



# Atmos Energy Corporation Dental Plan

## Summary Plan Description

Effective January 1, 2026



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**SUMMARY PLAN DESCRIPTION**  
**for eligible Regular Full-Time Employees of**  
**ATMOS ENERGY CORPORATION**  
**Effective January 1, 2026**

This booklet describes your Employer-sponsored dental benefits under the Atmos Energy Corporation Group Dental Plan (the “Plan”) as of January 1, 2026. 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. This Summary Plan Description does not create a contract of employment. All benefits becoming due under the Plan are funded directly by Atmos Energy Corporation.

This benefit booklet serves as the Summary Plan Description for the Plan for purposes of the Employee Retirement Income Security Act of 1974 (“ERISA”). It describes the highlights of your rights and obligations regarding dental benefits under the Plan, provided that you are a participant of the Plan. The Plan is a welfare benefit plan as defined by ERISA Section 3(1) and as established by the Plan Sponsor.

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. For more information about the Plan documents, refer to the section of this booklet entitled “**Your Rights under ERISA.**”

You will notice that some of the terms used in your booklet begin with a capital letter. These terms have a special meaning under the Plan and are listed in the **Glossary** in alphabetical order. Refer to the **Glossary** for a detailed explanation.

Atmos Energy Corporation has entered into an arrangement with Blue Cross and Blue Shield of Texas (BCBSTX) (called the “Claims Administrator”) which provides for the Claims Administrator to process benefit claims and provide certain other services under the Plan.

Blue Cross Blue Shield of Texas (BCBSTX) does not insure the benefits described in this booklet.

## **PREFERRED DENTIST PROGRAM**

A covered person is free to choose the services of a dentist who is either:

- a Participating Provider (In-Network Benefits); or
- a Provider (Out-of-Network Benefits).

Benefits will be determined and paid in either case, except that the covered person will generally incur less out-of-pocket cost if a Participating Provider is chosen.

BlueCare Dental allows you to receive services from a BCBSTX provider at predetermined rates. If you are already enrolled in the Plan, you do not need to enroll in this program. To receive benefits, you only need to make an appointment with BlueCare Dental dentist. You may obtain a list of participating dentists in your geographic area by calling **1-866-314-0266**.

When you choose to receive services from a Participating Provider, you may save on out-of-pocket expenses because the negotiated fees for services are not subject to the “reasonable and customary” rate limitation. Dentists in the network are not allowed to charge more than the lesser of the reasonable and customary rate or the negotiated fee, so the Plan will always pay the applicable percentage of the total bill. In addition, since the fees are usually lower, your portion or co-payment will usually be less.

However, when you choose to receive services from a Provider that is not a Participating Provider, you will be responsible for any charge above the reasonable and customary rate, in addition to other out-of-pocket expenses, such as any required Deductible.

**PLAN HIGHLIGHTS**

<b>Preventive, Diagnostic and Certain Therapeutic Services/General Services/Major Services</b>
<b><u>Maximum Benefit per Calendar Year</u></b>
Preventive, Diagnostic, and certain Therapeutic Services (including X-rays) - No Maximum
Basic and Major Treatment - \$2,000 Annual Maximum per person annually (combined)
<b><u>Individual Deductible per Calendar Year</u></b>
Preventive, Diagnostic, and certain Therapeutic Services (including X-rays) - No Deductible
All Other Services - \$50 Deductible per person/per Calendar Year
<b><u>Percentage of Covered Charges Payable by the Plan</u></b>
Preventive, Diagnostic, and certain Therapeutic Services (including X-rays) - 100%
Basic Services - 80%
Major Services - 50%

**Orthodontics**

Maximum Benefit Per Lifetime - \$2,000

Percentage of Covered Charges Payable by the Plan - 50%

## COVERED CHARGES AND SCHEDULE OF COVERAGE

Covered Charges are the charges for the dental services and supplies listed in this section. The benefit is intended to cover treatment that is customarily given by dentists throughout the country to eliminate oral disease and to replace missing teeth. Covered Charges are the actual charges, which are not more than the amount of the reasonable and customary charge for the service or supply as determined by the Claims Administrator. The Claims Administrator will determine the reasonable and customary charge of each treatment. The reasonable and customary charge is the lowest of:

- the usual charges of most other dentists or other providers in the same geographic area for the same or similar services or supplies; or
- the actual charge for the services or supplies.

