ONCOR
LIVE WELL

ONCOR BENEFIT HANDBOOK

Oncor Electric Delivery Company LLC
Employee Welfare Benefit Plan

Summary Plan Description

Effective July 1, 2020

Updated February 2022
(Pages 11, 13, 21, 27, 44, 48, 49, 55, 56, 61, 81, 124, and 145)

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Overview

ONCOR ELECTRIC DELIVERY COMPANY LLC EMPLOYEE WELFARE BENEFIT PLAN

Our company vision is to be the electric delivery company of choice for all customers and employees, and you help us achieve this every day through your dedication and hard work.

As an Oncor employee, you have access to a variety of benefit tools and resources. Our benefits program is comprehensive and competitive, making it a valuable part of your total rewards package.

The Oncor Electric Delivery Company LLC Employee Welfare Benefit Plan (the "Plan") is designed to:

- Offer benefit options that best meet your needs,
- Provide financial protection for you and your family,
- Focus on your health and overall wellbeing, and
- Offer benefits that are easy to use and understand.

This handbook is organized to help you understand your choices and to clearly explain how to access your benefits. If you have questions, Oncor provides contact information and resources to get the help and information needed.

Together, we embrace the Oncor mission – to empower our customers' modern lives through safe, reliable, and efficient delivery of electricity.

Thank you for helping us accomplish our mission!

Ultimate Software (UltiPro) – Oncor Active Employee Benefits Administrator

Through UltiPro, you can use resources to enroll and interact with the benefits plan, including:

- Make benefit enrollment elections,
- Update your information,
- Review payroll information,
- Add beneficiaries, and
- Get a copy of your Benefits Confirmation.

Oncor Benefits Site:

Go directly to **oncor.ultipro.com**

OR

Through the company intranet, **http://intranet.corp.oncor.com**: Once you are on the intranet, follow these steps:

- Click the ***Quick Connect*** down arrow,
- Click ***UltiPro,***
- Enter your Oncor email address and corporate password, and
- Click ***Sign In***.

You will not need to to create a user name or register as a first time user.

Oncor HR Service Center: 1.888.565.8803

Member Service Representatives available Monday through Friday from 7:30 a.m. to 5:30 p.m. CST

This handbook is a summary of the welfare benefits that Oncor Electric Delivery Company LLC makes available to active employees and their eligible Dependents. It serves as a summary plan description (SPD) under the Employee Retirement Income Security Act of 1974, as amended (ERISA). A different handbook describes the welfare benefits for Retirees, individuals receiving long-term disability (LTD) benefits, and their eligible Dependents.

This handbook summarizes the primary provisions of the Oncor Electric Delivery Company LLC Employee Welfare Benefit Plan (the "Plan") effective July 1, 2020. For complete details regarding the administration and operation of Oncor's welfare benefits, your rights, and your obligations under the Plan, you should refer to both this handbook and the Plan. **If there is any conflict between this handbook and the Plan, the Plan governs.**

ONCOR RESERVES THE ABSOLUTE RIGHT, IN ITS SOLE DISCRETION, TO AMEND, MODIFY, OR TERMINATE THE PLAN, IN WHOLE OR IN PART, AT ANY TIME AND FOR ANY REASON, INCLUDING BUT NOT LIMITED TO, THE RIGHT TO INCREASE, REDUCE, OR TERMINATE BENEFITS, FOR ALL EMPLOYEES OR FOR ANY GROUP OF EMPLOYEES; TO CHANGE CARRIERS, NETWORKS, ADMINISTRATORS, OR BENEFITS; TO INCREASE PREMIUMS, DEDUCTIBLES, COINSURANCE AMOUNTS, COPAYMENTS, OR OTHER PAYMENTS; OR ANY OTHER CHANGES.

The Plan Administrator's decisions regarding the interpretation of the Plan document and SPD are conclusive and binding on all persons, with the exception of denied claims, which may be appealed as described in ***Claim Review and Appeal Process*** in the **Plan Administration** section of this handbook. The Plan Administrator may, however, delegate some of its interpretation and decision-making authority to the insurers or Claims Administrators of the Plan. Benefits under this Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

Participation in benefit programs under the terms of the Plan documents for employees in collective bargaining units is subject to the applicable collective bargaining agreement.

When the Plan's benefits are changed, you will be notified by the Plan Administrator. If the Plan is terminated, in whole or in part, or terminated as to any employee group, benefits will be paid only for eligible expenses incurred up to the date of the Plan's termination. No benefits will be paid for expenses incurred after the date of the Plan's termination.

This electronic handbook uses interactive links to allow you to easily move through and search at your own pace:

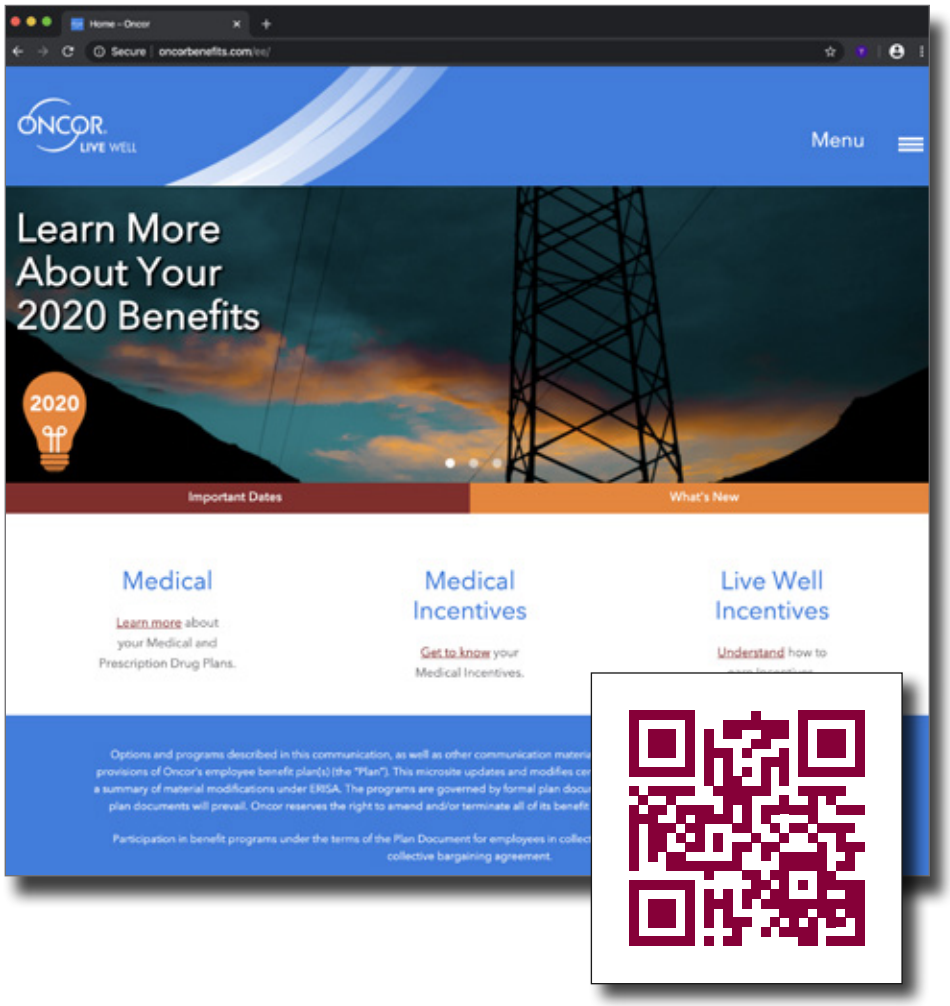
- The top navigation connects to the *main sections*.
- Click the arrows on either side of the page number to go to the *previous* or *next* page.
- All other links are underlined, and *website references* appear **underlined bold in dark red** and will open in another browser window, so you can easily switch back to the handbook.
- Click (the home icon) at the bottom of the page to return to the main Table of Contents.
- Click (the printer icon) at the bottom of the page to print the current page you are reviewing.

GETTING STARTED

How to Access Benefit Materials

You can access benefit materials, including this ***Oncor Benefit Handbook,*** and other documents, by:

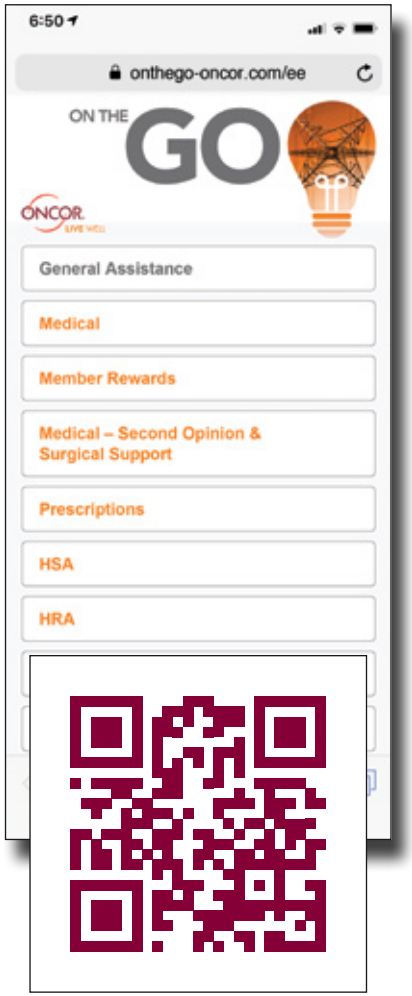
- Going to the Oncor intranet under the ***Live Well/Benefits*** page.
- Going directly to **oncorbenefits.com/ee**.



Oncor On the Go

With Oncor's mobile app, Oncor On the Go, you will have instant access 24/7 to benefit websites and phone numbers.

To load this app to your mobile device, go to the URL, **onthego-oncor.com/ee**, or scan the QR code here.



iPhone/iPad:

- Select the ***Add to Home Screen*** option from your browser's toolbar.
- Tap ***Add to Home Screen.***

Android:

- Click the ***Menu*** button, then the ***Bookmark*** button.
- Choose to add the site to your bookmarks.
- Access your bookmarks. Click and hold the bookmark you created.
- Select the ***Add Shortcut to Home*** option.

Affordable Care Act (ACA) Reporting

You will receive an IRS Form 1095-C Employer-Provided Health Insurance Offer and Coverage in the early part of each year, which provides information about your eligibility for coverage and enrollment under the Oncor Plan during the previous year. This annual statement may be used to show you had or were offered health coverage when you file your income tax return, and should be kept with your tax records.

The ACA requires Oncor to send this annual statement. You should expect to receive a 1095-C Form about January 31 of each year.

TOOLS AND RESOURCES CONTACT INFORMATION

Topic	Provider/Administrator	Web	Phone
Benefits and Live Well Information	**Oncor**	**http://intranet.corp.oncor.com** The Oncor ***Live Well*** intranet page	
Benefit Guides and Other Benefits Information	**Oncor**	**oncorbenefits.com/ee** The Oncor benefits site	
General Information	**Oncor HR Service Center**	**oncor.ultipro.com** To enroll Email: **OncorHR@ultimatesoftware.com**	**1.888.565.8803** Representatives available Monday through Friday from 7:30 a.m. to 5:30 p.m. CST Fax: **1.714.795.5049**
Dependent Verification	**Oncor HR Service Center**		**1.888.565.8803**
COBRA	**Chard Snyder**	**chard-snyder.com**	**1.888.993.4646** Fax: **1.513.459.9947**
Medical, Prescription Drug, and Tools to Manage Your Health	**Blue Cross and Blue Shield of Texas (BCBSTX)**	**bcbstx.com** Find Network providers, check claims, and access cost estimators	**1.877.213.6898** Customer Service to speak to your Health Advocate
	Scott & White Health Plan (SWHP) Option	**swhp.org** Find a Network provider, and review claims and Explanations of Benefits (EOBs)	**1.800.321.7947**
	CVS Caremark	**caremark.com**	**1.866.339.0593**
Health Savings Account (HSA) Claims	**Fidelity**	**netbenefits.com**	**1.800.544.3716**
Health Reimbursement Account (HRA) Claims **Health Care Flexible Spending Account (HCFSA)** **Dependent Care Flexible Spending Account (DCFSA)**	**ConnectYourCare**	**ConnectYourCare.com**	**1.877.292.4040**

Topic	Provider/Administrator	Web	Phone
Concierge and Advocacy Services	Health Advocacy Solutions	bcbstx.com	1.877.213.6898
Incentive Information	Navigate	oncorlivewell.com Email: info@oncorlivewell.com	1.888.596.6750
Telemedicine	MDLIVE	MDLIVE.com/bcbstx	1.888.680.8646
Rehabilitation Services	Airrosti Rehab Centers	airrosti.com	1.800.404.6050
Diabetes Support	Livongo	welcome.livongo.com/oncor Registration Code: **ONCOR**	1.800.945.4355
Employee Assistance Program	Magellan Health	MagellanAscend.com	1.800.327.6608
Tobacco Cessation and Weight Management Programs for BCBSTX Participants	Blue Cross and Blue Shield of Texas (BCBSTX)	bcbstx.com	1.877.213.6898 To enroll 1.866.412.8795 After enrolled
Breathe Tobacco Cessation Program for SWHP Participants	Scott & White Health Plan (SWHP)	swhp.org	1.800.321.7947
Dental Benefits	Aetna Dental	aetna.com	1.877.238.6200
Vision Benefits	UnitedHealthcare Vision	myuhcvision.com	1.800.638.3120
Life, Long-Term Disability (LTD), and Accidental Death and Dismemberment (AD&D) Insurance	MetLife Life Insurance		1.800.243.8786 (Option 2) to report an absence under FMLA (Family and Medical Leave Act) 1.888.565.8803 Report a death under the Life Insurance Plan to the Oncor HR Service Center 1.800.638.6420 (Option 2) for claim status only
Will Preparation	MetLife Legal Plans *For employees and spouses under Oncor's life insurance benefits*		1.800.821.6400

Plan Participation

EMPLOYEE ELIGIBILITY

When you enroll for medical, dental, or vision coverage, you also choose the eligible family members you want to cover. You can choose different coverage categories for each benefit option. For example, you can choose *You + Family* for medical coverage and *You Only* for vision coverage.

