



Atmos Energy Corporation Vision Plan

Summary Plan Description

Effective January 1, 2026



■ Introduction

Vision benefits are provided through a fully-insured group policy (the “Group Policy”) offered to Atmos Energy Corporation (the “Company” or “Policyholder”) through EyeMed Vision Care, LLC (“EyeMed”) and underwritten by Fidelity Security Life Insurance Company (the “Insurer”). This booklet contains information from the group vision care insurance certificate (the “Certificate”) issued to the Policyholder by the Insurer as well as additional information about your vision benefits. In the event of any conflict between the terms of the Certificate or Group Policy and the terms of this booklet or Plan document (with the exception of the Company’s right to terminate the Plan), the terms of the Certificate or Group Policy shall control. In the event of any conflict between the terms of this booklet and the terms of the Plan document, the terms of the Plan document shall control.

This booklet and the Certificate combined are intended to serve as the “Summary Plan Description” for the vision benefits provided under the Atmos Energy Corporation Vision Plan (the “Plan”) as in effect on January 1, 2026, and should be read together. Prior to January 1, 2026, the Plan may have treated you differently. Atmos Energy Corporation reserves the right to change, amend, modify, alter or terminate the Plan at any time and in any manner. The Summary Plan Description describes the benefits that are available to you under the Plan, as well as your rights and obligations under the Plan. We urge you to read your booklet and Certificate carefully to understand the benefits, exclusions, and general provisions of your vision benefits. Should you have any questions regarding your benefits or how the Plan works, please refer to your booklet and Certificate or you may call or write the Plan Administrator described in the “**General Information**” section later in this booklet.

The Summary Plan Description is incorporated by reference into the Plan and contains the terms and provisions of the Plan. Because the booklet is intended to be written in a nontechnical, easily understood manner, many of the complicated details, technical legal concepts, and special exceptions found in the Plan and Certificate have been omitted. 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.

**Atmos Energy Corporation
SCHEDULE OF BENEFITS**

Policyholder: Atmos Energy Corporation

An Insured Persons has the right to obtain vision care from the Provider of his or her choice. Benefits are payable as shown in the following Schedule of Benefits:

| <u>Benefit</u> | <u>In-Network Costs</u> | <u>Out-of-Network Reimbursements</u> | <u>Benefit Frequency</u> |
|---|--|---|---------------------------------|
| VISION EXAMINATION | | | |
| Comprehensive Eye Examination | \$10 Co- payment | up to \$42 | Once every calendar year |
| Retinal Imaging | \$0 Co-payment | Up to \$20 | Once every calendar year |
| VISION MATERIALS | | | |
| Standard Plastic Lenses | | | Once every calendar year |
| Single Vision | \$10 Co-payment | up to \$42 | |
| Bifocal | \$10 Co-payment | up to \$56 | |
| Trifocal | \$10 Co-payment | up to \$71 | |
| Lenticular | \$10 Co-payment | up to \$94 | |
| Frames | 20% off balance over \$130 allowance | up to \$93 | Once every calendar year |
| Contact Lenses (only one option available per Benefit Frequency) | | | Once every calendar year |
| Conventional | \$0 copay; 15% off balance over \$130 allowance | up to \$110 | |
| Disposable | \$0 copay; 100% of balance over \$130 allowance | up to \$110 | |
| Medically Necessary | \$0 Co-payment, Paid in full | up to \$210 | |
| Lens Options | | | Once every calendar year |
| Standard Polycarbonate (For covered Dependent children under 19 years of age.) | \$0 Co-payment | up to \$20 | |
| Standard Progressive Lenses (add on to Bifocal) | \$10 Co-payment | up to \$71 | |
| Premium Progressive Lenses (add on to Bifocal) | Tier 1 \$30 Co-payment Tier 2 \$40 Co-payment Tier 3 \$55 Co-payment Tier 4 \$10 Co-payment, 20% off retail | up to \$71 | |

| | | | |
|--|----------------------------|--|--|
| | price less \$120 allowance | | |
|--|----------------------------|--|--|

Please see the Certificate for a more detailed description of your vision benefits including any limitations and exclusions.