The possibility of an alternate treatment can also affect the amount of the Covered Charge. See the section of this booklet entitled “**Alternate Procedures.**”

## SCHEDULE OF COVERAGE

**The Preventive, Diagnostic and certain Therapeutic Services described in the table below are paid at 100%. No Deductible applies.**

<p><b><u>Preventive Services and Supplies:</u></b></p> <p>Cleaning and Scaling teeth (Prophylaxis) two times per Calendar Year.</p> <p>Fluoride treatments for a dependent child under 19 two times per Calendar Year.</p> <p>Space maintainers with fittings for a child under 19. (These are appliances used to keep teeth from moving into the space left when a tooth is pulled or lost.) Treatment must be to replace prematurely lost or pulled teeth.</p> <p>Sealants covered up until dependent turn 16 (not including age 16).</p>
<p><b><u>Diagnostic Services and Supplies:</u></b></p> <p>Oral exams two times per Calendar Year.</p> <p>X-rays and laboratory tests needed to diagnose a dental problem or to check the progress of treatment.</p> <p>Full mouth X-rays once every 60 months.</p> <p>Bitewing X-rays one time per Calendar Year.</p> <p>3<sup>rd</sup> Cleaning during Pregnancy.</p> <p>Brush biopsies covered as Type B services.</p>
<p><b><u>Therapeutic Services and Supplies:</u></b></p> <p>Emergency treatment will be given for dental pain when no other treatment but X-rays is given. If other treatment is given, payment will be made only for the other treatment.</p>

**The General Services described in the table below are paid at 80%, after the individual Deductible has been met each Plan Year.**

**Therapeutic Services and Supplies:**

Pulling teeth (extraction) and cutting procedures in the mouth (oral surgery) which is not due to orthodontic treatment.

Root canal work (endodontic treatment).

Treatment of gums and mouth tissues (periodontal treatment).

General Anesthetics for oral surgery, fractures, dislocations and treatment of gums. General Anesthetics is covered if it meets the guidelines for necessity, such as the treatment being rendered requires general anesthesia and if it doesn't require it was there was medical necessity for it. Extra charges for local Anesthetics are not covered.

Antibiotic drugs which are injected by a dentist or Physician.

**Fillings:**

Silver (amalgam), silicate, plastic, porcelain and composite posterior Fillings.

**Prosthetic Services and Supplies (Repairs and Rebasing):**

Repair or re-cementing of broken crowns, inlays, on-lays, bridgework and dentures. This does not include adjustments made to new dentures or bridgework during the first six months after they are installed. Those charges are considered to be included in the cost of the new denture or bridgework.

Extra charges are not covered.

Rebasing or relining an existing denture. If the Plan pays for a new denture, it will not pay to rebase or reline the old denture. The Plan will only pay for rebasing or relining if both of the following conditions are met:

- \* 6 months have passed since the denture was installed.
- \* 36 months have passed since payment was made under this Plan for rebasing or relining.

Adding teeth to fixed bridgework or partial dentures to replace missing natural teeth. The teeth that are being replaced must be lost before or while the person is covered under the Plan.

**The Major Services described in the table below are paid at 50%, after the individual Deductible has been met each Plan Year.**

**Restorative Services and Supplies:**

Crowns, inlays, onlays, implants and gold Fillings to repair a tooth broken down by decay or injury subject to the following condition and can only be completed once every 60 months.

Charges for these restorations are covered only if the tooth cannot be repaired with a less expensive type of filling. If the tooth can be repaired by a less expensive method, only the charge for the less expensive method will be covered.

Crowns and inlays which form part of a fixed bridge.

**Prosthetic Services and Supplies (Dentures and Fixed Bridges):**

Full or partial dentures and fixed bridgework are placed for missing natural teeth. The teeth that are being replaced can be lost before or while the person is covered under the Plan.

Full or partial dentures and fixed bridgework to replace an existing denture or bridge that cannot be made serviceable is covered once every 60 months.

Charges for replacement of a temporary denture by a permanent denture. The temporary denture must be replaced within 12 months after it was installed.

Charges for special techniques are not covered. Charges for any special work that you ask to have done on a standard denture are not covered. Charges made for adjustments to new dentures or bridgework more than six months after they are installed are not covered.

**The orthodontic services and supplies described in the table below are paid at 50%, subject to a \$2,000 lifetime maximum per person. There is no annual maximum for orthodontic services and supplies.**

**Orthodontic Services and Supplies:**

Covered Charges are charges made by a dentist for straightening teeth, including but not limited to:

- \* Diagnostic procedures
- \* Appliance to realign the teeth
- \* Oral surgery
- \* Pulling teeth (Extractions).

Orthodontic treatment is considered to have been received on the date the work is done.

**Benefits after Coverage Stops**

If orthodontic treatment is stopped for any reason before it is complete, the benefits will only pay for services and supplies actually received.

Benefits for orthodontics stop when coverage stops. There are no benefits available for charges made after coverage stops.

## DESCRIPTION OF COVERAGE

The dental benefits available under the Plan are described below. These benefits may be reduced if you or your Dependent have dental benefits under another plan. This is described in more detail in the section of this booklet entitled “**Notice of Coordination of Benefits.**”

### **Dental Care Benefit**

The Plan provides payment for a wide range of dental expenses (called Covered Charges) charged to you or your Dependent by a dentist or Physician while covered under the Plan.

These expenses must be needed for necessary dental care and treatment due to one of the following:

- Dental disease.
- Dental defect.
- Accidental injury to the teeth or mouth.