Employees

You are eligible to participate in the Plan if you are:

- A regular full-time employee,
- A part-time employee regularly scheduled to work 20 or more hours per week, or
- An employee on an approved leave of absence.

Coverage becomes effective for:

- **Current eligible employees:** January 1
- **New employees:** As long as you enroll within the first 30 days of employment, coverage begins on your date of hire. See ***When Coverage Begins*** in this section of the handbook for additional information. **Note:** Benefit premiums are collected retroactively to your date of hire.

Who Is Not Eligible

You are not eligible to participate in the Plan if you are:

- A leased or contract employee, consultant, or independent contractor,
- A non-resident alien with no U.S.-sourced income,
- An individual who is not paid directly by Oncor through the company's normal employee payroll, or otherwise characterized in Oncor's internal records as other than in one of the eligible classes described above (for example, an independent contractor, leased employee, or loaned employee), even if a court or administrative agency determines that such individual is a common-law employee, or even if Oncor subsequently agrees to retroactively treat or reclassify such individual as an employee,
- An employee who is covered under a collective bargaining agreement unless the collective bargaining agreement provides for coverage under the terms of the Plan,
- Temporary employees (including summer interns), or
- Part-time employees working less than 20 hours per week (assuming that the employee does not meet the definition of a "full-time employee" under the Affordable Care Act).

Attention: Retirees and Participants Receiving Long-Term Disability Benefits

Effective July 1, 2014, Oncor implemented the Oncor Retiree Welfare Plan (Retiree Plan) for eligible Retirees, participants receiving Long-Term Disability (LTD) benefits, and their eligible Dependents. If you are an eligible Retiree or LTD participant, you are not eligible to participate in this Plan, but you may be eligible for coverage under the Retiree Plan. You may access a copy of the ***Oncor Retiree Welfare Plan Summary Plan Description*** in the ***Oncor Benefit Handbook for Oncor Retirees and Long-Term Disability Participants*** by going to **oncorretirees.com** or by calling the Oncor Retiree Benefits Center at **1.833.253.4927**.

DEPENDENT ELIGIBILITY

You can also enroll your eligible Dependents for medical, dental, vision, life insurance, and accidental death and dismemberment (AD&D) insurance coverage. Your eligible Dependents are your:

- Legal spouse,
- For medical, dental, and vision coverage: Children up to age 26 and handicapped children over age 26 who were covered under the Plan before age 26. If you are covering a mentally or physically disabled child, you must submit the Dependent Child's Statement of Disability form to Blue Cross and Blue Shield of Texas (BCBSTX) or Scott & White Health Plan (SWHP) before the Dependent reaches the maximum age of 26. This form must be completed by the covered employee and the child's regular attending physician, and sent to BCBSTX or SWHP for their review and approval at least 30 days before coverage would end.
- For life insurance and AD&D coverage: Your unmarried children up to age 26.

Children

Your eligible children are your:

- Natural children (other than a child you birth as a surrogate for another individual),
- Legally adopted children (or children who have been placed with you for adoption),
- Stepchildren as long as you (the Oncor employee) are married to the children's parent,
- Foster children (as long as the children continue in the state foster care system and continue to be your foster children),
- Children for whom you (the Oncor employee) have Legal Guardianship,
- Children you are required to cover under a Qualified Medical Child Support Order (QMCSO), and
- Grandchildren, if the children live with you (the Oncor employee) and you claim the children as dependents on your federal income taxes.

Note: You will be required by the Plan Administrator to verify the eligibility of any person(s) covered as your Dependent or otherwise claiming coverage through you (e.g., as your spouse or your child). Requested information to verify your Dependent's eligibility must be remitted timely in order to grant coverage under the Plan for that person. Failure to timely remit information required by the Plan Administrator to verify eligibility of that person may result in not granting eligibility or coverage.

Call the Dependent Verification service at 1.888.565.8803 for more information about the Dependent verification requirements or if you don't receive verification documents within one week of adding a Dependent. Member Service Representatives can provide required forms and answer your questions.

By submitting your requested benefit elections, you are certifying that all the information you have provided is accurate. In the event that you fraudulently misrepresent your relationship to another person in order to obtain coverage for such person, or otherwise make a material misrepresentation regarding a person's eligibility to participate in the Plan, you and all persons who claim coverage through you may lose coverage under the Plan. In addition, you may be subject to employment disciplinary action, up to and including termination of employment.

Eligibility Reviews

Oncor has authority with respect to administering the eligibility provisions of the Plan. Accordingly, Oncor may, from time to time, request enrollment information from the Plan to determine a person's eligibility for Plan participation.

If Two Family Members Work for Oncor

If you and your spouse both work for Oncor and your spouse is eligible for coverage as an employee, only one of you can cover your Dependents. You can choose one of the following two options:

- One spouse can carry all family members under his or her coverage (one spouse elects family coverage and the other spouse elects no coverage), or
- Each spouse can be covered as an employee, but Dependent children can be covered as Dependents by only one spouse. One spouse should elect family coverage (you and children) and the other spouse should elect employee only coverage.

You cannot enroll your spouse in the Spouse Life Option. You must each be covered as an employee. If your Dependent child works for Oncor and is eligible for coverage as an employee, you cannot also cover that child as a Dependent. You should waive child life insurance.

Special Eligibility Rules for an HSA Medical Option

Health Savings Accounts (HSAs) provide a triple tax advantage – contributions, investment earnings, and amounts distributed for qualified medical expenses are all exempt from federal income tax, FICA tax, and most state income taxes. Due to an HSA's potential tax savings, federal tax law imposes strict eligibility requirements for HSA contributions. Before electing the HSA Medical Option, confirm that you are eligible to make contributions to an HSA. You are personally liable for tax penalties if ineligible HSA contributions are made on your behalf or HSA funds are used improperly. See IRS regulations for full and up-to-date information. You are ineligible to make HSA contributions if you:

- Are covered by other health coverage that is not a qualified high deductible health plan (with certain exceptions),
- Are enrolled in Medicare. To be entitled to Medicare benefits, an individual generally must be both eligible and enrolled. Eligibility for Medicare benefits alone does not make an individual ineligible for HSA contributions,
- Are eligible to be claimed as a dependent on another person's tax return,
- Have received Veterans Affairs medical benefits in the prior three months,
- Have received Indian Health Services medical benefits from an Indian Health Services facility during the previous three months,
- Have TRICARE coverage, or
- Have Medicaid coverage.

Be Sure to Enroll New Dependents

If you want to cover a new Dependent, you must enroll the new Dependent within 30 days of a qualified life event. However, you have 60 days to enroll new Dependents after birth, adoption, or placement for adoption.

If You Are an Active Employee When You Reach Age 65

By federal law, active employees who are eligible for Medicare can opt out of Oncor medical coverage but ***will not*** receive opt-out medical coverage credits (dollars).

You can enroll in **Medicare Part A**, which is provided by the government at no cost, UNLESS you are enrolled in an Oncor Health Savings Account (HSA) Medical Option. If you are enrolled in the Oncor HSA Option, you must decline all Medicare coverage (Medicare Part A and Medicare Part B). Otherwise, contributions to your HSA will be prohibited. If you enrolled in Medicare and contributions are made to your HSA, they may be taxable.

You may waive **Medicare Part B** if you are still covered by an Oncor medical option because the Oncor option is the primary payer of your benefits. You will need to prove you had other coverage when you later enroll in Medicare so you do not incur a late enrollment charge.

If you have questions about the proof of coverage form, call the Oncor HR Service Center.

If your spouse is enrolled in Medicare and you are younger than age 65 (not enrolled in Medicare), you are still eligible to participate in the HSA.

ENROLLING FOR COVERAGE

Benefit Options	
> Medical	> Employee Assistance Program (EAP)
> Dental	> Flexible Spending Accounts (FSAs) – Health Care FSA – Dependent Care FSA
> Vision	> Long-Term Disability (LTD)
> Life Insurance	> Vacation Purchase
> Accidental Death and Dismemberment (AD&D) Insurance	

Enrolling in the Plan

New Hire Enrollment

If you are a new employee, you will be provided enrollment information shortly after your hire date. Be sure to carefully review these materials. The materials are on **oncorbenefits.com/ee** and can be accessed as shown in ***Enrollment Tools*** in this section of the handbook.

Once you make your coverage decisions, log on to **oncor.ultipro.com** and follow the prompts to enroll. Be sure to specify which Dependents, if any, you want to enroll for each benefit option that allows Dependent coverage. You can also call the Oncor HR Service Center to enroll.

If you don't enroll within 30 days of your hire date, you will not be eligible to enroll for coverage until the next Annual Enrollment period, unless you have a qualified life event status change.

Annual Enrollment Period

During the Annual Enrollment period held each year in the fall, you decide whether you want to participate in some or all of the Plan options during the next calendar year. In some cases, you also choose the level of coverage you want. These coverage choices go into effect on the next January 1 and remain in effect for one year (through December 31) unless you make a mid-year election change based on a qualified life event status change. Some elections, such as Optional Life Insurance that is over the Guaranteed Issue amount, may be subject to approval by the carrier.

Your Elections Are Effective for a Full Year

Generally, you will not be able to change your elections until the next Annual Enrollment period. However, you may be able to change your elections if you have a qualified life event status change. To make a change:

- Log on to **oncor.ultipro.com** and change your election within 30 days following the qualified life event status change. (You have 60 days to enroll new Dependents after birth, adoption, or placement for adoption.)
- Any changes that you make to your benefits must be consistent with the qualified life event status change.

For more information about making changes to your benefits, see ***Changing Your Coverage*** later in this section or see the **Qualified Life Events** section of this handbook.

Examples of Qualified Life Event Status Changes

- Your marriage, divorce, annulment, or legal separation,
- The birth, adoption, or placement for adoption of a Dependent child,
- The death of your spouse or a covered Dependent child,
- Your gain or loss of Legal Guardianship of an eligible Dependent,
- A child's gain or loss of status as an eligible Dependent,
- A change in the employment status of you, your spouse, or an eligible Dependent (e.g., from part-time to full-time or vice versa), resulting in gain or loss of coverage,
- Enrollment of you or your covered Dependents in Medicare or Medicaid, or
- A court order requiring a change in coverage such as a Qualified Medical Child Support Order (QMCSO).

Coverage Categories

When you enroll for medical, dental, and vision coverage, you also choose a coverage category. There are four categories to choose from:

- You Only,
- You + Spouse,
- You + Children, or
- You + Family (Spouse and Children).

You can choose different coverage categories for each benefit option. For example, you can choose *You + Family* for medical coverage and *You Only* for vision coverage.

Working Spouse Surcharge

If your spouse is employed and is eligible for medical coverage through his or her employer (other than Oncor), you and your spouse should give careful consideration to covering your spouse under that plan. If your spouse is eligible for his or her own employer-sponsored coverage and you still decide to cover your working spouse under an Oncor medical option, you will be charged a surcharge through payroll deductions to cover your spouse.

However, the charge does not apply if your spouse:

- Is employed by Oncor,
- Is not employed, or
- Is employed, but not eligible for benefits with his or her employer.

Life Insurance Limits

You will be required to answer medical questions and satisfy Statement of Health (SOH) requirements, as determined by the insurance carrier, if:

- **During your initial enrollment period,** you:
  - Elect Optional Life Insurance greater than four times your annual base pay, or
  - Did not enroll in optional coverage and choose to do so at a later date, or
- **At the time of Annual Enrollment or a qualified life event status change,** you choose to increase your optional coverage by:
  - One times your pay if your total elected coverage will exceed four times pay, or
  - More than one times your annual base pay.

For more information, see the **Life and Accidental Death and Dismemberment (AD&D) Insurance** section.

Important!

If your spouse:

- **Becomes employed with access to medical coverage** through his/her employer-sponsored plan, notify the Oncor HR Service Center within 30 days of the date your spouse is eligible for coverage but did not enroll so the working spouse surcharge can be activated. At the time of notification, the surcharge will be retroactively charged to the date coverage could have begun had your spouse enrolled.
- **Loses access to his/her employer-sponsored plan,** remember to notify the Oncor HR Service Center within 30 days so the monthly spouse surcharge can be discontinued. No retroactive reimbursements can be made if the Oncor HR Service Center is notified after 30 days.