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■ Definitions

As you read through this booklet, you may come across some terms you are unfamiliar with. The following definitions are used throughout this booklet and will have the meaning stated below. The Certificate also contains a number of defined terms used in the Certificate.

“Annual Enrollment Period” – The period preceding the beginning of each Plan Year during which eligible Employees and Dependents may enroll to participate (or continue to participate) in the Plan.

“Claims Administrator” – EyeMed Vision Care, also referred to as EyeMed in this booklet. EyeMed Vision Care is referred to as the “Administrator” in the Certificate but performs the same claims administrator function.

“Company” or “Policyholder” – Atmos Energy Corporation.

“Dependent” – Dependents are:

- Your legal spouse (as further described below); and
- Your children who are under age 26 or who are over age 26 and mentally or physically incapacitated, as described below.

An individual will be considered your legal 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 Internal Revenue Code, ERISA, and the Affordable Care Act), and any regulations issued under such applicable Federal law. An individual also will be considered your legal 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 shall not be considered your spouse.

Your 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;
- or
- Any child who is the subject of a Qualified Medical Child Support Order (“QMCSO”) or a National Medical Support Notice (a “NMSN”).

Coverage for a child who is mentally or physically incapacitated will not be denied due to age, and he or she shall 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:

- o The child is incapacitated and became incapacitated prior to attaining any limiting age;
- o The child is not capable of self-support; and
- o 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.

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 Dependent 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 terminated.

“Employee” – a full-time employee of Atmos Energy Corporation, 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 Corporation, including approved voluntary time-off, military leave, FMLA leave, and workers’ compensation leave, will not impact your status as an Employee.

“Employer” – Atmos Energy Corporation.

“ERISA” – **The Employee Retirement Income Security Act of 1974, as amended.**

“Group Policy” - The written policy of insurance between the Insurer and the Policyholder.

“Insured” – An Employee enrolled for coverage under the Group Policy.

“Insured Person” – The Insured and any enrolled Dependents.

“Insurer” – **Fidelity Security Life Insurance Company**; also referred to as “We”, “Our”, and “Us” in the Certificate.

“Plan Administrator” – The individual(s) described in the “General Information” section of this booklet.

“Plan Year” – A period of one year beginning each January 1st.

■ Eligibility

Eligible Employees

If you are an Employee you may enroll in the Plan and become an Insured.

New Employees are eligible to enroll in the Plan on their date of hire.

Individuals classified as independent contractors are not eligible to participate in the Plan regardless if the Company, a court or government agency determines such individuals are in fact common law employees.

Eligible Dependents

You may enroll your eligible Dependents when you are eligible to enroll. Refer to the “Definitions” Section of this booklet to determine who qualifies as an eligible Dependent.

Cost of Coverage

The coverage under this Plan is fully paid by the Employee. All Employee contributions to this Plan are made on a pre-tax basis pursuant to the Atmos Energy Corporation Flexible Benefits Plan, which is subject to Section 125 of the Internal Revenue Code of 1986, as amended and limits the situations under which your contributions may be changed during the Plan Year.

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 a group health plan or insurance coverage of a child of an Insured. A NMSN is issued by a state or governmental agency and provides for health benefit coverage for a child of an Insured. 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 must specify the name and address of the Insured 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 or a Dependent is required by a medical child support order or NMSN to provide vision coverage for any of your children (an alternate recipient), you must submit that order or notice to Human Resources Partner at Atmos for a determination as to whether it is a QMCSO or a properly completed NMSN (which is deemed to be a QMCSO). 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 and NMSNs.

If you or a Dependent is required by a QMCSO or NMSN to provide vision coverage for any of your children, and you are not already enrolled as an Employee for vision coverage, you must enroll for vision

coverage at the same time you would enroll your child for coverage in order to comply with the terms of the QMCSO or NMSN.

■ **When Coverage Starts**

Your Coverage

You must enroll for coverage under the Plan. You will be eligible to enroll for coverage during the first 31 days you are eligible to participate, during an Annual Enrollment Period, or following a Special Enrollment Period or Change in Status.