Routine preventive dental services such as examining and cleaning teeth, are also included as Covered Charges, as shown on the preceding pages.

### **Deductible**

Each covered person must satisfy a Deductible each Calendar Year before any payment is made for certain Covered Charges. The Deductible is the amount of Covered Charges you must first pay each year, for each covered person. After the Deductible is met, the Plan pays the percentage of Covered Charges specified in the “**Schedule of Coverage**” section for the rest of that year, up to a Maximum Benefit, specified in the “**Plan Highlights**” section.

A \$50 per person, per Calendar Year Deductible applies to general and major services combined. There is no Deductible applicable with respect to Preventative, Diagnostic and certain Therapeutic Services (including X-rays).

### **Orthodontics**

This Plan provides payment for orthodontic treatment for you and your Dependents while covered.

The Plan pays the percentage of Covered Charges shown in the “Plan Highlights” section. The Plan allows reimbursement only after you have made payments. Therefore, you must submit receipt of payment for orthodontic treatment in order for benefits to be paid. There is a lifetime Maximum Benefit that applies to each covered person. It is also shown in the “**Plan Highlights**” section.

### **Benefit Determination**

The Plan pays Covered Charges for dental treatments that begin after you or your Dependent becomes covered under the Plan. The person must be covered on the date dental treatment is received. Most dental treatment is considered to have been received on the date the work is done. However, there are certain kinds of treatment that take more time to complete. In these cases, treatment will be considered to have been received on the date shown below:

- As to fixed bridgework, crowns, inlays, onlays and gold restorations, the date that is submitted on the claim.
- As to full or partial removable dentures, the date that is submitted on the claim.

### **Alternate Procedures**

There is often more than one way customarily used by dentists to treat a dental problem. Different materials or procedures may be used to correct the same problem. For example, a tooth could be repaired with an amalgam filling or with a more expensive cap (crown) or gold filling.

The Claims Administrator will allow as Covered Charges only the least expensive services and supplies, which are, appropriate and meet acceptable dental standards. You and the dentist may decide you want the more expensive treatment. If so, you must pay the charges, which are greater than the Covered Charge for the less expensive appropriate treatment. Because the Claims Administrator has this Alternate Procedures provision, it is important for you to obtain a Pre-Determination of Benefits. It will tell you how much the Claims Administrator will pay for treatment.

### **Assignment and Payment of Benefits**

Coverage, and your rights, under the Plan may not be assigned either before or after services or supplies are provided to you. A direction to pay a Participating Provider or 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 Participating Provider or Provider 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 Participating Provider or Provider or to or on behalf of the participant, as the Plan Administrator elects, in its complete discretion. Notwithstanding any other provision of this Plan, a participant’s written direction to pay any such Participating Provider or Provider directly is subject to the Plan Administrator’s discretion. Payment by this Plan to you, your covered Dependents, your beneficiary or a Participating Provider or 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 a Participating Provider or 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.

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. 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 his or her beneficiary upon request. A participant's designation of an authorized representative must be in writing.

## GENERAL EXCLUSIONS

The Plan Does Not Cover:

- Services and supplies furnished for the following reasons:
  - Injury which happens during work at any job for pay or profit.
  - Sickness for which payment is made or available through workers' compensation or a similar law.
- Expenses incurred before you or your Dependent becomes covered under the Plan.
- Your Dependent's expenses if the Dependent is receiving benefits for the same expenses under the Plan as an Employee.
- The dental care benefits may be reduced if you or your Dependent has dental benefits under another plan. This is described in the section of this booklet entitled "**Notice of Coordination of Benefits.**"
- Treatment by someone other than a dentist or Physician (as included in the definition of Physician) or dental technician under the direction of a dentist or Physician.
- Work done mainly to improve appearance (cosmetic treatment).
- Any work done or appliance used to increase the distance between nose and chin (vertical dimension).
- Mandibular repositioning appliances (orthotic).
- Facings or veneers on molar crowns or molar false teeth.
- Training or supplies used to educate people on the care of their teeth.
- Injury caused by war or international armed conflict.
- Charges for crowns and Fillings not shown in the "**Covered Charges**" section of this benefit.
- Replacement of a lost, missing or stolen denture or bridgework.
- Replacement of an orthodontic appliance.
- Services furnished by any Employer-provided medical facility.
- Charges for failure to keep scheduled visits.

- Charges for completion of forms.
- Any services and supplies for which payment is made or available under any dental care program funded by the Federal government or any state or political subdivision.
- Any services or supplies that do not meet accepted dental standards.
- Experimental services and supplies.
- Treatment of temporomandibular joint disorders.

## **ELIGIBILITY FOR COVERAGE**

### **Employees**

You are eligible to participate as an Employee if you are 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 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 Corporation 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 are not eligible to participate in the Plan.

### **Dependents**

Dependents are:

- Your legal spouse (as further described below); and
- Your children who are under age 26.

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").

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.

### **Legal Spouse**

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 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 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.