ENROLLMENT TOOLS

Oncor provides numerous resources to help you enroll, including:

- **Benefits Site – oncorbenefits.com/ee.** Go to **oncorbenefits.com/ee** to explore this helpful benefits site. You will find:
  - Information about **Oncor medical options and incentives, Live Well Incentives,** and **Tools**,
  - **Important Dates** sections to alert you when an upcoming event is about to occur,
  - **What's New** where you will find internal Oncor benefits news articles posted throughout the year, and
  - **QuickLinks** to additional information.
- **Health Advocacy Solutions (HAS) for all Oncor participants covered by a BCBSTX medical option** provides concierge and advocacy services. The HAS toll-free customer service number is on the back of your BCBSTX ID card. The HAS Customer Service Representatives are ready to assist you with your questions using a holistic approach to health management and they will help you use the appropriate Oncor programs that are available to you. Their services include the Nurseline, Women's and Family Health Program, Member Rewards, and Consumer Medical among others.
- **The Oncor Live Well intranet page** is located on the Oncor intranet at **http://intranet.corp.oncor.com.** You can find information about the Live Well Incentive Program and a quarterly goals worksheet, along with other helpful information about this program. Information about the Live Well Incentive Program is also available at **oncorbenefits.com/ee**.
- **Annual Enrollment information.** Each fall you will receive information about benefits for the coming year and instructions about how to enroll.

PAYING FOR COVERAGE

You and Oncor share the cost of your benefits coverage. Your contributions toward the cost of your benefits will be deducted from your pay each pay period:

- **On a pre-tax basis for medical, dental, vision, AD&D insurance, Health Savings Account (HSA) contributions, Flexible Spending Account (FSA) contributions, and Vacation Purchase.** This means your contributions are deducted from your pay before federal, state, and Social Security taxes are withheld. You never pay taxes on any of these contributions.
- **On an after-tax basis for life insurance for you and your Dependents.** This means your contributions are deducted from your pay after taxes are withheld.

If You Waive Oncor Medical Coverage

If you opt out of medical coverage, you can receive credits (dollars) each month. You must attest that you and all of your federal tax dependents have other coverage. This coverage must:

- Be outside of Oncor,
- Meet the minimum essential coverage requirements of federal law, and
- Not be individual coverage, either on or off the federal or a state exchange.

The Oncor medical options do not offer opt-out of medical coverage credits for waiving Oncor medical coverage if you are:

- Eligible for Medicare, or
- An Oncor employee and covered by Oncor benefits through another family member who is also an Oncor employee.

If You Waive Oncor Dental Coverage

If you opt out of dental coverage, you can receive credits (dollars) each month.

Working Spouse Surcharge

If your spouse is eligible for medical coverage through his/her employer (other than Oncor) and you enroll your spouse in an Oncor medical option, you will be charged a working spouse surcharge each month for your Oncor-sponsored coverage.

If your spouse loses access to his/her employer-sponsored plan, remember to notify the Oncor HR Service Center right away so the monthly spouse surcharge can be discontinued. Retroactive reimbursements cannot be made.

> **Important!**
>
> Cost, credit, and surcharge information will be announced in your Annual Enrollment materials each year.

Tobacco Surcharge

If you and/or your spouse covered by an Oncor medical option uses tobacco, you will pay a tobacco surcharge each paycheck. You may complete a free Tobacco Cessation Program to avoid the surcharge.

Here is how it works if you and/or your spouse:

- **Has not used tobacco products during the past 24 months:**
  - The surcharge does not apply. No action is required for the non-tobacco user.
- **Is a tobacco-product user:**
  - **Complete the *Tobacco Cessation/Physician Affidavit*** and submit with appropriate documentation of Tobacco Cessation Program completion to Cover-Tek and the surcharge will be waived, or
  - Do nothing and the surcharge will apply.
- **Has been tobacco free for the last six months:**
  - **Complete the *Tobacco Cessation/Physician Affidavit*** and submit with appropriate documentation of Tobacco Cessation Program completion to Cover-Tek and the surcharge will be waived, or
  - Do nothing, and the surcharge will apply.

If You Submit an Affidavit

The surcharge will stop as soon as administratively possible (up to three pay periods). The surcharge will not be retroactively refunded.

Oncor Considers These Tobacco Products

Tobacco products include, but are not limited to:

- Cigarettes,
- Cigars,
- e-Cigarettes,
- Cigarillos,
- Pipes,
- Chewing Tobacco,
- Snuff,
- Dip, and
- Loose Tobacco Smoked via Pipe or Hookah.

Free Tobacco Cessation Programs

For more information about **free Tobacco Cessation Programs**, log on to **oncorbenefits.com/ee**.

Tobacco Cessation/Physician Affidavit

The Tobacco Cessation/Physician Affidavit is available on the Oncor intranet at LiveWell/Benefits/Health Care Resources under Tobacco Cessation and Weight Management Programs. In addition, it is posted on **oncorbenefits.com/ee**.

Pre-Tax and After-Tax Contributions

You pay for most Plan options on a pre-tax basis. This means your contributions are deducted from your pay before federal, state, and Social Security taxes are withheld. Assuming you use these funds to pay for eligible expenses, you never pay any taxes on these contributions.

For other benefits, you pay your contributions on an after-tax basis. This means your contributions are deducted from your pay after taxes are withheld.

Benefits Coverage	Paying for Coverage
Medical, dental, and vision coverage	You pay your share of these costs on a **pre-tax** basis.
Health Savings Account (HSA) or Health Reimbursement Account (HRA)	If you enroll in the: > HSA Medical Option or HRA Medical Option, Oncor makes an automatic contribution to your HSA or HRA, based on your medical option coverage category. The automatic contributions are prorated based on the number of eligible full months remaining in the year upon enrollment in the medical option. You can earn additional medical option incentive funding if you (or your spouse in some cases) participate in certain wellness and preventive activities. > You also can make employee **pre-tax** contributions to your HSA, up to IRS limits (but employee contributions are not allowed to the HRA).
Employee Life Insurance Option	The company provides Basic Life Insurance for you equal to one times your annual base pay up to a maximum benefit of $1 million. You pay imputed income tax on the value of company-provided life insurance in excess of $50,000. You may purchase Optional Life Insurance on an after-tax basis.
Spouse Life Insurance Option and Child Life Insurance Option	You pay for these benefits with **after-tax** dollars.
Accidental Death and Dismemberment (AD&D) Insurance	The company provides Basic AD&D for you equal to two times your annual base pay at no cost to you. You can purchase Optional AD&D for you and your family on an **after-tax** basis.
Flexible Spending Account (FSA) Options > Health Care FSA > Dependent Care FSA	You can contribute **pre-tax** dollars to one or both of your FSAs. You may enroll in the Health Care FSA even if you are not covered by an Oncor medical option.
Long-Term Disability (LTD) Benefit Option	Oncor provides LTD benefits equal to 66⅔% of your base pay at no cost to you. LTD benefit payments are taxable because Oncor is paying the full cost of the coverage for you.
Vacation Purchase Option (where applicable)	Oncor provides paid vacation days to eligible employees based on total length of service with Oncor. If you are eligible, you can purchase additional vacation on a **pre-tax** basis.

Insured and Self-Funded Options

Medical benefits, except those under the Scott & White Health Plan (SWHP) Option, Prescription Drug benefits, and dental benefits are self-funded. This means the benefits are paid from Oncor's general assets rather than through an insurance contract. Although insurance companies (such as BCBSTX, CVS Caremark, and Aetna) provide administrative services (such as claims determination and administration, utilization review, case management, and similar services), all benefits are paid from Oncor's general assets.

Life Insurance, AD&D Insurance, long-term disability, vision benefits, and the SWHP Option are provided through contracts with insurance companies. For insured benefits, Oncor and Plan participants pay a premium to the insurance company to provide the coverage. The insurance company makes all benefit determinations and pays all benefits.

Premiums Paid in Error

It is your responsibility to notify the Plan Administrator to disenroll Dependents within 30 days after they cease to be eligible. If you do so, your Dependent will be disenrolled and your premiums will be adjusted accordingly for the remainder of the Plan Year. However, if you fail to notify the Plan Administrator within such 30-day period, while your Dependent will not be eligible to continue coverage, IRS rules do not allow you to change your premiums. Therefore, your premiums will not be adjusted for the remainder of the Plan Year and you will not be reimbursed for any premiums paid.

> **If your Dependent children reach age 26,** they are automatically "aged out" and their coverage will end at the end of the month of their 26th birthday. They will receive a COBRA notification. See ***Dependent Eligibility*** earlier in this section of the handbook for exceptions that apply to mentally and physically disabled children over age 26.

DESIGNATING A BENEFICIARY

When you enroll, you must log on to **oncor.ultipro.com** and designate a beneficiary for your Life Insurance options.

> **Important Beneficiary Designation Information**
>
> You must designate a beneficiary for Basic Life, Optional Life, and AD&D insurance.

Your Life Insurance Beneficiary

When you enroll and, if applicable, are approved for the Employee Life and Employee AD&D Options, you will be asked to designate a primary beneficiary – someone who will receive benefits if you die. If you wish, you can designate more than one beneficiary. If you designate two or more beneficiaries, you should indicate the respective percentages for how benefits should be divided. Your beneficiary designation will apply to your Employee Life and Employee AD&D Options and to your Survivor's Benefit, a non-ERISA-covered benefit, which normally equals one month's base pay. For the Spouse Life, Child Life, and Dependent AD&D Options, you are the designated beneficiary.

You should also designate a contingent beneficiary, the person(s) who would receive your death benefit in the event your primary beneficiary predeceases you.

Your beneficiary designations take effect on the day you complete your beneficiary designation through the Oncor HR Service Center.

Changing Your Life Insurance Beneficiary

You can change your beneficiary designation at any time by updating it at **oncor.ultipro.com** or by calling the Oncor HR Service Center.

Because family situations change, you may want to review your beneficiary designation from time to time.

If You Do Not Designate a Life Insurance Beneficiary

If you do not designate a beneficiary or if your beneficiary dies before you, benefits will be paid to your survivors or to your estate according to the provisions established by MetLife within each specific option.

WHEN COVERAGE BEGINS

As long as you enroll within the first 30 days of employment, coverage for you and your Dependents begins on your date of hire. For Basic Life Insurance, Basic AD&D Insurance, and LTD coverage, your participation starts on the day you begin Active Work if you are not Actively at Work on your first day of employment. See the **Glossary** for the definition of ***Active Work or Actively at Work***.

Delayed Life Insurance Coverage Date

If you are not Actively at Work on the date your Employee Life Insurance is due to start, coverage will not start until the day you are back at work. However, the Optional Life Insurance benefit will take effect on the eighth calendar day following your return to Active Work, provided that you have been Actively at Work for at least 20 hours during the seven calendar days preceding that date.

For the Spouse Life and Child Life Options, your Dependent must not be confined at home under a doctor's care, be receiving or applying to receive disability insurance from any source or be hospitalized. In these situations, coverage will start when the Dependent is no longer confined, hospitalized, or receiving or applying for disability insurance from any source.

CHANGING YOUR COVERAGE

Changing Your Plan Elections

Once you make your Plan elections during Annual Enrollment, they are effective for the next calendar year. Because of tax advantages under the Plan, the IRS restricts the coverage changes you can make after Annual Enrollment. However, under certain circumstances, you can enroll for coverage or change your elections during the year. These circumstances include the following:

- You qualify for a special enrollment under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as described on this page.
- You have a qualified life event status change that affects eligibility of you, your spouse, or your Dependents.
- The Plan receives a court order, such as a Qualified Medical Child Support Order (QMCSO).
- You, your spouse, or your Dependent enrolls in Medicare, Children's Health Insurance Program (CHIP), or Medicaid.

Special Enrollment Rights

If you do not enroll in the medical, dental, vision, or Health Care Flexible Spending Account Option for yourself or your Dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the other employer stops contributing toward your coverage or your Dependents' other coverage). However, you must request enrollment within 30 days after your coverage or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this Plan within ***60 days*** of the date you or your Dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your Dependent(s) become eligible for a state-granted premium subsidy toward this Plan, you may request enrollment under this Plan within ***60 days*** after the date Medicaid or CHIP determines that you or the Dependent(s) qualify for the subsidy.

If you or your Dependent currently has health plan coverage that is *not* COBRA continuation coverage and employer contributions end toward that coverage or your Dependent's coverage, you may be able to enroll for coverage under this Plan.

If you or your Dependent has COBRA continuation coverage and that coverage is exhausted, you may be able to enroll for coverage under this Plan. You have a special enrollment right at the end of your COBRA continuation coverage period if you have received continuation coverage for the maximum time period available to you.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new Dependents. However, you must request enrollment within 30 days after the marriage and within 60 days after the birth, adoption, or placement for adoption.

To request special enrollment or to obtain more information, contact the Oncor HR Service Center.