Coverage generally starts on the date you enroll for coverage.

Dependent Coverage

You must enroll your Dependents for coverage under the Plan. Dependent coverage starts on the latest of:

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

Please see below under “**Special Enrollment Period**” to learn about how the coverage start date for you and your Dependents may be affected in the case of a birth, adoption, or placement for adoption.

Special Provisions 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 must enroll in order to participate. Typically, you enroll on-line and authorize your Employer to deduct the required contribution from your pay. You will be able to enroll during the 31-day period following the date you first become eligible to participate in which case coverage is effective on the date of your eligibility, and each Annual Enrollment Period thereafter. Refer to the section of this booklet entitled “**Annual Enrollment Period.**” If you do not enroll when you are first eligible to participate or during an Annual Enrollment Period or during a Special Enrollment Period, you will be considered a “late enrollee.” Refer to the section of this booklet entitled “**Late Enrollees.**”

You must enroll as an Employee in order to enroll your eligible Dependents for the Dependent benefits available under the Plan.

If you do not have a Dependent when you enroll, you may enroll for the Dependent benefits within 31 days of the date you acquire your first Dependent. Refer to the section of this booklet entitled “**Special Enrollment Period**” for more information on enrolling a new Dependent.

Annual Enrollment Period

An “Annual Enrollment Period” is a period of time each year during which you may enroll in vision benefits offered under the Plan. The Annual Enrollment Period is established by your Employer. 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 vision coverage election. You and your eligible Dependents must enroll in the same plan. Coverage will be effective the first day of the following Plan Year (i.e., the next January 1).

Special Enrollment Period

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

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 group 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 terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

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. Coverage is effective on the date of your enrollment.

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 acquired through marriage, birth, adoption, or placement for adoption. 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 the 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 eligible to be 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. Coverage is effective on the date of your enrollment.

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

Late Enrollees

A late enrollee is a person who does not enroll when they are first eligible to enroll in the plan or during a Special Enrollment Period. A late enrollee can enroll only during an Annual Enrollment Period unless they incur a Change in Status which makes them eligible for coverage.

Who Pays for the Coverage?

The coverage under this Plan is contributory. The contribution rates to participate in a specific coverage level are subject to change each year based on two elements (1) the cost to administer the Plan and (2) the Plan's claim experience. Each Plan Year's rates will be communicated during the Annual Enrollment Period for that Plan Year.

If you enroll in the Plan, your contributions toward Plan coverage will automatically be paid on a pre-tax basis through the Atmos Energy Corporation Benefits Plan.

Changes of Election

Generally, your election to participate in the Plan for a Plan Year is irrevocable during the year. However, midyear changes to your participation in the Plan which cause an adjustment to your pre-tax premium contributions under the Atmos Energy Benefits Plan are permitted when there is a Change in Status, as described below. You must elect to change your participation and any associated pre-tax premium contribution election within 31 days of the Change in Status. Likewise, you may change your elections during the year on account of a Special Enrollment Period, as described above.

Proof of Dependent Status

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

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 dependent 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.

Change in Status Events

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;
- A change in employment status. A termination 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, student status, 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 Atmos Energy Benefits Plan under the following circumstances:

- Significant changes in the cost of your benefit;
- Significant changes in the coverage of your benefit; or
- You, your spouse, or your Dependent become eligible for COBRA continuation coverage or become eligible (or cease to be eligible) for Medicare or Medicaid.

There may be other circumstances that result in a mid-year election change to your benefits and you will be advised accordingly by the Plan Administrator.

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 the Plan or a medical plan of the spouse’s, or Dependent’s employer; and
- The election change corresponds with that gain or loss of coverage.

If you desire to change your election to participate in the Plan due to a Change in Status event, such change must be made within thirty-one (31) days of the event and will be effective on the date you make the change. If you do not change your election within the thirty-one (31) day period following the Change in Status, you must wait until the next Annual Enrollment Period to do so unless you experience a Special Enrollment Period before then. Your election must follow the Consistency Rule for a Change in Status.