## WHEN COVERAGE STARTS

### Your Coverage

You must enroll to get coverage. Refer to the section of this booklet entitled “**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.

### Dependent Coverage

You must enroll your Dependents for coverage. Refer to the section of this booklet entitled “**How to Enroll.**”

Coverage starts on the latest of:

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

### 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 Corporation 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. You must also provide documentation for your added dependent(s) such as birth certificate for a newborn or marriage license for a spouse.** If birth certificate is not available within 31 days of birth, submit the hospital vital records with your enrollment change request.

## HOW TO ENROLL

You must enroll in order to participate. You enroll by filing a written request with 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, 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, 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. Proof of dependent status must be submitted for supporting documentation with the enrollment request in order to add dependents to the Plan.

### **Annual Enrollment Period**

An “Annual Enrollment Period” is a period of time each year during which you may enroll in dental benefits offered under the Plan. The Annual Enrollment Period is agreed on 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 dental coverage election. You and your eligible Dependents must enroll in the same Plan option.

### **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 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.

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. Other qualifying life events may also permit midyear election changes to your benefit elections.

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.

### **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.

## 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. The Company employs an outside actuary to develop the required contribution rates using the contracted administrative and projected net claims costs for that Plan Year. The developed rates reflect the Company's cost sharing philosophy, which subsidizes a portion of these costs for participants.

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 section 125 cafeteria plan

## Changes of Election

Additional mid-year changes to your participation in the Plan which cause an adjustment to your contributions under the Atmos Energy Corporation Dental Benefits Plan are permitted when there is a Change in Status, as described below.

### 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, death of a Dependent, or Qualified Medical Child Support Order;
- 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 Corporation Dental Benefits Plan 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 ceases 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.

### **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 or dental plan of the spouse’s, or Dependent’s employer; and
- The election change corresponds with that gain or loss of coverage.

Notably, the consistency rule is not applicable to Change in Status events which also qualify as a HIPAA Special Enrollment Period.

Enrollment 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. You must provide any proof of change of status that is requested by the Plan Administrator and/or the Claims Administrator. Proof of dependent status must be submitted for supporting documentation with the enrollment request in order to add dependents to the Plan.

Mid-year changes to a Plan option are permitted if due to a Change in Status event, or if you relocate to an area where the Plan option you had previously elected is no longer available, or if a new option becomes available as a result of the relocation.

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. Federal guidelines do not permit a change to your contributions during the Plan Year unless a change in family status or HIPAA Special Enrollment event occurred.

**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 in this situation.

### **Uniformed Services Employment and Reemployment Rights Act (“USERRA”)**

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 Corporation’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 means 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 means 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. 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. The Company will maintain all employer paid benefits (i.e., basic life and long term disability benefits) during an approved FMLA leave.

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

### **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 for 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 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 or a Dependent is required by a medical child support order or NMSN to provide dental coverage for any of your children (an alternate recipient), you must submit that order or notice to your local Human Resources Partners at Atmos Energy Corporation for a determination as to whether it is a QMCSO or a properly completed NMSN (which is deemed to be a QMCSO) as defined in the Omnibus Budget Reconciliation Act of 1993 and the Child Support Performance and Incentive Act of 1998. 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 or a Dependent is required by a QMCSO or NMSN to provide dental coverage for any of your children, and you are not already enrolled as an Employee for dental coverage, you must enroll for dental coverage at the same time you would enroll your child for coverage in order to comply with the terms of the QMCSO or NMSN.

## **PRE-DETERMINATION OF BENEFITS**

Pre-determination of benefits is a way of telling you ahead of time how much will be paid for dental work. It will help to avoid unexpected expenses.

Many times, dental work is likely to cost more than **\$300**. If so, you should ask the dentist to file for Pre-Determination of Benefits with the Claims Administrator. Most dentists know about this procedure.

Here is how it works:

- Obtain a dental claim form from your Employer, or you may print a copy from [www.bcbstx.com](http://www.bcbstx.com).
- Give the dental claim form to your dentist. The dentist will tell the Claims Administrator what work needs to be done. This work is called the treatment plan.
- The dentist lists the services and charges on the claim form and sends it to the Claims Administrator.
- The Claims Administrator will tell you and the dentist what amount the Plan will pay. You should discuss the treatment plan with the dentist before the work is done.

If the dentist changes the treatment plan, the amount of payment may change. If the dentist makes a major change, a new dental claim form should be sent to the Claims Administrator.

If you do not use Pre-Determination of Benefits, payment will be based on the information the Claims Administrator has about the case.

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

Blue Cross Blue  
Shield of Texas  
P. O. Box 660247  
Dallas, Texas 75266-0247

## CLAIMS AND APPEALS INFORMATION

### How To File A Claim

Request a claim form from your Employer, the Plan Administrator or the Claims Administrator. The form has instructions on how to fill it out and where to send the claim. Please read the form carefully. Answer all questions and send all required information.

If you ask for a claim form but do not receive it within 15 days, you can file a claim without it by sending in the bills and describing the situation in a letter.