Qualified Life Event Status Changes

You may be able to change your elections during the year if you have an eligible qualified life event status change, as long as your change is consistent with the qualified life event status change. Changes can be made to your medical, dental, and vision coverage; to your Flexible Spending Account Options (Health Care FSA and Dependent Care FSA) in some circumstances; and to your life insurance and AD&D insurance coverage. Any change in life insurance benefits may require a Statement of Health (SOH) and approval by the insurance carrier.

Eligible changes in status include the following:

- You marry, divorce, legally separate, or have your marriage annulled.
- Your spouse or Dependent dies.
- You have a baby (other than a child you birth as a surrogate for another individual), you adopt, or you have a child placed with you for adoption.
- Your gain or loss of Legal Guardianship of an eligible Dependent.
- A child's gain or loss of status as an eligible Dependent.
- You, your spouse, or your Dependent starts or ends employment.
- The work schedule for you, your spouse, or your Dependents changes (a switch from part-time to full-time employment and vice versa, a strike or lockout, or the start of or return from an unpaid leave of absence resulting in either gaining or losing coverage).
- Your Dependent becomes eligible or ineligible for coverage (for example, he or she reaches the Plan's eligibility age limit).
- Your or your covered Dependent's eligibility for Medicare or Medicaid.
- A court order requiring a change in coverage, such as a Qualified Medical Child Support Order (QMCSO), for an eligible Dependent.
- A change in your home address causes you, your spouse, or your Dependents to lose eligibility for an option.
- New coverage becomes available for you, your spouse, or your covered Dependent children and the cost is significantly different from Oncor's.

In addition, you can change your coverage during the year *only if* ***both*** *the following apply:*

- The qualified life event status change as shown on this page causes you, your spouse, or your Dependent to lose or gain eligibility for accident or health coverage under the Plan (or under a spouse's or Dependent's accident or health plan), and
- Your election change is consistent with the gain or loss of coverage.

If you have an eligible qualified life event status change and need to change your coverage during the year, you must make the change within 30 days of the qualified life event status change (within 60 days for birth, adoption, or placement for adoption). If you don't, you can't make a coverage change until the next Annual Enrollment period, unless you once again meet one of the conditions to make an election change (for example, if you have another qualified life event status change).

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) could have an effect on your benefit coverage or elections. Notify the Oncor HR Service Center if you become aware of an order like this affecting you.

You can write to the Oncor HR Service Center to get a free copy of the Plan's procedures for determining whether a court order qualifies as a QMCSO. See the **Glossary** for an explanation of a ***QMCSO***.

> **Important Notice**
> Following a qualified life event status change, you must log on to **oncor.ultipro.com** or call the Oncor HR Service Center within 30 days (or 60 days for a birth, adoption, or placement for adoption), to make any changes in your benefit elections.

WHEN COVERAGE ENDS

Different benefit options have different provisions related to when coverage ends. You can continue your health care coverage and your employee and Dependent Life Insurance during an approved leave of absence or during a disability leave (as long as you are receiving LTD benefits). Your life insurance ends when you (the Oncor employee) is on a Military or Personal Leave of Absence. In the event you die while an active Oncor employee, your Dependents are automatically enrolled in a Surviving Spouse/Beneficiary election through Oncor.

> Benefits for Retirees and participants receiving LTD benefits are described in the *Oncor Retiree Welfare Plan Benefits Handbook* on **oncorretirees.com**.

When Medical and Dental Coverage Ends

Your medical and dental coverage generally ends on your last day worked if:

- **You terminate Oncor employment** (voluntarily, through severance, or layoff). In some situations, you may be able to continue coverage under COBRA, as described in the **Qualified Life Events** section of this handbook.
- **You retire.** You may be eligible for Retiree medical, dental, vision, and life insurance coverage under the Retiree Plan.
- **You die.** Your survivors may be eligible for survivor health care coverage.

Your coverage also ends if:

- You fail to remit required premiums.
- You no longer meet the eligibility requirements for coverage.
- Oncor determines that you have violated an employment policy or rule of Oncor or the Plan (termination may be retroactive if Oncor determines that you have committed an act of fraud or intentional misconduct).
- Oncor terminates the Plan or ceases to offer a benefit under the Plan.

A covered individual may also lose coverage for violating an employment policy or rule, or for committing fraud, or providing false or inaccurate information to obtain benefits under the Plan. Under some circumstances, termination of coverage can be applied retroactively.

Scott & White's medical coverage ends at the end of the month in which an employee terminates.

Coverage for your Dependents usually ends at the same time as your own coverage. Coverage for your spouse ends if you become divorced. Coverage for your children ends if they reach the maximum age or no longer meet the eligibility requirements. For more information, see ***Dependent Eligibility*** earlier in this section.

When Vision Coverage Ends

Your vision coverage generally ends on the last day of the month in which you terminate employment for any reason.

When EAP Coverage Ends

Your coverage and your eligible household members' coverage under the EAP will end when:

- **Your employment with Oncor terminates.** Coverage ends on the last day of the pay period in which your employment ends (except as provided under applicable law).
- **You have a change in employment status that affects your eligibility to participate in the EAP.** Coverage ends on the last day of the pay period in which your employment status changes.
- **You retire.** Coverage continues through the end of the month in which you retire.
- **The Plan or the EAP option ends.** Coverage for you and your eligible Dependents ends on the date the EAP is terminated.
- **You die.** Your eligible Dependents will be covered through the end of the month following the month of your death.

Coverage for your Dependents usually ends at the same time as your own coverage. If you become divorced, coverage for your ex-spouse continues through the last day of the month in which the divorce is final.

When Active Life Insurance Coverage Ends

In addition to other situations, Employee Life Insurance coverage ends the date your employment ends for any reason or on the last day for which a premium is paid for your coverage. However, if you are receiving benefits under the Oncor Long-Term Disability Option, your life insurance continues unchanged. In some cases, you can continue coverage under the portability feature or convert coverage to an individual policy; however, portability is not applicable to Program A employees.

Dependent Life Insurance ends when your employment ends, you retire, or you are no longer participating in the Life Insurance Program, your employment otherwise ends, or the Plan ends. A conversion privilege may apply for Spouse Life Insurance.

For a complete list of events that may result in the end of employee and/or Dependent coverage, refer to the Certificate of Insurance for this benefit.

When Your Active Spouse Life Insurance Option Ends

In addition to other situations, the Active Spouse Life Option ends when your employment ends or your spouse no longer meets the eligibility requirements for coverage. However, coverage is portable and can be continued when you leave the company or when your spouse becomes ineligible. Otherwise, a conversion privilege may apply. For a complete list of events that may result in the end of coverage, refer to the Certificate of Insurance for this benefit.

If you retire from Oncor, you can continue the Retiree Spouse Life Option in retirement.

When Your Child Life Insurance Option Ends

In addition to other situations, the Child Life Option ends when your employment ends, you retire, or your child no longer meets the eligibility requirements for coverage. However, you or your spouse can elect to convert the Child Life Option coverage. For a complete list of events that may result in the end of coverage, refer to the Certificate of Insurance for this benefit.

> To review the Certificate of Insurance, contact the Oncor HR Service Center.

When Active Life Insurance Program A Coverage Ends

In addition to other situations, employee coverage ends when you leave the company. In some cases, you can convert coverage to an individual policy; however, portability is not applicable to Program A employees.

Dependent Life Insurance ends when your employment ends (including when you retire), you are no longer participating in the Life Insurance Program, or the Plan ends. A conversion privilege may apply for Spouse Life Insurance.

For a complete list of events that may result in the end of employee and/or Dependent coverage, refer to the Certificate of Insurance for this benefit.

When AD&D Coverage Ends

In addition to other situations, coverage under the AD&D Insurance Options (including coverage for your Dependents) ends when you retire, when your employment ends, or when you enter the armed forces. Coverage for your Dependents also ends if they no longer meet the eligibility requirements for coverage. There are no conversion or portability rights for AD&D coverage.

For a complete list of events that may result in the end of coverage, refer to the Certificate of Insurance for this benefit.

When Long-Term Disability Insurance Ends

LTD benefits will end at the earliest of:

- The date the Group Policy ends,
- The date insurance ends for your class,
- The end of the period for which the last premium has been paid,
- The date you cease to be in an eligible class. You will cease to be in an eligible class on the date you cease Active Work in an eligible class, if you are not disabled on that date.
- The date your employment ends or you retire.

If the Plan Ends

Oncor currently intends to continue these benefits indefinitely. However, the company reserves the right to end, suspend, withdraw, or amend the Plan in whole or in part, from time to time, in the sole discretion of the company. If the Plan or any benefit option should end, benefits may be paid for any valid claims incurred prior to such termination.

Medical

Medical *(continued)*

MEDICAL BENEFITS

The Oncor Medical Benefit Options are designed to protect you financially against the high costs of a serious medical condition, as well as providing benefits for minor illnesses and injuries. Oncor believes that wellness and prevention are the keys to a healthy, long life. In support of this belief, Oncor emphasizes wellness and preventive care through the design of the the Health Savings Account (HSA) Medical Option and the Health Reimbursement Account (HRA) Medical Option, as well as the financial rewards provided by participating in the Live Well Incentive Program.

This section of the handbook describes how the medical options work.

Medical Coverage Decisions

When you enroll for coverage each year, you choose the eligible Dependents you want to cover and the medical option that best fits your situation.

When you choose a medical option, you receive the prescription drug and mental health coverage that goes with that option, and you may be eligible for a Health Savings Account (HSA) or Health Reimbursement Account (HRA).

The Scott & White Health Plan (SWHP) Option is only available to those living in certain geographic locations and is not available to new participants effective January 1, 2015.

Special Eligibility Rules for an HSA Medical Option

Under Internal Revenue Service (IRS) rules, you are not eligible to open an HSA or participate in an HSA Medical Option if you have other coverage, including Medicare, Tricare, tribal plans, an FSA (even if it is your spouse's FSA), or another employer's plan. Refer to ***Special Eligibility Rules for an HSA Medical Option*** in the **Plan Participation** section of this handbook. Your Dependents' coverage under another health care plan will not prevent you from enrolling them in the HSA Medical Option, as long as you are not covered under the Dependent's plan.

About the Networks

The HSA and HRA Medical Options use the Blue Cross and Blue Shield of Texas (BCBSTX) PPO Plan Network. A Network is a group of doctors, hospitals, and other facilities that contract with medical plan administrators (like BCBSTX) to offer discounted rates to their participants.

Providers can leave or join a Network at any time, so be sure there are several doctors and hospitals that you're comfortable using in the Network you choose. You cannot switch medical options within a Plan Year simply because your doctor or preferred health care facility leaves your Network.

Under the BCBSTX Medical Options

You have more freedom to choose any provider for your medical care. When you choose In-Network providers, the Plan usually pays a higher portion of the costs, and you pay a smaller amount. When you choose providers outside the Network, the Plan usually pays a lower portion of the costs, and you pay a higher amount.

If care is not available from Network providers as determined by the Claims Administrator, and the Claims Administrator approves your visit to an Out-of-Network provider **prior to the visit**, In-Network benefits will be paid. Otherwise, Out-of-Network benefits will be paid for covered services.

Medical Care Away from Home

If you or a Dependent needs medical care while away from home, you can use the BCBS PPO Network. To find a nearby doctor or hospital when away from your home, call Health Advocacy Solutions at **1.877.213.6898**. You can also use the Doctor and Hospital Finder at **bcbstx.com**. Your BCBSTX member ID card is recognized throughout the United States. You should not have to pay up-front for medical services, except for the usual Coinsurance expenses (non-covered services, Deductibles, Coinsurance amounts, or Copayments). BCBSTX will provide an Explanation of Benefits (EOB) after the claim is processed.

If you need Emergency Care while away from home, you do not need to contact BCBSTX before getting the treatment you need. But you should call BCBSTX as soon as possible after you receive emergency treatment. If the option determines that the care was an emergency, benefits are paid at the In-Network rates.

Call Health Advocacy Solutions (BCBSTX) at **1.877.213.6898** or log on to **bcbstx.com** to locate a Network doctor, obtain doctor recommendations, learn about hospital cost and quality, and have appointments scheduled for you, along with many other helpful services.

BCBSTX *ParPlan*

In addition to In-Network providers, when you consult an Out-of-Network provider, you should inquire if he or she participates in the Claims Administrator's *ParPlan*, a simple direct-payment arrangement. If the provider participates in the *ParPlan*, he or she agrees to:

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

You will receive Out-of-Network benefits and be responsible for:

- Any Deductibles,
- Coinsurance amounts, and
- Services that are limited or not covered under the Plan.

The Scott & White Health Plan (SWHP) Option

You must use In-Network providers to receive benefits from this medical option (except in a medical emergency).

The Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with a covered childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ACCOUNTS FOR TAX SAVINGS

When you enroll in the Health Savings Account (HSA) or Health Reimbursement Account (HRA), you will be eligible for an account you can use to pay your out-of-pocket health care expenses. You can also choose to set up a Health Care Flexible Spending Account (HCFSA) if you enroll in the HRA.