If contributions increase or decrease during the Plan year due to the addition or loss of an eligible covered Dependent which is due to a Change in Status event, the Company will automatically change the deduction from your pay to equal the new contribution amount.

Changes to an election which affect your contribution and are not related to a Change in Status must be made during an Annual Enrollment Period or Special Enrollment Period. Federal guidelines do not permit a change to your contributions during the Plan year unless a Change in Status or Special Enrollment Period occur.

Example: You want to add your spouse to your coverage during the Plan Year. You have been married two years and there has been no change in your spouse's employment status. You must wait until the next Annual Enrollment Period to add your spouse. Conversely, if you are single when you enroll in coverage and are subsequently married during the Plan Year. You may enroll your spouse for coverage within 31 days of the marriage which is a Change in Status event.

Uniformed Services Employment and Reemployment Rights Act

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' 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 shall receive the same benefits as existed before your USERRA Leave, subject to any changes that affected 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, as described under the section titled "**Alternative Coverage Under USERRA,**" below by continuing to the required contributions plus a 2% administrative fee.

Leave of Absence Under The Family and Medical Leave Act

If you take a leave of absence under the Family and Medical Leave Act of 1993 ("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 shall 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) shall 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 shall 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 shall 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.

During an approved FMLA leave, the Company will maintain an employee's benefits as if the employee continued to be actively employed. The employee's required contributions remain the same as if the employee had not taken leave. The use of FMLA leave will not result in the loss of any employment benefit that accrued prior to the start of the employee's leave. If paid leave is substituted for unpaid

FMLA leave, contributions for participating in the medical, dental, supplemental life, dependent life and accidental death and dismemberment (AD&D) plans, along with the vision, flexible spending accounts, Retirement Savings Plan and MVG Union Savings Plan, as appropriate will be deducted as a regular payroll deduction. If the leave is unpaid, the required contributions must be submitted to Dallas Human Resources Partner. In such cases, Atmos' obligation to maintain coverage in the above mentioned plans ceases if an employee's contributions are more than 30 days late. Prior to cancellation of coverage in the above mentioned plans as a result of lapsed contributions, Atmos will provide at least 15 days written notice to the employee that coverage will cease if the employee's contributions are not paid within the 30-day grace period. Atmos Energy will maintain all employer paid benefits (i.e., basic life and long term disability benefits) during an approved FMLA leave.

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 Corporation's Leave of Absence Policy for more information or you may contact your Human Resources Partner at Atmos Energy Corporation.

■ Termination of Coverage

Except as provided under the section of this booklet entitled "Continuation of Coverage" your coverage will end automatically on the earliest of the following dates:

- the last day of the month in which you cease to be eligible for coverage;
- the date you die;
- the last day of the month for which the required premium has been paid; or
- the date the Group Policy is terminated or discontinued.

Except as provided under the section of this booklet entitled "Continuation of Coverage" the coverage of any Dependent will end automatically on the earliest of the following dates:

- the last day of the month in which your coverage ends or the Dependent ceases to be eligible for coverage;
- the date your Dependent dies;
- the last day of the month for which the required premium has been paid; or
- the date the Group Policy is terminated or discontinued.
- Termination of coverage will not prejudice any existing claim.

■ Vision Benefits, Limitations and Exclusions

Please see the Certificate for a description of your vision benefits including any limitations and exclusions.

■ Continuation of Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a Change in Status 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, and 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 plus a 2% administration fee (150% during the period of a disability extension).

This Section generally explains COBRA continuation 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:

- The Employee dies;
- The Employee’s hours of employment are reduced;
- The Employee’s employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from the Employee.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The Employee dies;
- The Employee’s hours of employment are reduced;
- The Employee’s employment ends for any reason other than his or her gross misconduct;
- The 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.

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.

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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 his or her 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.

The 18-month period of COBRA continuation coverage can also be extended to 29 months due to disability:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security 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 total 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.

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.

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, the spouse and dependent children in your family can get 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 getting COBRA continuation coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent 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.