### When Claims Must be Filed

To claim dental benefits, you must give the Claims Administrator written proof of your loss or expenses within 365 days of the date of service.

No benefits are payable for claims submitted after the period of 365 days from the date of service. You can request that benefits be paid for late claims if you can show that:

- It was not reasonably possible to give the written proof of loss or expenses during the period of 365 days from the date of service.
- The proof was given to the Claims Administrator as soon as was reasonably possible.

It is important to keep separate records for each person in your family since maximum amounts, Deductible amounts and other provisions generally apply separately to each person.

The Claims Administrator may request additional information in order to process a claim.

The Claims Administrator can request any needed proof of loss or expenses in connection with a claim under the Plan. This includes the following:

- Dentist's or Physician's statement of treatment.
- Study models.
- X-rays taken before and after services are performed.

## **How and When Claims Are Paid**

All benefits will be paid to you after the Claims Administrator receives satisfactory proof of loss or expenses.

Any dental care benefits continued for your Dependents after your death will be paid to one of the following:

- Your surviving spouse.
- Your Dependent child who is not a minor, if there is no surviving spouse.
- A hospital or a person who makes charges to your Dependents for services that are covered under this Plan.
- The legal guardian of your Dependent.

## **Benefit Determinations**

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

Urgent claims or appeals are those claims or appeals that require notification or approval prior to receiving dental care, where a delay in treatment as a result of the application of the time periods for making non-urgent 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 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 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 dental 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 afforded a reasonable amount of time, taking 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 afforded you to provide the specified additional information.

A denial notice will comply with the requirements set forth below in the "**Denial Notification Requirements**" section.

### **Pre-Service Claims**

Pre-service claims or appeals are those claims or appeals that require notification or approval prior to receiving dental 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 afforded 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 in the "**Denial Notification Requirements**" section.

### **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 dental 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 afforded 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 in the "**Denial Notification Requirements**" section.

### **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 dental exigencies, and the Claims Administrator will notify you of the benefit determination (whether 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 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;
- 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; and
- A description of available internal appeals and any 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 by following the Claims Review Procedure described below.

### **Claims Review Procedure**

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 a claim for review in writing with the Plan Administrator (all references to you will include your duly authorized representative for the remainder of this section). You must file a claim for review 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 claim for review, and the review 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. 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, the Plan 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 a claim for review 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 or not medically necessary or appropriate, the Plan 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 review, nor the subordinate of any such individual. The Plan 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 Plan 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.

In the case of an urgent care appeal, the Plan Administrator will notify you of the Plan's benefit determination on review 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.

In the case of a pre-service appeal, the Plan Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt by the Plan of your request for review.

In the case of a post-service appeal, the Plan Administrator will notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 30 days after receipt by the Plan of the claimant's request for review.

The Plan Administrator will provide you with written or electronic notification of the Plan's benefit determination on review. In the event of an adverse benefit determination on review, 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 and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under ERISA Section 502(a);
- 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; and
- 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 two appeals of an adverse benefit determination prior to bringing a civil action under ERISA Section 502(a).

### **Legal Actions**

You cannot bring any legal action for benefits under the Plan 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 for benefits, 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.

## **NOTICE OF COORDINATION OF BENEFITS**

Coordination of benefits is an arrangement among group dental plans which provides guidelines for the administration of benefit payments when a person is covered under more than one of these plans. These guidelines establish consistent rules for an order of payment by the plans. They are also designed to permit total benefit payments to be made up to an amount equal to, but not in excess of, a predetermined portion of the covered person's expenses. Without this provision, an overpayment of benefits could result.

Coordination of benefits considers the amount payable by all the group dental plans involved, other than Medicare or Medicaid. The amount of benefits paid by an individual plan depends on whether that plan is determined to be "Primary" or "Secondary," according to the coordination of benefit rules. If the Plan is Primary, it pays its benefits first, without regard to the amount payable by other plans. In other words, the Primary Plan pays the same amount of benefits it would have paid if there was no coordination of benefits.

Benefit payments under a Secondary Plan, on the other hand, are reduced to take into account the amount paid by a Primary Plan. The Secondary Plan pays the amount it would have paid if it was Primary, less the amount actually paid by a Primary Plan.

There is an exact method of determining the amount the Secondary Plan will pay. First, the amount of benefits the Secondary Plan would have paid if it was Primary is determined. Next, the amount of benefits actually paid by any Primary Plan or Plans is subtracted. The Secondary Plan pays the difference.

There are two important facts you should note about this formula. First, the formula is designed to prevent benefit payments from being greater than the largest amount payable by any one of the plans involved. Also, if the amount of benefits paid by a Primary Plan or Plans is greater than that of the Secondary Plan, the Secondary Plan will not pay any benefits. Therefore, duplicate coverage may not be valuable. You may wish to discontinue some of the coverage on yourself and your Dependents.