How the HSA, HRA, and HCFSA Work

HSA or HRA Option	Oncor makes automatic contributions to your account each year based on your coverage level – plus you can earn additional medical option incentive funding if you complete certain wellness activities. The employer contribution is prorated based on the number of eligible full months remaining in the year upon enrollment.
HCFSA	If you are enrolled in the HRA Option or the Scott & White Health Plan (SWHP) Option, or waive medical coverage, you can participate in the HCFSA. An HCFSA allows you to set aside pre-tax money for eligible health care expenses for you and your Dependents. HCFSAs are subject to "use it or lose it" IRS rules so you need to budget carefully. If you are also in an HRA, your HCFSA funds will pay medical, prescription drug, dental, and vision expenses first until your HCFSA funds are depleted. Then, you may use available HRA funds for these expenses, if available. If you are enrolled in the HSA, you may not participate in an HCFSA.

Key Differences Between the HSA and HRA

HSA	You can participate in the HSA if you are not covered by any medical plan other than a high deductible health plan (for example, if you are covered by your spouse's medical plan or Medicare). You have a triple tax advantage with an HSA: > Contributions are tax-free. > Earnings accumulate tax-free. > Payments and withdrawals for qualified health care expenses are exempt from federal income tax and state tax (in most states). You can choose how you want to invest from a range of investments offered through Fidelity. Your account is yours to keep even if you no longer participate in an Oncor-sponsored plan, leave the company, or retire.
HRA	Per IRS regulations, you cannot contribute to an HRA. As long as you continue enrollment in the Oncor Electric Delivery Company LLC Employee Welfare Benefit Plan or the Oncor Retiree Welfare Plan, your account balance rolls from year to year. The account balance does not earn interest.

Health Savings Account (HSA)

If you select the HSA Option, you will be eligible to open a Health Savings Account (HSA). This is a bank account in your name, and you and Oncor can make contributions to the account. Contributions are tax-free, and payments made from the account for qualified health care expenses are not taxed. The account belongs to you and remains yours even if you drop Oncor medical coverage, retire, or leave the company.

If you and your family are covered under the HSA Option, qualified medical, prescription, dental, and vision out-of-pocket expenses, including the out-of-pocket Deductible, may be paid on a tax-free basis from this account. Individuals must be qualified federal tax dependents for their expenses to be eligible; if you withdraw funds for a nonqualified expense, you will owe tax on the withdrawal plus a 20% tax penalty.

HSA Administrator: Fidelity

Contact Fidelity

Phone: **1.800.544.3716**
Website: **netbenefits.com**

If You Are a New HSA Participant

If you are electing the HSA Option for the first time, you must open your HSA at **netbenefits.com** to:

- Receive Oncor's automatic contribution and incentives to your HSA,
- Elect your payroll contribution amount, and
- Request a Fidelity HSA debit card and/or check for your account.

If this is your first visit to **netbenefits.com**, click ***Register Now*** and follow the instructions to set up your User Name and Password. Fidelity requires a physical address to open an HSA. If you have a P.O. Box address, you must provide a physical address through the Oncor HR Service Center.

If you have already established a User Name and Password with Fidelity, you can use the same login information (User Name and Password) from those accounts to access NetBenefits at **netbenefits.com** for your Fidelity HSA.

Your HSA Belongs to You

Since your HSA is a personal bank account, unused funds and earnings remain in your account until you use them. If you die, the balance in the account goes to your named beneficiary.

In either case, once you are logged on to NetBenefits:

1. Click ***Open*** next to ***Health Savings Account***.
2. Select ***Open Fidelity HSA***.
3. Click ***Get Started*** and follow the prompts to complete your application.
4. Review and confirm your application information.
5. Select ***Confirm My Information***.
6. Review and agree to terms of your new Health Savings Account.
7. Select ***Open Account***.

If you do not have access to NetBenefits, contact a Fidelity Representative at **1.800.544.3716** and choose the Health Savings Account prompt for assistance.

If You Are Already an HSA Participant

Unless you make a change during Annual Enrollment, your current year HSA contribution elections will roll over to the next calendar year.

Important!

The IRS sets annual HSA contribution limits. Changes can be made to your elections throughout the year.

HSA and Medicare If You Are Still Actively Working

The Health Savings Account (HSA) Medical Option provides qualified, high deductible medical coverage with an HSA to help you pay for your share of medical expenses. The HSA Medical Option includes individual and family In-Network Deductibles, Coinsurance, and Out-of-Pocket Maximums. For additional information about the HSA Medical Option, refer to ***Health Savings Account (HSA) Medical Option*** in this section of the guide.

Under Internal Revenue Service (IRS) rules, you are not eligible to contribute to an HSA or participate in an HSA Medical Option if you have other coverage, including Medicare, Tricare, tribal plans, an HCFSA (even if it is your spouse's HCFSA), or another employer's plan. Refer to ***Special Eligibility Rules for an HSA Medical Option*** in the **Plan Participation** section of this handbook. Your Dependents' coverage under another health care plan will not prevent you from enrolling them in the HSA Medical Option as long as you are not covered under the Dependent's plan.

Things to Consider

If you plan to continue working after turning 65 and are participating in the HSA Medical Option:

- Consider waiving Medicare Part A until you are actually ready to retire. For information, contact the Social Security Administration at **1.800.772.1213** (TTY: 1.800.325.0778) or **ssa.gov**.
- Do not enroll in Medicare Part B.
- Oncor's annual contribution to the HSA can continue as long as you are not enrolled in Medicare.
- Oncor's wellness incentives to the HSA can continue as long as you are not enrolled in Medicare.
- You may continue to make contributions to your HSA as long as you are not enrolled in Medicare.
- The IRS sets annual HSA contribution limits.
- Any contributions over the maximum (either from Oncor or your contributions) may be considered taxable income and/or penalties may apply.
- You will not be penalized for delaying your Medicare Part A and Part B coverage, as long as you enroll within eight months of your retirement, or otherwise losing your coverage under the Plan.

Note: Enrollment to Medicare Part A is automatic; the Social Security office has rules of when Part A takes effect. For additional information, contact the SSA office.

If you do enroll in Medicare Part A or Part B while you are still working, contributions made to the HSA either by Oncor or you may be considered taxable by the IRS, and may result in penalties.

For additional information, review **IRS Publication 969**.

If you are enrolled in the HSA Medical Option, it is important for you to know that you can enroll in Medicare Part A anytime during or after your initial enrollment period starts. If you sign up within six months of your 65th birthday, your coverage will start at one of these times:

- The first day of the month after you turn 65, or
- The month before you turn 65 if your birthday is the first of the month.

After that, your coverage start date will go back retroactively six months from when you sign up.

Because HSA contributions are prohibited for individuals who are covered under Medicare, contributions cannot be made in that window of time.

If any contributions are made to your HSA, you have until April 15 to withdraw that amount; otherwise, the funds may be subject to penalties. If you find yourself in this situation, consult a tax specialist for any questions or concerns you may have.

For all other questions or concerns, contact Oncor HR Advocacy at **oncres1@oncor.com**.

> **It is your responsibility to confirm eligibility in the plan.**

Health Reimbursement Account (HRA)

If you enroll in the HRA Option, Oncor will establish a Health Reimbursement Account (HRA) for you. Only Oncor may contribute to this account. You can earn additional funding through incentives for various wellness activities. Your account balance rolls from year to year while you remain covered under the Oncor Electric Delivery Company LLC Employee Welfare Benefit Plan or the Oncor Retiree Welfare Plan. You cannot contribute to this account, and the account does not earn interest.

Qualified medical, prescription, dental, and vision out-of-pocket health care expenses, including the out-of-pocket Deductible, for you and your Oncor-covered Dependents may be paid on a tax-free basis from this account.

If you terminate employment and do not enroll in continuation medical coverage through COBRA, only qualified expenses incurred before termination are eligible, subject to timely claims filing, and any unused funds are forfeited.

The account is a notation in Oncor's records that you have those funds available for qualified health care expenses. As long as you remain enrolled in the Oncor Electric Delivery Company LLC Employee Welfare Benefit Plan or Oncor Retiree Welfare Plan, the account balance may roll over from year to year.

HRA Administrator: ConnectYourCare

Contact ConnectYourCare

Phone: **1.877.292.4040**
Website: **ConnectYourCare.com**

ConnectYourCare administers the HRA. This provider offers:

- Call Center with representatives to help you 24 hours a day, seven days a week.
- State-of-the-art technology through the participant portal and mobile technology. You can eliminate the hassle of receipts with the instant camera upload feature.
- Personalized advice and coaching.

Moving from the HRA Option to the HSA Option

If you move coverage from the HRA Option to the HSA Option, your HRA balance can still be used but it will be limited to eligible dental and vision expenses until your HSA Deductible has been met.

Flexible Spending Accounts (FSAs)

FSAs are available to all eligible employees. You do not have to be enrolled in an Oncor medical option to participate.

FSAs give you the opportunity to lower your taxes by paying on a pre-tax basis for eligible:

- Health care expenses for you and your FSA Dependents, and
- Dependent day care expenses.

You must make an election each year during the Annual Enrollment period to participate in these accounts. You may also enroll when you are a new hire or in the event of a qualified life event, described in the **Qualified Life Events** section of this handbook. The FSAs are funded entirely with your voluntary contributions, which are made with pre-tax dollars from your pay – before federal income and Social Security taxes are withheld.

If you choose to participate in one or both FSAs, note:

- **Avoid the "use it or lose it" rule.** Budget carefully because you will forfeit any money left in the account at the end of the year. Unused funds do not carry over from year to year. This is an IRS tax rule. You must re-enroll each year to participate in one or both FSAs.
- **Each account is separate.** You cannot transfer money between the Health Care FSA (HCFSA) and Dependent Care FSA (DCFSA). So, consider your needs carefully for the upcoming year.

Defining a Dependent

The FSAs define "Dependent" differently than the Oncor benefit options. See ***Dependent (for FSAs)*** in the **Glossary** section of this handbook for details.

- **You cannot change your contribution amount** to either account until the next Annual Enrollment, unless you have a qualified life event.
- **If you retire or terminate employment,** generally only eligible expenses incurred during the calendar year prior to termination will be reimbursable from your HCFSA or DCFSA, subject to timely claims filing.

You can visit **ConnectYourCare.com** for detailed lists of eligible and ineligible expenses for both accounts.

Health Care Flexible Spending Account (HCFSA)

Each year Annual Enrollment materials announce HCFSA contribution amounts for the coming year.

- **If you participate in an HCFSA only (no Oncor medical coverage).** You may use the ConnectYourCare debit card to pay for eligible expenses or use the online bill pay feature available at **ConnectYourCare.com**.
- **If you are enrolled in an HCFSA and an HRA Option.** Both accounts will be administered by ConnectYourCare, and may be accessed by using your debit card. Your HCFSA funds will pay medical, prescription drug, dental, and vision expenses first until your HCFSA funds are depleted. Then, you may use available HRA funds for these expenses, if available.
- **If you are enrolled in an HSA Option.** You may not participate in an HCFSA. You can contribute pre-tax money into your HSA to be reimbursed for eligible health care expenses.

Dependent Care Flexible Spending Account (DCFSA)

Each year Annual Enrollment materials announce DCFSA contribution amounts for the coming year. This account allows you to set aside before-tax dollars to pay for Dependent day care expenses so you and your spouse can work.

> **Defining a Dependent**
>
> The FSAs define "Dependent" differently than the Oncor benefit options. See ***Dependent (for FSAs)*** in the **Glossary** section of this handbook for details.

HCFSA and DCFSA Administrator: ConnectYourCare

> **Contact ConnectYourCare**
>
> Phone: **1.877.292.4040**
> Website: **ConnectYourCare.com**

ConnectYourCare administers the HCFSA and the DCFSA. This provider offers:

- A Call Center with representatives to help you 24 hours a day, seven days a week.
- State-of-the-art technology through the participant portal and mobile technology. You can eliminate the hassle of receipts with the instant camera upload feature.
- Personalized advice and coaching.

> **Remember!**
>
> **You have until March 31 each year to submit claims related to the prior year.**

Health Care FSA (HCFSA)

Once you make the election for the HCFSA, ConnectYourCare will send you a debit card that you can use to pay for any health care-related (medical, dental, or vision) expenses.

How you can be paid from your HCFSA:

- Use a health care payment debit card that shows your real-time account balance. This card is accepted at all IIAS-compliant merchants.
- With online claim reimbursement, your claim information is entered online for reimbursement via direct deposit or check.
- You may submit a paper claim for reimbursement. This service offers 24-hour claim adjudication and can pay you through direct deposit or a paper check.

Dependent Care FSA (DCFSA)

If you enroll in this account, you may use the online bill pay feature at ConnectYourCare.com to pay your expenses. Or, you may choose to pay the expense out of pocket and file a claim for reimbursement.

HEALTH SAVINGS ACCOUNT (HSA) MEDICAL OPTION

The HSA Medical Option uses the Blue Cross and Blue Shield of Texas (BCBSTX) PPO Network. The HSA Medical Option provides qualified, high-deductible medical coverage with an HSA to help you pay for your share of medical expenses. The HSA Medical Option includes individual and family In-Network Deductibles, Coinsurance, and Out-of-Pocket Maximums. Refer to *Your Guide to Benefits* that you receive as a new hire and during Annual Enrollment each year for specific information.