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 Your 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:

- (1) the Company terminates all of its vision benefit plans;
- (2) you fail to pay the premium due for the continuation coverage and do not pay it within the 30-day grace period;
- (3) you, your spouse, or your Dependent becomes entitled to coverage under Medicare after making the COBRA continuation coverage election; or
- (4) you or your beneficiary becomes 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below under "**Contact Information**". For more information about your rights under the Employee Retirement Income Security Act (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. (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.

Alternative Coverage Under USERRA

If you are called to active military duty, and you elect to continue your coverage during such duty, your coverage may be continued for up to 24 months if you pay 102% of the applicable premium under USERRA. 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

All notices described in this Section should be submitted to the Plan Administrator at the following address.

Atmos Energy Corporation

P.O. Box 650205

Dallas, TX 75265

Attn: Plan Administrator

■ Claims Provisions

The Claims Administrator, First American Administrators, Inc (“FAA”), a wholly-owned subsidiary of EyeMed Vision Care, LLC, will process the claims and make payment or issue a denial notice under the Plan.

For out of network claims, this is how we communicate the OON process:

If you saw an out-of-network eye doctor, your next step is to send a completed out-of-network claim form. You can find this form on eyemed.com or by calling EyeMed’s Customer Care Center at 1-866-800-54571. Once completed, you can submit either online at eyemed.com or by mail. Please include the claim form and the itemized receipt. If sending by mail, be send to:

First American Administrators, Inc.

Attn: OON Claims

P.O. Box 8504

Mason, OH 45040-7111

Notice of Claim

For services received from in-network providers, the provider will handle all claims and administrative services for you by submitting charges directly to the Claims Administrator.

For services received from out-of-network providers, you must submit a written notice of claim and proof of loss to the Claims Administrator as soon as reasonably possible (refer to the Certificate for more information) to:

First American Administrators, Inc

Attn: OON Claims

PO Box 8504

Mason, OH 45050-7111

The written notice should include sufficient information to identify the covered Employee, the Policyholder (Atmos Energy Corporation), and your Group Policy Number (1013183). You may print an electronic copy of an approved notice from EyeMed at www.eyemed.com.

Please see the Certificate for more information about in-network and out-of-network providers.

Claim Forms

If the Claims Administrator receives a notice of claim that does not contain all of the necessary information, the Claims Administrator will send you the forms for filing proof of loss along with a request for the missing information. If these forms are not sent within 15 days, you will meet the proof of loss requirement by giving the Claims Administrator a written statement of the nature and extent of the loss within the time limit stated in the "Proof of Loss" provision, below.

Proof of Loss

Written proof of loss must be given to the Claims Administrator within 90 days after the date of loss. If it was not possible to give written proof in the time required, the Claims Administrator will not deny the claim for this reason if the proof is filed as soon as reasonably possible. Proof of loss must be given to the Claims Administrator within 1 year after it is due unless you are legally incapable of doing so.

Payment of Claims

Benefits will be paid within 30 days after the Claims Administrator receives a sufficient notice of claim and proof of loss. If your claim for benefits is denied you will be provided with a denial notice that explains the reason for the denial.

Time of Payment

Benefits due under Atmos Energy will be paid immediately, and no later than 30 days, following receipt of sufficient written notice of claim and proof of loss by the Claims Administrator.

■ General Provisions

Overpayment

If the Claims Administrator pays a benefit under the Group Policy, and it is later shown that a lesser amount should have been paid, the Insurer will be entitled to a refund of the excess, and the Claims Administrator will attempt to recover the overpayment. This applies to payments made to you, to your insured Dependent, or to the provider of vision services, supplies and treatment.

Legal Action

Time Frames and Procedures for Appealing Claims – First Level

If your claim is denied, in whole or in part, you may file a first-level appeal. The first-level appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member’s eye care provider that will assist FAA in completing its review of the member’s first-level appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your first-level appeal and notify you in writing of its decision.

Enforce Your Rights

If your claim for vision benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

When you have completed all appeals mandated by ERISA, additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)), see, 29 U.S.C. 1132(a)(1)(B), you have the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.