Each case is different. Make sure you understand what each plan pays for, and how the coordination of benefits provision works for each plan. Consider the amount you are paying for each plan. Based on this information, make a decision as to what coverage is best for you and your Dependents. But remember, while you may wish to drop some of your duplicate coverage, you should always make adequate provisions for unexpected dental care needs.

### **Which Plan is Primary?**

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 that covers that person as a dependent of the person whose birthday is earlier in the Calendar Year will be Primary to a plan that 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 that covered one of the parents longer will be Primary to the plan that 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.

### **Children of Divorced or Separated Parents**

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.
- The plan of the parent without custody will pay benefits next.

There may be a court decree that has specific terms giving one parent financial responsibility for the dental expenses of the dependent child. If the plan which covers the parent with financial responsibility knows the specific terms of the court decree, it is Primary to any other plan that covers that dependent child.

A plan may cover a person as an employee or dependent of that employee. This Plan will be Primary to any plan that covers the person as a terminated or retired employee, or as a dependent of that terminated or retired employee. The other plan may not have a rule for terminated or retired employees similar to this rule. In this 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.

### Examples

The examples shown below are meant to illustrate, in simple terms, how the Coordination of Benefits provision works.

In the examples, John is the Atmos Energy Corporation employee, and his expenses are considered **Primary** under the Atmos Energy Corporation Plan. Jane, his spouse, works for another employer and has dental coverage under her employer's plan. Her expenses under her employer's plan are considered **Primary**, while they are paid as Secondary under the Atmos Energy Corporation Plan.

Example A illustrates how benefits would be payable under the Atmos Energy Corporation Plan with respect to John. (John's expenses are Primary under this plan.)

#### Example A

\$200	Claim
<u>- 50</u>	Deductible
\$150	Balance
<u>x 80%</u>	Coinsurance (General Services)
\$120	Benefit Payable under the Atmos Energy Corporation Plan

Example B illustrates how benefits would be payable under the Atmos Energy Corporation Plan with respect to Jane. (Jane's expenses are **Secondary** under the Atmos Energy Corporation Plan. In this example, the total claim amount is \$200, and Jane's plan - which is **Primary** - paid \$105 in benefits.)

#### Example B

\$200	Claim
<u>- 50</u>	Deductible
\$150	Balance
<u>x 80%</u>	Coinsurance (General Services)
\$120	Benefit Payable based on the Atmos Plan Design
<u>\$105</u>	Paid by Primary Coverage (Jane's Plan)
\$ 15	Additional Benefit Payable under the Atmos Energy Corporation Plan

If Jane's Primary coverage had paid \$120 or more in benefits, no benefit would be payable under the Atmos Energy Corporation Plan.

### **Refund to the Plan of Overpayment of Benefits**

If the Plan pays dental 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 Plan if:

- All or some of the expenses were not paid by you or your Dependent or did not legally have to be paid.
- All or some of the payment made exceeded the benefits under the Plan.
- All or some of the expenses were recovered from or paid by a source other than this Plan. This may include payments made as a result of claims against a third party of negligence, wrongful acts or omissions.

The refund equals the amount paid under the Plan in excess of the amount that should have been paid. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If the refund is due from another person or organization, you and your Dependent agree to help the Plan get the refund when requested. If you, or any other person or organization that was paid, do not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

### **Subrogation**

In the event you or your Dependent suffers an injury or sickness as a result of a negligent or wrongful act or omission of a third party, the Plan has the right to pursue subrogation.

The Plan will be subrogated and succeed to your or your Dependent's right of recovery against a third party, and may use this right to the extent of the benefits under this Plan.

You and your Dependent agree to help the Plan use this right when requested. The amount of the recovery will be reduced by a proper share of the legal fees and expenses needed to obtain the recovery.

## WHEN COVERAGE STOPS

### Your Coverage

Coverage will stop on the earliest of the following:

- When your employment ends.
- When you stop being an eligible Employee.
- When you stop making contributions.
- When the Plan is terminated.

When you stop being an active Employee, contact the Plan Administrator to find out what rights you may have to continue coverage. Also, refer to the “**Continuation of Coverage**” section of this Booklet.

### Your dependent coverage

Coverage for all of your Dependents stops when your coverage stops or when you stop making contributions for the dependent coverage, whichever happens first.

Coverage for an individual Dependent stops sooner if one of the following happens:

- The Dependent becomes covered as an Employee under this Plan.
- The Dependent stops being an eligible Dependent.

### Coverage for Mentally or Physically Incapacitated Dependent Children

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.

## **BENEFITS AVAILABLE AFTER COVERAGE STOPS**

Some benefits are paid after coverage stops.

### **Dental Care Benefit**

The Claims Administrator will pay dental care benefits in the following cases:

- When a tooth or teeth are first prepared for fixed bridgework, crowns, inlays, onlays or gold restorations while the person is covered and the service or supply is given within 60 days after coverage stops.
- When a tooth is opened for root canal work while the person is covered and the work is completed within 60 days after coverage stops.
- When the impression for full or partial removable dentures is taken while the person is covered and the dentures are installed within 60 days after coverage stops.