How the HSA Medical Option Works

- An HSA is set up in your name to help you pay your health care expenses. Oncor makes an automatic contribution to this account based on your medical option category. You can earn incentive contributions and make contributions, too, subject to annual IRS limits.
- Each year, you must meet a Deductible before the option starts to pay benefits. If you choose individual coverage, you must satisfy the individual Deductible. If you choose any other coverage level such as *You + Spouse, You + Child(ren), or You + Family,* you must satisfy the family Deductible. (For Deductible amounts, refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information.)
- After you meet the Deductible, the option's Coinsurance is 80% for most In-Network expenses and 60% for most Out-of-Network expenses. Your Coinsurance is the remaining 20% or 40% of covered expenses.
- You can use your HSA funds to pay your share of covered expenses.
- When you use In-Network providers for eligible preventive care expenses, there is no Deductible, and the option pays 100%.
- If you reach the Coinsurance maximum during the year, the option pays 100% of most covered expenses for the rest of the year.
- With this option, you receive prescription drug coverage through CVS Caremark.

> When you reach age 65 and you are an active employee enrolled in an HSA Medical Option, see ***If You Are an Active Employee When You Reach Age 65*** in the **Plan Participation** section of this handbook for details.

About the Deductible

The Deductible is the amount of covered medical expenses you and your family pay each year before the HSA Medical Option starts to pay medical, mental health, or prescription drug benefits.

If you have individual coverage (the *You Only* coverage category), you must meet the individual Deductible each year before the option starts paying benefits. If you have family coverage (the *You + Spouse, You + Child(ren),* or *You + Family* coverage category), you must meet the family Deductible each year before the option starts paying benefits. The family Deductible is met when combined expenses from one or all covered family members reach the family Deductible amount.

All eligible medical, prescription drug, and mental health and chemical dependency expenses (including those that you pay through your HSA) count toward the annual medical Deductible. However, the following charges ***do not*** count toward the Deductible:

- Any charges that are not covered by the option,
- Charges that exceed the Allowable Amount or other option limits, and
- The penalty for failure to precertify an Out-of-Network hospital, mental health, chemical dependency, or maternity admission.

Note that there are separate Deductibles for In-Network and Out-of-Network Services.

About Coinsurance

You share in the cost of medical services through Coinsurance after you have met your Deductible.

Coinsurance is the portion of charges that you and the option pay for covered services. Usually, the option pays 100% or 80% for In-Network Services and 60% for Out-of-Network Services. Your Coinsurance is the remaining percentage (usually 0% or 20% for In-Network Services and 40% for Out-of-Network Services). See additional information on the ***Fact Sheet: Overview of the HSA and HRA Medical Options*** for your Network later in this section.

About the Annual Coinsurance Maximum

The HSA Medical Option places a maximum on the amount of money you have to pay each year for your share of covered medical expenses. This is called the Coinsurance maximum.

If you have individual coverage (the *You Only* coverage category), the HSA Medical Option pays 100% of charges after you meet the individual Coinsurance maximum each year. If you have family coverage (the *You + Spouse, You + Child(ren),* or *You + Family* coverage category), the option pays 100% of covered charges after combined expenses from all covered family members reach the family Coinsurance maximum.

The following charges do not count toward the annual Coinsurance maximum:

- The annual Deductible,
- Any charges that are not covered by the option or that exceed the Allowable Amount or other option limits, and
- The penalty for failure to precertify an Out-of-Network hospital, mental health, chemical dependency, or maternity admission.

> The annual Deductible and Coinsurance maximum equal the annual Out-of-Pocket Maximum.

About the HSA

Oncor makes an automatic contribution to the HSA and you can make tax-free contributions, too. In addition, you can earn additional medical option incentive funding if you (and your spouse) complete certain wellness and preventive activities.

> When you choose this option, an HSA in your name will be set up. Because your HSA is your individual account, you are required to provide certain information to Fidelity to complete the process of opening your HSA. It is your responsibility to make sure your account is open and that contributions are being accepted. For example, you must provide a physical address (not a P.O. Box). If your account is not successfully opened by March 31 of the year following enrollment, you will not receive Oncor contributions and any of your payroll deductions will be returned to you on a taxable basis.

If you don't use the balance in your HSA, it will roll over to the next year. Funds in your HSA are yours to keep, even if you leave Oncor. The annual Oncor contribution to your HSA depends on your coverage category. You (or your spouse) can earn medical incentives by participating in certain wellness and preventive activities.

Contributions to the HSA

Oncor makes an automatic contribution to your HSA, based on your coverage category. Refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information. The contribution is credited to your account as soon as administratively practical (or the date your participation in this option begins if you enroll during the year). The amount of the HSA contribution is prorated depending on your enrollment date.

You can receive incentive contributions into your HSA when you (or your spouse) take certain wellness and preventive actions. Refer to *Your Guide to Benefits* that you receive as a new hire and during Annual Enrollment each year for specific information. Incentive contributions are made to your HSA the year following completion of the incentive activity. You can also contribute tax-free dollars to your HSA through payroll deductions, or you can contribute after-tax dollars by completing an online transfer to your HSA. (Remember to deduct these contributions from your tax return.) The maximum amounts you can contribute are set by the IRS and are based on the coverage category you choose.

The IRS limits the amount you and Oncor can contribute to your HSA during the year, and there may be penalties if you exceed these limits. Visit **netbenefits.com** for a list of limits. You can elect a contribution amount, make changes to, or stop your contribution elections anytime after Annual Enrollment by going to **netbenefits.com**. If you are between ages 55 and 65, you can also contribute additional "catch-up" contributions.

When you enroll, you may receive information about how to complete the set-up for your account with Fidelity in order to manage your HSA dollars. Remember to adjust your contribution amount to reflect any Oncor incentives added to your account during the year. You'll need to abide by all laws and regulations regarding the HSA. It is your responsibility to ensure that the account is opened and maintained.

Once your account has been activated and opened, you'll receive an HSA debit card that you can use to pay your expenses from the HSA. If you don't use all of the money in your HSA, it will roll over to the next year.

Covered Expenses

You can use your HSA to pay for eligible health care expenses, including medical, prescription drug, dental, and vision Deductibles and Coinsurance, as well as other health care expenses not covered by insurance.

When you visit an In-Network provider, you typically do not pay at the time of service. However, some providers may require payment at the time of service. The claim is sent to the administrator to determine the Allowable Amount. You then receive an Explanation of Benefits (EOB) statement outlining your final cost. Your provider receives the same statement and bills you for the final amount.

You may be able to then pay with an HSA check or a convenient HSA debit card, assuming your provider accepts Visa. Typically, your provider's bill will list the accepted forms of payment.

There are no fees for replacement of debit cards. You can set up a four-digit PIN to use, if necessary, at the time of payment. Your card cannot be used at an ATM and there are no cash-back allowances. When you order prescription drugs, you can pay with the HSA debit card when you pick up your prescription. You can also use your HSA debit card for the mail order service.

Tips on Using Your HSA Debit Card

Here are some tips for making the best use of your HSA debit card:

- **You can choose Debit or Credit when you swipe your card.** If you set up a four-digit PIN (recommended for security), you will need to choose the **Debit** option.
- **Use your card only for eligible health care expenses.** Separate health care items from any other items that you're purchasing (such as food, cosmetics, and magazines). Pay the health care expenses with your HSA debit card and pay for other items separately.
- **Save your itemized receipts.** Receipts must show the date, the name of the item purchased, and the cost. An Explanation of Benefits (EOB) statement is also valid documentation. As required by the IRS, this documentation substantiates your purchase – meaning it shows that your purchase is eligible to be paid from your HSA.

HEALTH REIMBURSEMENT ACCOUNT (HRA) MEDICAL OPTION

The HRA Medical Option uses the Blue Cross and Blue Shield of Texas (BCBSTX) PPO Network. The option includes individual and family In-Network Deductibles, Coinsurance, and Out-of-Pocket Maximums. Refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information.

How the HRA Medical Option Works

For most medical expenses, the HRA Medical Option works like this:

- An HRA is set up in your name.
- You can use your HRA to pay your share of covered expenses.
- Each year, you must meet the individual or family Deductible before the medical option starts to pay benefits (except for eligible preventive care benefits).
- Once you meet the Deductible, the HRA Medical Option's Coinsurance is 80% for most In-Network expenses and 60% for most Out-of-Network expenses.
- When you receive eligible preventive care, there is no Deductible, and the option covers expenses at 100%.
- If you reach the Coinsurance maximum during the year, the option pays 100% of most covered expenses for the rest of the year.
- With the HRA Medical Option, you receive prescription drug coverage through CVS Caremark.

About the Deductible

The Deductible is the amount of covered medical expenses you pay each year before the medical option starts to pay benefits. Under the HRA Medical Option, there is an annual medical Deductible and an annual prescription drug Deductible.

Each covered person must meet the annual medical Deductible each year before the medical option starts paying medical or mental health benefits, and each covered person must meet the annual prescription drug Deductible each year before the option starts paying prescription drug benefits. Both an individual and family Deductible may apply for both medical and prescription drug coverage.

Each medical option also has family medical and prescription drug Deductibles. The family Deductibles provide protection against high Deductible expenses for larger families. The family Deductibles are two times the individual Deductible amounts. The family Deductibles are met when two persons each meet the individual Deductible or when combined expenses from all covered family members reach the family Deductible amounts. Once you meet the family Deductibles, you won't have to pay additional Deductibles for the rest of the year.

Only prescription drug expenses count toward the individual and family prescription drug Deductible.

All eligible medical expenses (including those that you pay with HRA funds) count toward the annual medical Deductible. However, the following charges do not count toward the medical Deductible:

- Any charges that are not covered by the medical option or that exceed the Allowable Amount or other option limits,
- Expenses that count toward the prescription drug Deductible, and
- The penalty for failure to precertify an Out-of-Network hospital, mental health, chemical dependency, or maternity admission under the HRA Medical Option. Refer to ***How Precertification Affects Your Benefits*** in this section of the handbook.

About Coinsurance

You share in the cost of medical services through Coinsurance. There are no Copayments under the HRA Medical Option (except for prescription Copayments).

> Separate Deductibles and Coinsurance maximums are required for In-Network and Out-of-Network Services.

Coinsurance is the portion of charges that you and the option pay for covered services. Usually, the option pays 100% or 80% for In-Network Services and 60% for Out-of-Network Services. Your Coinsurance is the remaining percentage (usually 0% or 20% for In-Network Services and 40% for Out-of-Network Services). See additional information on the ***Fact Sheet: Overview of the HSA and HRA Medical Options*** for your Network.

About the Annual Coinsurance Maximum

The HRA Medical Option places a maximum on the amount of money you have to pay each year for your share of covered medical expenses. This is called the Coinsurance maximum. Once you or a covered Dependent reaches the Coinsurance maximum, the option pays 100% of most covered expenses for that person for the rest of the calendar year. The ***Fact Sheet*** for your medical option shows your Coinsurance maximums under each option.

The Coinsurance maximum applies to each covered person each calendar year. If combined expenses for all family members reach the family Out-of-Pocket Maximum, the option pays 100% of most covered expenses for all family members for the rest of that calendar year.

Note that there is a separate Coinsurance maximum for prescription drugs.

The following charges do not count toward the annual Coinsurance maximum:

- The annual Deductible,
- Any charges that are not covered by the option or that exceed the Allowable Amount or other option limits, and
- The penalty for failure to precertify an Out-of-Network hospital, mental health, chemical dependency, or maternity admission.

> The annual Deductible and Coinsurance maximum equal the annual Out-of-Pocket Maximum.

About the HRA

Oncor may provide funding to the HRA to help offset your out-of-pocket expenses.

Eligibility for an HRA

You are eligible for the HRA if you enroll in the HRA Medical Option. The HRA is not available if you choose any other medical option. However, you won't forfeit existing HRA funds if you choose another medical option.

Contributions to the HRA

Oncor makes an automatic contribution to your HRA, based on your coverage category. Refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information. The contribution is credited to your account as soon as administratively practical (or the date your participation in this option begins if you enroll during the year). The amount of the HRA contribution is prorated depending on your enrollment date. Due to IRS guidelines, you may not make contributions to your HRA.

You can earn additional incentives by participating in certain wellness and preventive activities. Certain incentive contributions are made to your HRA the year following completion of the incentive activity.

Covered Expenses

The main purpose of the HRA is to help you pay your share of covered medical expenses.

In addition, you can use your HRA to pay a variety of other eligible health care expenses, including dental and vision expenses – even if not enrolled in those plans. You can also use your HRA to pay other health care expenses that are not covered.

In general, you can use the HRA to pay the same health care expenses that are payable through the Health Care Flexible Spending Account (HCFSA). (See ***Eligible Health Care Expenses*** in the **Flexible Spending Accounts** section of this handbook). As long as an expense qualifies as an itemized medical deduction on your federal income tax return, it is eligible for reimbursement through the HRA.

The money that goes in and out of your HRA is not considered taxable income to you. However, when you pay expenses through your HRA, you give up the right to deduct those same expenses on your tax return. For more information, see the **Flexible Spending Accounts** section of this handbook.

