA Leave, subject to any changes that effected the work force as a whole, immediately upon return. You and your Dependents covered under the Plan may continue to be covered under this Plan during your USERRA Leave by paying the portion of the contribution for the coverage for your family.

### **LEAVE OF ABSENCE UNDER THE FAMILY AND MEDICAL LEAVE ACT**

If you take a leave of absence under the Family and Medical Leave Act (“**FMLA**”), you may continue your coverage during the period of your FMLA leave of absence, provided that you pay any required contributions under the Plan.

In general, an FMLA leave will not exceed a period of 12 weeks. However, an Employee who is the spouse, daughter, son, or nearest blood relative of a “covered service member” (defined below) will be provided up to 26 weeks of job-protected FMLA leave to care for such covered service member. For purposes of this paragraph, covered service member will mean a member of the armed forces, including a member of the National Guard or Reserves, who is undergoing medical treatments, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a “serious injury or illness.” For purposes of this paragraph, serious injury or illness will mean an injury or illness incurred by the covered service member in line of duty on active duty of the armed forces that may render the covered service member medically unfit to perform the duties of the

covered service member’s office, grade, rank or rating.

You may elect to either pre-pay your required contributions, pay your required contributions on the same schedule as they would have been due had the leave not been taken. If you notify the Employer during your leave that you will not be returning to work, your coverage under the Plan will be terminated on the date following the date you gave such notice to your Employer. If you choose not to retain medical coverage during FMLA leave, your coverage under this Plan, subject to any changes that affect the work force as a whole, will be restored upon your return to service with the Employer. You will be treated as though no service or coverage interruption had occurred.

Please review Atmos Energy’s Leave of Absence Policy for more information.

### **OTHER APPROVED LEAVES OF ABSENCE**

If you take an approved leave of absence other than USERRA Leave or FMLA leave, you may have the option to continue your coverage under this Plan provided you pay any required contributions toward your coverage. Please review Atmos Energy’s Leave of Absence Policy for more information or you may contact Human Resources at Atmos Energy.

### **CONTINUATION OF HEALTH COVERAGE UNDER COBRA**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your Spouse or Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**This “CONTINUATION OF HEALTH COVERAGE UNDER COBRA” subsection generally explains COBRA continuation**

## **TERMINATION OF COVERAGE**

coverage, when it may become available to you and members of your family, and what you need to do to protect the right to receive it.

### **QUALIFYING EVENTS AND QUALIFIED BENEFICIARIES**

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;

- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the plan as a "Dependent Child."

### **AVAILABILITY OF COBRA COVERAGE**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

### **You Must Give Notice of Some Qualifying Events**

**You** must notify the Plan Administrator within 60 days of the following occurrences:

- Your divorce or legal separation from your Spouse; or
- The date any of your Dependent Children no longer qualifies as a Dependent under this Plan (i.e., age 26).

Written notice of a qualifying event must be sent to:

Atmos Energy Corporation  
P.O. Box 650205  
Dallas, TX 75265  
Attn: Plan Administrator

Contact the Plan's COBRA Administrator, Health Equity, at 1-877-722-2667, for additional information, including a description of any required information or documentation.

## **TERMINATION OF COVERAGE**

### **PROVISION OF COBRA COVERAGE**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A covered Employee may elect COBRA continuation coverage on behalf of their Spouse and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

#### ***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

#### ***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, your Spouse and Dependent Children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second

qualifying event. This extension may be available to the Spouse and any Dependent Children receiving COBRA continuation coverage if you die; become entitled to Medicare benefits (under Part A, Part B, or both); become divorced or legally separated; or if the Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

### **TERMINATION OF COBRA CONTINUATION COVERAGE**

COBRA continuation coverage may terminate before the end of the maximum period of coverage outlined above if any of the following events occur:

- The Employer terminates all of its health benefit plans;
- You fail to pay the premium due for the continuation coverage and do not pay it within the 30-day grace period;
- You, your Spouse or your Dependent becomes entitled to coverage under Medicare; or
- You or your Spouse or Dependents become covered, after making the COBRA continuation coverage election, under another group health plan.

#### **Are there other coverage options besides COBRA Continuation Coverage?**

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

#### **IF YOU HAVE QUESTIONS**

## **TERMINATION OF COVERAGE**

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

All notices described in this "**CONTINUATION OF HEALTH COVERAGE UNDER COBRA**" subsection should be submitted to the Plan Administrator at the following address:

Atmos Energy Corporation  
P.O. Box 650205  
Dallas, TX 75265  
Attn: Plan Administrator

### **ALTERNATIVE COVERAGE UNDER THE VETERANS BENEFITS IMPROVEMENT ACT OF 2004**

If you are called to active military duty, and you elect to continue your coverage during such duty, your coverage may be continued for a certain period at 102% of the applicable premium under the Veterans Benefits Improvement Act of 2004. However, this continuation of coverage is an alternative to COBRA continuation coverage, and does not provide the right to extend coverage upon a second qualifying event that is available under COBRA continuation coverage.