The Claims Administrator will not pay for expenses which are payable under any other group dental plan.

## CONTINUATION OF COVERAGE

### **Disability**

Your Employer may continue coverage when you are away from work due to disability.

### **Continuation of 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, 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.

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:

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

### **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

If you fail to timely provide notice of the qualifying event, your right to COBRA will be lost.

Contact the Plan's COBRA Administrator, HealthEquity at 1-877-722-2667, for additional information, including a description of any required information or documentation.

### **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.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

### **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.

### **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 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 receiving 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.

### **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 dental 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; or
- (4) you or your beneficiary becomes covered, after making the COBRA continuation coverage election, under another group dental 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 dental plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

## **If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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](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).

## **USERRA Coverage**

If you are called to active military duty, you may elect to continue your coverage during such duty for up to 24 months at 102% of the applicable premium. 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:

Health Equity  
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

### **COBRA Claims**

If you are receiving COBRA continuation coverage, file a claim by completing a claim form and attaching your bills to the form. “COBRA” should be written on each of the bills.

### **USERRA Coverage**

For more information about USERRA coverage, please contact your Plan’s USERRA Administrator at:

The Standard  
P.O. Box 3877  
Portland, OR 97208  
844-505-6024

## NOTICE OF PRIVACY RIGHTS

**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 medical information, which includes information regarding dental conditions and benefits, the Plan receives about you.

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the “Privacy Regulations”). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 (“GINA”) and the Health Information Technology for Economic and Clinical Health Act (“HITECH”) under the American Recovery and Reinvestment Act of 2009 (“ARRA”), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan’s privacy procedures with respect to your medical information, including “genetic information” (as defined in Section 105 of GINA), that is created or received by the Plan (your “Protected Health Information” or “PHI”). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan’s duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services (“HHS”) and the office to contact for further information about the Plan’s privacy practices.

### **How the Plan Will Use or Disclose Your PHI**

Other than the uses or disclosures discussed below, any use or disclosure of your PHI by the Plan will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts 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. The minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a dental care provider for treatment;
- uses or disclosures made to the individual;

- disclosures made to HHS;
- uses or disclosures that are required by law;
- uses or disclosures that are required for the Plan's compliance with legal regulations; and
- uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan:

**For Payment.** Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and dental payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

**For Treatment.** Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your dentist requests information on what other drugs you are currently receiving during the course of treating you.

**For the Plan's Operations.** Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of dental insurance or dental benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of dental care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.

The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

**To Individuals Involved in Your Care.** The Plan is permitted to disclose your PHI to your family members, other relatives and your close personal friends involved in your dental care or the payment for your dental care if:

- the PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- you have either agreed to the disclosure or have been given an opportunity to object

and have not objected; and

- the PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

**For Appointment Reminders.** Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other dental related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

**To the Plan Sponsor.** PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that the Plan has been amended to provide that PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

**When Required by Law.** The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

**For Workers' Compensation.** The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

**For Public Health Activities.** When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

**To Report Abuse, Neglect or Domestic Violence.** When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

**For Public Health Oversight Activities.** The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or

disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

**For Judicial or Administrative Proceedings.** The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

**For Other Law Enforcement Purposes.** The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

**To a Coroner or Medical Examiner.** When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

**For Research.** The Plan may use or disclose PHI for research, subject to certain conditions.

**To Prevent or Lessen a Serious and Imminent Threat.** When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

**State Privacy Laws.** Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan will comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

## **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 agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

**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,” for as long as the Plan maintains the PHI and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings. 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 dental records and billing records about individuals maintained by or for a covered dental 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. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

**Right to Amend.** You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

**Right to Receive an Accounting of PHI Disclosures.** At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made:

(1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; or (5) as part of a limited data set. 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.** 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 your 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 to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

### **The Plan’s Duties With Respect to Your PHI**

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. In the event of any material change to the uses or disclosures, the individual’s rights, the duties of the Plan or other privacy practices stated in this Notice, the Plan will post the change or the revised Notice, or, alternatively, information about the change to the Notice and the means to obtain the revised Notice, will be provided to you in the Plan’s next annual benefits mailing.
- The Plan is required to notify you of any “breach” (as defined in 45 CFR 164.402 of the Privacy Regulations) of you unsecured PHI.

## **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 Privacy 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 Sr. 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.

## GLOSSARY

(These definitions apply when the following terms are used in this booklet.)

### **Anesthetic**

A drug that produces loss of feeling or sensation either generally or locally.

**\*Local**            The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

**\*General**        The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

### **Bitewing**

Dental X-ray showing (approximately) the coronal (crown) halves of the upper and lower jaw.

### **Calendar Year**

A period of one year beginning each January 1.

### **Claims Administrator**

Blue Cross Blue Shield Blue of Texas (BCBSTX) is the Claims Administrator. The Claims Administrator does not insure the benefits described in this booklet.