If your claim for benefits is denied you may file a lawsuit in state or federal court. No lawsuits may be brought to recover under the Group Policy until 60 days after written proof of loss has been given to the Claims Administrator. No lawsuit may be brought more than 3 years after proof is required to be filed.

Conformity to Law

Any provision of the Group Policy which, on its Effective Date, is in conflict with the statutes of the jurisdiction in which it was issued is changed to conform to the minimum standards of those statutes.

Assignment

Coverage, and your rights, under the Plan and Group Policy 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 Group Policy 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 Insured Person under this Plan that is entered into, under, or on behalf of, the Plan (and not merely between a Insured Person and the provider), the Claims Administrator reserves the unilateral right and discretion to make benefit payments to the provider or to or on behalf of the Insured Person, as the Claims Administrator elects, in its complete discretion. Notwithstanding any other provision of this Plan, an Insured Person's written direction to pay any such provider directly is subject to the Claims 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 shall any provider be considered a participant or beneficiary under this Plan for any purpose.

Disclosures of information about an Insured Person can only be made to such person or such person's authorized representative and in accordance with applicable law. Only an Insured Person, or an Insured Person's authorized representative on the Insured Person's behalf, is entitled to request and receive information regarding the Plan, including such information required under ERISA to be disclosed to the Insured Person upon request. An Insured Person's designation of an authorized representative must be in writing.

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.

■ Statement of ERISA Rights

As a participant in this Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as division offices, worksites, all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room at the Employee Benefits Security Administration.

b. Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

c. 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 on the rules governing your COBRA Coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA.

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 may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen 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.

■ General Information

Plan Name, Insurance Policy Number:

Atmos Energy Corporation Health and Welfare Benefit Plan

Policy # 1013183

EMPLOYER/PLAN SPONSOR:

Atmos Energy Corporation

c/o Senior 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:

The Vision Benefits provided under the Plan are fully insured through Fidelity Security Life Insurance Company. The sole obligation of the Atmos Energy Corporation is to pay premiums to Fidelity Security Life Insurance Company. EyeMed Vision Care, acting on behalf of Fidelity Security Life Insurance Company, is solely responsible for paying benefits under the insurance contract.

PLAN ADMINISTRATOR:

Senior Vice President, Human Resources (972) 855-3324

CLAIMS ADMINISTRATOR:

FAA/EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040

AGENT FOR SERVICE OF LEGAL PROCESS:

The Plan Sponsor

PLAN CONTRIBUTIONS AND FUNDING ARRANGEMENTS:

The Vision Benefits provided under the Plan are fully insured by an insurance contract with Fidelity Security Life Insurance Company.

PLAN YEAR:

The financial records of the Plan are kept on a Plan Year basis. The Plan Year begins each January 1st for a twelve-month period ending December 31st.

CLAIMS FILING PROCEDURES:

This information is explained in the Section of this benefit booklet entitled "Claims Provisions"

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (“the Association”) protects you by paying your covered claims if your life or health insurance company is insolvent. The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don’t live in Texas, you may still have some protections. Only the policyholders of insurance companies that are members of the Association, which includes Fidelity Security Life Insurance Company, are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the Texas Insurance Code, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)

Residents of other states, ONLY if the following conditions are met:

- 1) The policyholder has a policy with a company domiciled in Texas;
- 2) The policyholder’s state of residence has a similar guaranty association; and
- 3) The policyholder is not eligible for coverage by the guaranty association of the policyholder’s state of residence.

Limits of protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long-term care insurance, or \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on a single life; or

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

Group Annuities

- Present value of allocated benefits up to a total of \$250,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contract holder regardless of the number of contracts.

Other Policy Types

Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance

Guaranty Association

1717 West 6th Street, Suite 230

Austin, Texas 78703-4776

800-982-6362 or www.txlifega.org

Texas Department of Insurance

P.O. Box 12030

Austin, TX 78711

800-252-3439 or www.tdi.texas.gov

Atmos Energy SPD Vision Plan-2026