### **KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you must keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### **CONTACT INFORMATION**

For more information about COBRA continuation coverage, please contact your Plan's COBRA Administrator at:

HealthEquity  
P.O. Box 226101  
Dallas, TX 75222  
1-877-722-2667

**NOTICE OF PRIVACY PRACTICES  
THIS NOTICE DESCRIBES HOW HEALTH  
INFORMATION ABOUT YOU MAY BE USED AND  
DISCLOSED AND HOW YOU CAN GET ACCESS TO  
THIS INFORMATION  
PLEASE REVIEW IT CAREFULLY**

**THIS PORTION OF THE SUMMARY PLAN DESCRIPTION CONSTITUTES THE HIPAA PRIVACY NOTICE AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This HIPAA Privacy Notice Section of the Summary Plan Description gives you advice required by law. This Section applies to health information the Plan receives about you.

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**") protect the manner in which your protected health information ("**PHI**") may be used and disclosed by the Plan. The purpose of this notice is to provide you with information regarding your PHI privacy rights.

**GENERAL RULES REGARDING HEALTH INFORMATION**

Information about you and your health is personal. The Plan is committed to protecting health information about you (*i.e.*, PHI) which is obtained in connection with the operation and administration of the Plan. This notice will tell you about the ways in which the Plan and its Business Associates (*e.g.*, the third party administrators such as Blue Cross (referred to as the "**Business Associate**")) may use and disclose PHI about you. It also describes your rights regarding and certain obligations the Plan has regarding the use and disclosure of PHI.

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to your PHI;
- notify you following a breach of unsecured PHI; and
- follow the terms of the notice that is currently in effect.

**How the Plan Will Use or Disclose Your PHI**

The following categories describe different ways that the Plan may use and disclose PHI. Except as described below, authorization or an opportunity to object is not required for these uses or disclosures. In most cases, the Plan tries not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the

intended purpose of the use, disclosure or request. For each category of uses or disclosures this notice will give some examples. Not every use or disclosure in a category will be listed. In addition, many of the uses and disclosures may be performed on the Plan's behalf by a Business Associate. However, all of the ways the Plan is permitted to use and disclose PHI will fall within one of the categories described below.

- **For Treatment.** The Plan may receive, use and disclose PHI about you to provide you with or help you to obtain health treatment or services. For example, the Business Associate may request and receive from your doctor information about the health condition for which you are seeking treatment in order to determine if the treatment you are seeking is covered by the Plan. The Plan may also contact you to provide information about treatment alternatives or other health-related benefits that may be of interest to you.
- **For Payment.** The Plan may receive, use and disclose PHI about you so that the bills for health treatment and services you have received may be paid by the Plan. For example, the Business Associate may need to have information about a surgery that you have received to determine payment for services. Similarly, the Plan may receive use and disclose PHI to the Plan Administrator in order to provide it with information necessary to process an appeal that you file.
- **For Health Care Operations.** The Plan may receive, use and disclose PHI about you for purposes of the Plan's operations such as underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance, for legal or auditing functions or for general management and administrative activities. For instance, the Business Associate or an outside auditing firm on behalf of the Plan may perform a claims audit. The Plan, except with respect to the long-term care insurance program, is prohibited from using or disclosing your genetic information for underwriting purposes.
- **Plan Sponsor Information Request.** The Plan may disclose to Atmos Energy and the affiliates who participate in the Plan (collectively the "**Company**") summary health information (*i.e.*, de-identified statistical information that summarizes the claims history, claims expenses or type of claims experienced by covered persons under the Plan) for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or determining Plan design.

The Plan may also disclose to the Company information on whether a person is participating in the Plan and his or her benefit elections.

The Plan may also disclose PHI to the Company for specific plan administration purposes such as treatment, payment or health care operations, as described above.

The Company can only be provided PHI regarding covered persons as provided in the Plan document and consistent with this notice.

The Company cannot use PHI for employment-related actions or to administer other benefit plans.