### **Covered Charges**

Actual charges for dental services and supplies described in the section of this booklet entitled “**Covered Charges**” and the “**Schedule of Benefits**” that do not exceed the reasonable and customary rates.

### **Employer**

Atmos Energy Corporation.

### **Fillings**

Silver Amalgam, a particularly durable material used to fill cavities, that is usually placed on the tooth surface used for chewing. Porcelain, Silicate, Acrylic, Plastic or Composite Fillings, materials used to fill cavities that have less durability, thus they are placed on non-stress bearing surfaces of front teeth because the color more closely resembles the natural tooth than does the color of Silver Amalgam.

### **Fluoride**

A solution of Fluorine which is applied Topically to the teeth for the purpose of preventing dental decay.

**In-Network Benefits**

The charges based on the BlueCare Dental Schedule of Maximum Payments for Covered Charges. These services must be performed or prescribed by a dentist who is a Participating Provider and necessary in terms of generally accepted dental standards.

**Out-of-Network Benefits**

The reasonable and customary charges for Covered Charges by a Provider. These services must be performed or prescribed by a dentist who is not a Participating Provider and are necessary in terms of generally accepted dental standards.

No more than the reasonable and customary charge for dental expenses will be covered by the Plan.

**Participating Provider**

A dentist who has been selected by BCBSTX for inclusion in BlueCare Dental. These Participating Providers agree to accept BCBSTX BlueCare Dental Schedule of Maximum Payments as payment in full for services rendered. The Participating Providers are listed in the BlueCare Dental Directory.

**Physician**

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).
- Doctor of Osteopathy (D.O.).

**Plan Administrator**

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

**Plan Sponsor**

Atmos Energy Corporation.

**Plan Year**

The Calendar Year.

**BlueCare Dental Schedule of Maximum Payments**

This is a fee agreement with a Participating Provider in which such Participating Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

**BlueCare Dental**

This is a program to offer a covered person the opportunity to receive dental care from dentists who are designated by us as Participating Providers. When dental care is given by Participating

Providers, the covered person will generally incur less out-of-pocket cost for the services rendered. The Participating Providers are listed in the BlueCare Dental Directory.

### **BlueCare Dental Directory**

The list that consists of selected dentists who:

- are located in the covered person's area; and
- have been selected by BCBSTX to be Participating Providers and are part of BlueCare Dental. These Participating Providers agree to accept BCBSTX Schedule of Maximum Payments as payment in full for services rendered.

### **Prophylaxis**

The removal of tartar and stains from the teeth. The cleaning of the teeth by a dentist or dental hygienist.

### **Provider**

A dentist who is not a Participating Provider

### **Scale or Scaling**

To remove calculus (tartar) and stains from the teeth with special instruments.

### **Topical or Topically**

Painting the surface of the teeth, as in fluoride treatment, or application of a cream-like Anesthetic formula to the surface of the gum.

## YOUR RIGHTS UNDER ERISA

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:

- a. 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.
- b. 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.
- 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 dental 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 spouse or 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, 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 dental 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 medical child support order, after exhausting the claims appeal procedure, 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.

## PLAN INFORMATION

**Name of Plan:** Atmos Energy Corporation Health and Welfare Benefit Plan

**Name and Address of Employer who is the Plan Sponsor:**

Atmos Energy Corporation  
c/o Sr. Vice President, Human Resources  
P.O. Box 650205  
Dallas, Texas 75265-0205

**Source of Contributions and Funding:**

The Plan is funded by direct benefit payments from the general assets of your Employer. The Employee's contribution toward the cost of the Plan is at a rate determined by your Employer.

**Plan Details:**

The Plan's provisions relating to eligibility to participate and termination of eligibility, as well as a description of the benefits provided by the Plan, are described in detail in this Summary Plan Description.

**Plan Amendment or Termination:**

The Plan Sponsor reserves the right to modify, suspend, amend or terminate the Plan at any time. Your Employer does not promise the continuation of any benefits, nor does it promise any specific level of benefits at or during retirement. Any benefits, rights or obligations of participants and beneficiaries under the Plan following termination are described in detail in this Summary Plan Description.

**Employer Identification Number of Plan Sponsor (EIN)** 75-1743247

**Agent for Legal Process**

The Plan Sponsor named above to the attention of the General Counsel, or the Plan Administrator named below.

**Plan Number (PN)** - 511

**Plan Type**

The Plan described in this Summary Plan Description is a Welfare Benefit Plan for purposes of ERISA.

**Plan Years**

The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends on each December 31.

**Plan Administrator**

The Sr. Vice President of Human Resources at Atmos Energy Corporation who may be reached at P.O. Box 650205, Dallas, Texas 75265-0205 and (972) 855-3324

**Type of Administration**

The Plan is administered on behalf of the Plan Administrator by the Claims Administrator. The benefits are paid from funds provided by the Employer on behalf of the Plan in accordance with a contract with the Claims Administrator. The Claims Administrator may be reached at Claims P. O. Box 660247 Dallas, Texas 75266-0247 and (866) 314-0266.

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