- **Pursuant to Your Authorization.** Other uses and disclosures of PHI not covered by this notice or the laws that apply to the Plan, such as uses and disclosures for marketing or the sale of your PHI, will be made only with your written permission. If you sign an authorization giving the Plan permission to use or disclose PHI about you, you may revoke that authorization, in writing, at any time effective with respect to future uses and disclosures of your PHI.
- **Substance Use Disorder (“SUD”) Patient Records.** The Plan generally does not maintain SUD records, including those that are subject to any federally assisted program that provides substance use or alcohol treatment, diagnoses or referrals to treatment (a “**Part 2 Program**”). However, if the Plan receives or maintains any information about you from a Part 2 Program through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, the Plan may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this notice. If the Plan receives or maintains your Part 2 Program record through specific written consent you provide to the Plan or another third party, the Plan will use and disclose your Part 2 Program record only as expressly permitted by you in your consent. SUD treatment records received from a Part 2 Program, or testimony relaying the content of such records, may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless: (1) you provide written consent; or (2) the Plan receives a court order accompanied by a subpoena or other legal requirement compelling disclosure and you, or the holder of your SUD treatment records, are provided notice and an opportunity to be heard.

### **SPECIAL SITUATIONS**

The Plan will use or disclose PHI about you in the following special situations as follows:

- As required by federal, state or local law.
- To avert a serious threat to the health or safety of you, someone else or the public.

- If you are a member of the military or a veteran, to military command authorities.
- In connection with national security or intelligence activities or protective services for government officials.
- For workers’ compensation or similar programs.
- To respond to a court or administrative order, a subpoena, discovery request or other lawful process.
- As requested by federal, state and local law enforcement officials or a correctional institution.
- For public health activities, such as disease control, child abuse or neglect or the Federal Food and Drug Administration with respect to adverse events or product defects.
- To government authorities for victims of abuse, neglect or domestic violence.
- With respect to a decedent, to a coroner or medical examiner.
- To organ procurement organizations to facilitate organ, eye or tissue donations or transplants.
- To facilitate medical research, subject to special rules and restrictions under HIPAA.
- For activities authorized by law for oversight of the health care system or government benefit programs.
- The Plan may disclose PHI for intelligence and national security activities that are authorized by law.
  - To the Department of Health and Human Services (“**HHS**”) to investigate or determine the Plan’s compliance with the HIPAA privacy rules.

### **Your Privacy Rights With Respect to PHI**

**Right to Request Restrictions on PHI Uses and Disclosures.** You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is not required to comply with your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

**Right to Inspect and Copy PHI.** You have a right to inspect and obtain a copy of your PHI contained in a “designated record set.” To the extent that the Plan uses or maintains an electronic health record, you have a right to

obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "**designated record set**" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals.

**Right to Amend.** You have the right to request the Plan to amend your PHI or a record about you in a designated record. If the request is denied you may file a written statement of disagreement.

**Right to Receive an Accounting of PHI Disclosures.** You have the right to request an "**accounting of disclosures.**" This is a list of the disclosures the Plan made of PHI about you for reasons other than treatment, payment or health care operations or pursuant to your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

**Right to Receive Confidential Communications.** You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

**Right to Receive a Paper Copy of This Notice Upon Request.** You have the right to obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

#### **A Note About Personal Representatives**

You may exercise any of the above rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative.

#### **CHANGES TO THIS NOTICE**

The Plan reserves the right to change this notice, effective for PHI the Plan already has about you as well as any information it receives in the future.

#### **Your Right to File a Complaint**

You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

#### **Contact Information**

If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan. The contact information for the Privacy Official is Senior VP, Human Resources, Attn: HIPAA Privacy Officer, Atmos Energy Corporation, Three Lincoln Centre, Suite 1800, 5430 LBJ Freeway, Dallas, TX 75240-2601, (972) 855-4026. The contact information for the Complaint Official is Associate General Counsel, Attn: HIPAA Complaint Officer, Atmos Energy Corporation, Three Lincoln Centre, Suite 1800, 5430 LBJ Freeway, Dallas, TX 75240-2601, (972) 855-3089.

## **MEDICARE NOTICE OF CREDITABLE COVERAGE**

Please read this portion of the Benefit Booklet carefully as it has information about the Prescription Drug coverage available under the Plan, and about your options under Medicare's Prescription Drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in your area. Information about where you can get help to make decisions about your Prescription Drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Atmos Energy has determined that the prescription drug coverage offered by the Plan is, on average for all Plan Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to enroll in a Medicare drug plan, you may keep your prescription drug coverage under the Plan, in which case, you will still be eligible to receive all of your current health and prescription drug benefits. Before enrolling in any Medicare drug plan, you should compare your current coverage, including which drugs are covered, with the coverage and cost of other plans offering Medicare prescription drug coverage in your area. If you do decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your Dependents will not be able to get the Plan coverage back until the next open enrollment period, unless you have a qualifying life event that permits you to change your enrollment election.

### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Atmos Energy and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the Atmos Energy's Benefits Office at 972-855-4032 for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if the coverage through

## **MEDICARE NOTICE OF CREDITABLE COVERAGE**

the Plan changes. You also may request a copy of this notice at any time.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

### **For more information about Medicare prescription drug coverage:**

Visit [www.medicare.gov](http://www.medicare.gov)

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage may be available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

## ERISA INFORMATION

### **INFORMATION CONCERNING EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

If the Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

The Plan Administrator will furnish Summary Plan Descriptions, annual reports, and summary annual reports to you and other Plan Participants and to the government as required by ERISA and its regulations.

The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information that the Claims Administrator has that will aid the Plan Administrator in making its annual reports.

Claims for benefits must be made in writing on a timely basis in accordance with the provisions described in this Benefit Booklet. Claim filing and claim review procedures are found in the subsections entitled "**Benefit Determinations**" in the "**HOW TO RECEIVE HEALTHCARE BENEFITS**" section of this Benefit Booklet.

BCBSTX, as the Claims Administrator, is not the ERISA “Plan Administrator” for benefits or activities pertaining to the Plan.

The Plan Administrator has given the Claims Administrator full and complete discretionary authority to determine initial claims for benefits and appeals in accordance with the benefits and procedures detailed in the Plan as described in this Benefit Booklet. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Plan’s provisions and determining questions of eligibility and benefits. The Plan Administrator may make exceptions to the coverage provisions of the Plan when it deems necessary or appropriate, and any such exception will not constitute binding precedent with respect to any other coverage situation. Any decision made by the Plan Administrator or Claims Administrator will be final and conclusive and will be subject to review only if a court of competent jurisdiction determines its action is

arbitrary or capricious or otherwise a clear abuse of discretion.

### **STATEMENT OF ERISA RIGHTS**

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as division offices, worksites or union halls, all Plan documents, including insurance contracts, copies of collective bargaining agreements and a copy of the latest annual report (Form 5500 Series), filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room at the Employee Benefits Security Administration.
- 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 updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies; and
- 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.

You are entitled to continue health coverage for yourself and eligible Spouse and Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are

## **ERISA INFORMATION**

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, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain, without charge, copies of documents relating to the decision and to have the Plan review and reconsider your Claim.

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 Administrator and do not receive them within 30 days, you may file suit in a federal court. In such 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 which is denied or ignored, in whole or in part, and you disagree with that denial, you must file an appeal of that denial in accordance with the claims procedures described in this Summary Plan Description. After the appeal is denied in accordance with the claims procedures, 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 domestic relations order or a medical child support order, after exhausting the claims appeal procedure, you may file suit in federal court.

If it should happen that the 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. If you have any questions about the Plan, you should contact the Plan Administrator.

If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension & Welfare Benefits 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.

## **ERISA INFORMATION**

### **ERISA PLAN ADMINISTRATION INFORMATION**

#### **NAME OF THE PLAN:**

Atmos Energy Corporation Health and Welfare Benefit Plan (“**Health and Welfare Plan**”)

This Benefit Booklet describes the medical benefits provided under the Health and Welfare Plan

#### **EMPLOYER/PLAN SPONSOR:**

Atmos Energy Corporation  
c/o Sr. Vice President, Human Resources  
P.O. Box 650205  
Dallas, Texas 75265-0205

#### **EMPLOYER IDENTIFICATION NUMBER:**

75-1743247

#### **PLAN NUMBER:**

511

#### **TYPE OF PLAN:**

Welfare Benefit Plan

#### **TYPE OF PLAN ADMINISTRATION:**

Self-administration and contract administration. The Plan Administrator is responsible for the overall administration of the Plan but has delegated the administration of the Medical Benefit Options to the Claims Administrator and has delegated the day-to-day administration of the Plan to the Atmos Director, Benefits.

#### **PLAN ADMINISTRATOR:**

Sr. Vice President, Human Resources  
(972) 934-9227

#### **AGENT FOR SERVICE OF LEGAL PROCESS:**

The Plan Sponsor

#### **PLAN CONTRIBUTIONS AND FUNDING ARRANGEMENTS:**

The Plan is self-funded by the Employer and benefits are paid from the general assets of the Employer. Employees contribute toward the cost of this Plan at a rate determined by the Employer.

#### **PLAN YEAR:**

The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends on each December 31.

#### **CLAIMS ADMINISTRATOR**

Blue Cross Blue Shield Texas

#### **CLAIMS FILING PROCEDURES:**

This information is explained in the subsection entitled “**Benefit Determinations**” in the **HOW TO RECEIVE HEALTHCARE BENEFITS**” section of this this Benefit Booklet.

#### **CLAIM REVIEW PROCEDURES:**

This information is explained in the subsection entitled “**CLAIMS REVIEW PROCEDURES**” in the “**HOW TO RECEIVE HEALTH CARE BENEFITS**” Section of this Benefit Booklet.

#### **HSA ADMINISTRATOR**

HealthEquity