How to Pay Expenses Through Your HRA

If you enroll in the HRA Medical Option, to use your HRA dollars, simply use your HRA debit card when you're at an In-Network doctor's office or pharmacy. The correct amount will automatically be deducted from your HRA (or your HCFSA first, if you have elected to have an HCFSA) as long as you have available funds in your account. In addition, unverified expenses may become taxable to you the following tax year.

If You Don't Use Your HRA Funds

If you don't use all of the money in your HRA, it will roll over to the next year.

If you leave Oncor or if you are no longer eligible for coverage, HRA coverage will end and you typically will forfeit the balance in your account. However, you have until March 31 of the following year to submit expenses incurred up to the date coverage ends. In addition, you may be able to continue HRA participation under COBRA if you continue your HRA Medical Option coverage under COBRA.

If you die, survivors can use the existing account balance for reimbursement of expenses incurred through the coverage end date. Or, if your survivors choose not to continue coverage, then the HRA coverage will end. Survivors will have up to three months after coverage ends to submit incurred expenses. After that, any remaining HRA balance will be forfeited.

> If you retire, refer to the Oncor Retiree Welfare Plan Summary Plan Description in the *Oncor Benefit Handbook for Oncor Retirees and LTD Participants.*

GENERAL INFORMATION ABOUT HSA AND HRA MEDICAL OPTIONS

Allowable Amount

Under the BCBSTX options, when you choose to receive services, supplies, or care from a provider that does not contract with BCBSTX (a non-contracting provider), you receive Out-of-Network benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX Non-Contracting Allowable Amount. The non-contracted provider is not required to accept the BCBSTX Non-Contracting Allowable Amount as payment in full, and may balance bill you for the difference between the BCBSTX Non-Contracting Allowable Amount and the non-contracting provider's billed charges. You will be responsible for this balance-bill amount, which may be considerable. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan and any applicable Deductibles, Coinsurance amounts, and Copayment amounts.

Benefits Based on Allowable Amounts

Under the options, the Coinsurance (usually 80% when you receive services from In-Network providers and 60% when you receive services from Out-of-Network providers) is based on the Allowable Amounts.

- When you receive care from In-Network providers, the provider bills the option at the provider's regular rate. Then the option reduces the bill to the Allowable Amount. (The provider has agreed to accept the Allowable Amount as payment.) The option then pays 80% of the Allowable Amount, and you pay the other 20% of the Allowable Amount.
- When you receive care from Out-of-Network providers, the provider bills the option at the provider's regular rate. The option calculates what the Non-Contracting Allowable Amount would be and pays 60% of that amount. Since the providers have not agreed to accept the Allowable Amount as payment, you are responsible for paying the entire remaining amount (which usually will be greater than 40% of the bill).

Here's an example: Say you have health care charges of $1,000. Under the Network, the Allowable Amount is $700 and the Non-Contracting Allowable Amount is $500. Assuming you've met any Deductible requirements and the option pays 80% In-Network and 60% Out-of-Network, payments would be:

	In-Network	Out-of-Network
Full charge	$1,000	$1,000
Allowable Amount	$700	$500 (Non-Contracting)
Option pays percentage of Allowable Amount	80% of $700 = $560	60% of $500 = $300
You pay remainder	$700 – $560 = $140	$1,000 – $300 = $700

In this example, you pay $140 if you receive services from In-Network providers, or you pay $700 if you receive services from Out-of-Network providers. Note that this is a very simple example to show how the concept works. The actual negotiated Network Allowable Amounts may vary depending on the physician's billing practices and the geographic area. The percentage the option pays also may vary depending on the type of expense.

About Covered Charges

The option pays benefits for services and supplies that are specifically covered by the option. Covered charges are shown on the ***Fact Sheet*** in this section for your medical option. To be covered, a medical service must also be Medically Necessary.

Medical Options: Incentive Opportunities

Oncor makes automatic contributions to both the HSA Medical Option and the HRA Medical Option. You may make pre-tax contributions to the HSA if you choose that option.

In both options, you can earn incentives based on certain wellness and preventive actions you and, in some cases, your spouse complete within certain timelines.

Refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information.

In addition, you may be eligible to earn Member Rewards when you shop for certain medical procedures. Call a Health Advocate or log in to Blue Access for Members (BAM) to learn more.

BCBSTX participants will also have access to medical and surgical decision support services through Consumer Medical. Participants who engage in surgical decision support services for certain elective surgeries will be eligible for an incentive. (See ***About Medical and Surgical Decision Support Services*** in this section of the handbook.) These incentives are subject to applicable income taxes.

Annual Physical with Biometric Screening Incentive

When you have your biometric screening at your physician's office, take a *Physician Results Form* with you. Your doctor must then fax the completed form to the number shown on the form.

A *Physician Results Form*:

- Can be downloaded from the intranet or from **oncorbenefits.com/ee**, and
- Is available on the Oncor intranet at ***Live Well/Benefits/Annual Enrollment.***

To confirm that your completed *Physician Results Form* has been received and/or check your health risk factors, you can call Navigate, the Incentive Information provider, at **1.888.596.6750** or email **Info@oncorlivewell.com**.

Fact Sheet: Overview of the HSA and HRA Medical Options

	HSA Medical Option		HRA Medical Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Network/Provider Choice	You can go to any doctor you choose, but your benefits will be higher when you use In-Network providers. Utilizes the Blue Cross and Blue Shield of Texas (BCBSTX) PPO Network			
Deductible	Refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information.			
> You Only				
> Family				
Coinsurance Maximum				
> You Only				
> Family				
Out-of-Pocket Maximum				
> You Only				
> Family				
	Plan Pays			
Physician's Services				
> Doctor's office visits for illness or injury > Specialist's office visits for illness or injury > Consultation services of a physician or other professional provider	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
Adult Preventive Care				
> Annual physical exam – one exam per calendar year > Cardiovascular screening > Prostate cancer screening after age 40, including digital rectal exam and PSA – one per year > Well-woman exam – one exam per year (includes one Pap test each year) > Mammogram – one per year > Immunizations (includes immunizations for travel) > Female sterilization	100% (No Deductible)	100% of the Non-Contracting Allowable Amount (No Deductible)	100% (No Deductible)	100% of the Non-Contracting Allowable Amount (No Deductible)

	HSA Medical Option		HRA Medical Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Preventive Care *(continued)*				
> Colorectal cancer screening after age 50, including annual fecal occult blood testing, 5-year sigmoidoscopy, or 5-year colonoscopy **Note:** 1 colonoscopy or sigmoidoscopy is covered every 5 years.	100% (No Deductible) when billed as routine/preventive. These services, when billed as diagnostic, will be subject to Deductible and Coinsurance.		100% (No Deductible) Regardless if billed as preventive/routine or diagnostic	
	Plan Pays			
Well-Baby/Well-Child Preventive Care				
> Pediatric exams > Immunizations, including: – Immunizations for travel – Routine immunizations: diphtheria, Haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization that is legally required for the child > Screening test for hearing during the first 31 days following birth, and necessary diagnostic follow-up care related to the screening test until the child reaches age 2	100% (No Deductible)	100% of the Non-Contracting Allowable Amount (No Deductible)	100% (No Deductible)	100% of the Non-Contracting Allowable Amount (No Deductible)
Inpatient Hospital Care				
> Hospital room and board up to the semiprivate room rate (precertification required)	80% after you meet Deductible	60% after you meet Deductible, penalty for no precertification	80% after you meet Deductible	60% after you meet Deductible, penalty for no precertification
> Intensive care unit > Services and supplies provided by the hospital during confinement, such as medicines, lab tests, use of operating rooms and special equipment, and anesthetics and their administration > Inpatient physician's and surgeon's services > Consultations > Physical therapy, anesthesia, blood transfusions (if not replaced), and treatment of pulmonary tuberculosis	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Renal dialysis	80% after you meet Deductible	Not covered	80% after you meet Deductible	Not covered
> Private duty nursing	80% after you meet Deductible			

	HSA Medical Option		HRA Medical Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays			
Inpatient Hospital Care *(continued)*				
> Organ transplants > Cosmetic, reconstructive, or plastic surgery: – To correct an injury that occurs while the patient is enrolled in the option – Following cancer surgery – To treat or correct a congenital defect for a newborn – To treat or correct a congenital defect (other than conditions of the breast) for a Dependent child – To correct craniofacial abnormalities, improve functioning, or create a normal appearance from a congenital defect, trauma, tumor, infection, or disease for a Dependent child under age 19 – Following mastectomy	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
Outpatient Care				
> Outpatient surgery > Services and supplies provided for outpatient treatment at a hospital, ambulatory surgical facility, or radiation therapy center > Second surgical opinions when you want to confirm the need for surgery > Laboratory, X-ray, and other diagnostic procedures > Anesthetics and their administration, when administered by someone other than the operating physician > Services of a certified registered nurse-anesthetist (CRNA) > Radiation therapy > Oxygen and its administration, provided the oxygen actually is used > Blood, blood plasma, and blood plasma expanders, when not replaced by or for the patient > Injectable drugs administered by or under the direction of a physician or other professional provider > Professional local ground or air ambulance service to the nearest hospital appropriately equipped for treatment of the patient's condition > Urgent care clinic visit > Physical therapy, speech therapy, occupational therapy, and other physical medicine services	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Emergency room. If possible, contact your In-Network physician before going to the ER to determine if Emergency Care is needed.	80% after you meet Deductible			

	HSA Medical Option		HRA Medical Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays			
Care in Other Settings				
> Home health care for chronically ill or disabled patients. Services must be provided by a qualified nurse or fully licensed therapist. Services provided by relatives or persons living with you are not covered. You must precertify home health care before services begin. Custodial Care is not covered. Skilled nursing facility expenses include: – Room and board, equipment, routine services and supplies, and usual nursing services. (Nursing services must be provided by RNs, LPNs, or APNs.) – Physical, occupational, speech, and respiratory therapy by licensed therapists. > Admission requires precertification. Custodial Care is not covered. > Home infusion therapy (precertification required)	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Hospice care (precertification required)	100% after you meet Deductible	60% after you meet Deductible	100% (No Deductible)	60% after you meet Deductible
Family Planning/Maternity Care				
> Office visits (prenatal and postnatal)	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> In-hospital delivery services (precertification required) **Note:** The option does not limit childbirth-related hospital stays to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section. In addition, the option does not require a provider to receive authorization for any length of stay that is less than the above period.	80% after you meet Deductible	60% after you meet Deductible, penalty for no precertification	80% after you meet Deductible	60% after you meet Deductible, penalty for no precertification
> Newborn nursery services, including initial exam > Services and supplies provided by a birthing center when low-risk pregnancy > Midwife services (must be licensed and certified) > Infertility services (diagnosis and testing only) > Outpatient contraceptive services and devices > Male sterilization services (vasectomy)	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Maternity coverage for Dependent children – Normal pregnancy	No coverage except for complications of pregnancy			
– Complications of pregnancy	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Maternity coverage for surrogate and gestational surrogate pregnancies	No coverage			

	HSA Medical Option		HRA Medical Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays			
Other Services and Supplies				
> Chiropractic services. Note that lab and X-ray charges related to chiropractic treatment are covered under "Outpatient Care."	80% after you meet Deductible, for up to 25 visits per year (combined In-Network and Out-of-Network)	60% after you meet Deductible, for up to 25 visits per year (combined In-Network and Out-of-Network)	80% after you meet Deductible, for up to 25 visits per year (combined In-Network and Out-of-Network)	60% after you meet Deductible, for up to 25 visits per year (combined In-Network and Out-of-Network)
> Surgical treatment of temporomandibular joint (TMJ) disorder. (Non-surgical treatments are not covered.) > Foot care and orthotics > Allergy tests and treatments > Treatment of acquired brain injury, including neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing, treatment, and remediation	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Bariatric surgery (after meeting precertification requirements)	80% after you meet Deductible	Not covered	80% after you meet Deductible	Not covered
> Treatment of diabetes, including: – Podiatric appliances to prevent complications of diabetes – Diabetic management services and diabetes self-management training when ordered by your physician Note that insulin and supplies are covered under the Prescription Drug Program. > Rental of durable medical equipment (such as wheelchairs and hospital beds) > Orthopedic braces and crutches, casts, and special surgical and back corsets > Dressings, bandages, trusses, and splints that are custom designed to assist joint function (when prescribed, directed, or applied by a physician) > Prosthetic appliances, including replacements needed because of a patient's growth to maturity > Dietary formulas for treatment of phenylketonuria (PKU) or other heritable diseases > Reduction mammoplasty covered if Medically Necessary	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible

	HSA Medical Option		HRA Medical Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays			
Other Services and Supplies *(continued)*				
> Wigs (if required due to a medical condition)	80% after you meet Deductible, up to $500 per calendar year (combined In-Network and Out-of-Network)	60% after you meet Deductible, up to $500 per calendar year (combined In-Network and Out-of-Network)	80% after you meet Deductible, up to $500 per calendar year (combined In-Network and Out-of-Network)	60% after you meet Deductible, up to $500 per calendar year (combined In-Network and Out-of-Network)
Hearing Care				
> Routine hearing exam	100% (No Deductible)	100% of the Non-Contracting Allowable Amount (No Deductible)	100% (No Deductible)	100% of the Non-Contracting Allowable Amount (No Deductible)
> Hearing therapy	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Hearing aids	80% after you meet Deductible, 1 pair every 36 months	60% after you meet Deductible, 1 pair every 36 months	80% after you meet Deductible, 1 pair every 36 months	60% after you meet Deductible, 1 pair every 36 months
Dental Care				
> Treatment of accidental injury to healthy unrestored natural teeth and supporting tissues. Treatment must be completed within 24 months following the initial treatment. Injuries due to biting or chewing are not covered. > Surgical removal of tumors, cysts, and fully bony impacted teeth when Medically Necessary > Services to treat or correct a congenital defect for a newborn child	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
Routine Vision Care				
> Routine vision exam – 1 exam per calendar year	100% (No Deductible)	100% of the Non-Contracting Allowable Amount (No Deductible)	100% (No Deductible)	100% of the Non-Contracting Allowable Amount (No Deductible)
> Vision hardware, eyeglass lenses and frames, and contact lenses	Not covered			

	HSA Medical Option		HRA Medical Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays			
Mental Health and Chemical Dependency (BCBSTX)				
> Mental health – Outpatient	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Mental health – Inpatient (precertification required)	80% after you meet Deductible	60% after you meet Deductible, penalty if no precertification	80% after you meet Deductible	60% after you meet Deductible, penalty if no precertification
> Chemical dependency – Outpatient	80% after you meet Deductible	60% after you meet Deductible	80% after you meet Deductible	60% after you meet Deductible
> Chemical dependency – Inpatient (precertification required)	80% after you meet Deductible	60% after you meet Deductible, penalty if no precertification	80% after you meet Deductible	60% after you meet Deductible, penalty if no precertification

Charges That Are Not Covered

Although the options cover most health care expenses, they do not cover all medical charges. The following charges are not covered under the HSA Medical Option or HRA Medical Option:

- A diagnosis of gender dysphoria is required to receive counseling services, gender transformation surgery, and other services based on medical necessity,
- Allergy and specific non-standard allergy services and supplies including, but not limited to, skin titration, cytotoxicity testing treatment of non-specific candida sensitivity, and urine autoinjections,
- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in this handbook,
- Any non-emergency charges incurred outside the United States if you traveled to such location to obtain prescription drugs or supplies,
- Artificial organs including any device intended to perform the function of a body organ,
- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood-derived clotting factors,
- Charges submitted for services by an unlicensed hospital, physician, or other provider, or not within the scope of the provider's license,
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the option,
- Cosmetic services and plastic surgery, including treatment, surgery, service, or supplies to alter, improve, or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons,
- Costs for services resulting from the covered person's commission of or attempt to commit a felony,
- Counseling services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counseling,
- Court-ordered services, including those required as a condition of parole or release,
- Custodial Care,
- Dental services, including any treatment, services, or supplies related to the care, filling, removal, or replacement of teeth, and treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth (unless services or treatment is medical in nature),
- Disposable outpatient supplies or devices, including sheaths, bags, elastic garments, support hose, bandages, bedpans, blood or urine testing supplies (except Glucometers), and other home test kits (except diabetic supplies); splints, neck braces, compresses, and other devices not intended for reuse by another patient,
- Drugs, medications, supplies, and services covered under the CVS Caremark Pharmacy Plan are not covered under the medical option,
- Educational services and supplies related to training or retraining services, or testing, including evaluation or treatment of learning disabilities and other developmental, learning, and communication disorders, behavioral disorders, training, or cognitive rehabilitation,
- Examinations and treatments required to obtain employment, required by any law of a government, required for securing insurance or school admissions, required for professional or other licenses, required to travel, or required to attend a school, camp, or sporting event, or participate in a sport or other recreational activity,
- Experimental or investigational drugs, devices, treatments, or procedures,
- Facility charges for care, services, or supplies provided in rest homes, assisted-living facilities or similar institutions, health resorts, spas, sanitariums, or infirmaries at schools, colleges, or camps,
- Food items such as infant formulas, nutritional supplements, vitamins, medical foods, and other nutritional items, even if the sole source of nutrition,
- Growth aids, including any treatment, device, drug, service, or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones,
- Hearing services or supplies that do not meet professionally accepted standards or hearing exams given during a stay in a hospital or other facility,

Charges That Are Not Covered *(continued)*

- Home birth services and supplies relating to childbirth occurring in the home or in a place not licensed to perform deliveries,
- Home uterine activity monitoring,
- Home, workplace, or any other environment or vehicle alterations, including bathroom equipment, exercise equipment, air purifiers, air conditioners, water purifiers, waterbeds, pools, whirlpool pumps, sauna baths, equipment or supplies to aid sleeping, transportation devices, including stair-climbing wheelchairs or personal transporters, or any vehicle or other transportation device,
- Infertility services, treatments, procedures, or supplies that are designed to enhance fertility or the likelihood of conception have a lifetime limit of $15,000 medical and $5,000 prescription drug expenses,
- Maternal health care services for surrogate and gestational surrogate pregnancies,
- Medicare or payment for that portion of the charge for which Medicare or another party is the primary payer,
- Miscellaneous charges, such as charges to be in a physician's practice or to have preferred access to physician services, charges for canceled or missed appointments, or charges the recipient has no legal obligation to pay,
- Non-Medically Necessary services, including but not limited to, those treatments, services, prescription drugs, and supplies that are not Medically Necessary, as determined by BCBSTX or CVS Caremark, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services (even if prescribed, recommended, or approved by your physician),
- Nursing or home health aide services provided outside the home (such as in conjunction with school, vacation, work, or recreational activities),
- Personal comfort and convenience items and services, including telephones, televisions, barber/beauty services, housekeeping, cooking, cleaning, shopping, security, or other home services,
- Private duty nursing during your stay in a hospital and outpatient private duty nursing services except as specifically described elsewhere in this handbook,
- Services and supplies provided in connection with treatment or care that is not covered under the option,
- Services, devices, and supplies to enhance strength, physical condition, endurance, or physical performance,
- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage under the option, unless coverage is continued under COBRA,
- Services of a resident physician or intern rendered in that capacity,
- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law, or any household member,
- Services provided where there is no evidence of pathology, dysfunction, or disease except as specifically provided in connection with covered routine care and cancer screenings,
- Sexual dysfunction or sexual enhancement treatments, drugs, services, or supplies, including surgery, drugs, implants, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; sex therapy, sex counseling, marriage counseling, or other counseling or advisory services,
- Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body, or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine,
- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate),
- Transportation costs for routine transportation to receive outpatient or inpatient services,

Charges That Are Not Covered *(continued)*

- Unauthorized services, including any service obtained by or on behalf of a covered person without precertification by BCBSTX when required. This exclusion does not apply in a medical emergency or in an urgent care situation.
- Vision-related services and supplies are not covered under the medical options.
- Over-the-counter weight-loss treatments, drugs, or supplies intended to decrease or increase body weight or control weight, or
- Work-related illness or injuries related to employment or self-employment, including any injuries that arise out of any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state, or federal law.

SCOTT & WHITE HEALTH PLAN OPTION

Scott & White Health Plan Participation

The Scott & White Health Plan (SWHP) Option may be available to you if you live in a geographic area where it is offered. Additionally, the SWHP Option is only available if you were covered under this option before January 1, 2015, and continued your coverage under it.

The SWHP Option is frozen to every new participant, effective January 1, 2015.

If you elect the SWHP Option, you will receive prescription drug coverage under the CVS Caremark Prescription Drug Program.

If you select SWHP coverage, the coverage applies to you and all your family members. You can't enroll some members under SWHP and others under another medical option.

The SWHP Option is an insured HMO, which is fully administered by Scott & White. Documentation describing the benefits available under, and other important information about, the SWHP Option is available from Scott & White, and will be provided to you by Scott & White if you are currently a participant or upon your request to Scott & White. This information regarding the SWHP Option is incorporated in and made a part of this summary plan description. To receive this information, you can:

- Contact Scott & White directly at **1.800.321.7947** or by logging on to **swhp.org**, or
- Contact the Oncor HR Service Center at **1.888.565.8803** or by logging on to **oncor.ultipro.com**.

PRESCRIPTION DRUG COVERAGE

When you enroll in a medical option, you also receive prescription drug coverage through CVS Caremark.

CVS Caremark Pharmacy Benefits

The Prescription Drug Program covers charges for outpatient prescription drugs for the treatment of an illness or injury, subject to certain limitations and exclusions. Prescriptions must be written by a licensed prescriber.

Your prescription drug benefit coverage is based on CVS Caremark's preferred drug guide (formulary). The preferred drug guide includes both preferred and non-preferred brand-name prescription drugs and value/preventive generic prescription drugs and other generic prescription drugs. Your Coinsurance/Copayment expenses may be higher if your physician prescribes a covered prescription drug not appearing on the preferred drug guide. Generic prescription drugs may be substituted by your pharmacist for brand-name prescription drugs. You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available.

Coverage of prescription drugs may, in CVS Caremark's sole discretion, be subject to CVS Caremark requirements or limitations. Prescription drugs covered by this program are subject to drug utilization review by CVS Caremark and/or your provider and/or your Network pharmacy. For example, some prescriptions may have to be approved prior to being covered by the option. This is called prior authorization.

The benefits provided by the Prescription Drug Program vary somewhat depending on the medical option you choose. For details about how prescriptions are covered, see the ***Fact Sheet: Overview of the HSA and HRA Prescription Drug Coverage Options*** in this section for your specific medical option.

Generally, the program covers drugs and medicine that require a prescription and can be obtained only through a licensed pharmacy. The program does not cover medical supplies or over-the-counter medications, such as cough syrup or cold remedies, even if your doctor prescribes them.

The Prescription Drug Program has contracted with Network providers to fill Oncor employees' prescriptions at lower rates. To receive the highest benefits, it's important that you use In-Network providers. The only exception is if you or your covered Dependent needs an emergency prescription and a participating pharmacy is not available. In that case, you may submit a paper claim for reimbursement.

Drugs and medicines that you receive during a hospital admission are covered under your medical option instead of the prescription drug program.

If you have a job-related medical condition, your prescriptions should be considered for coverage under workers' compensation instead of the prescription drug program.

Retail Pharmacy Benefits

You can purchase both short-term (30-day or less) supplies and long-term (90-day maintenance drugs) through a Network retail pharmacy.

To purchase a prescription at a Network retail pharmacy:

- Present your CVS Caremark ID card when you pick up your prescription.
- Pay any Deductibles, Coinsurance amounts, or Copayments required, based on your medical option and whether you purchase a generic, value/preventive generic, preferred brand, or non-preferred brand drug. If you participate in:
  - **The HSA Medical Option.** You can use your HSA debit card or pay from your pocket if you want to save your HSA dollars.
  - **The HRA Medical Option.** Simply present your ConnectYourCare card when you're at the pharmacy and the correct amount will automatically be deducted from your HRA (if funds are available).

Tips on Using Your ConnectYourCare Or HSA Debit Card

Here are some tips for making the best use of your ConnectYourCare or HSA Debit card:

- **You can choose Debit or Credit when you swipe your card.** If you set up a four-digit PIN (recommended for security), you will need to choose the **Debit** option.
- **Use your card only for eligible health care expenses.** Separate health care items from any other items that you're purchasing (such as food, cosmetics, and magazines). Pay the health care expenses with your card and pay for other items separately.
- **Save your itemized receipts.** Receipts must show the date, the name of the item purchased, and the cost. An Explanation of Benefits (EOB) statement is also valid documentation. As required by the IRS, this documentation substantiates your purchase – meaning it shows that your purchase is eligible to be paid from your account. You do not have to submit receipts or EOBs to BCBSTX when using your card.

If You Want to Use the Mail Order Pharmacy Benefits for Maintenance Prescriptions

Each prescription is limited to a maximum 90-day supply when filled at a Network mail-order pharmacy. Prescriptions for less than a 30-day supply or more than a 90-day supply are not eligible for coverage when dispensed by a Network mail-order pharmacy.

You can use the mail-order service if you take maintenance medication for ongoing conditions like diabetes or high blood pressure:

- Complete the mail-order form.
- Include a check or your debit or credit card information for your payment (the amount you pay is based on whether you purchase a generic, preferred brand, or non-preferred brand drug).
- Mail your completed order form (along with your prescription and payment). Use the special mail-order envelope contained in your prescription drug package. The address also is listed on the order form.
- Your prescription will be mailed to your home. (It usually takes about 7 to 10 days to receive your prescription.)

Specialty Guideline Management and Step Therapy Program

The Specialty Guideline Management Program reviews the use of specialty medicines to make sure they are safe, clinically appropriate, and cost-effective. As part of this program, CVS Caremark will work with your doctor to review your medicine and treatment plan and decide whether they meet drug-specific guidelines. Clinical information from your doctor is often necessary to complete the review. Following approval, you can look forward to immediate access to CVS Caremark's specialty pharmacy.

This program is designed to provide the personalized care, education, and support needed for you to get the full benefit of your treatment with specialty medicines. Services include:

- Access to an on-call pharmacist 24 hours a day, seven days a week,
- Coordination of care with you and your doctor,
- Convenient delivery directly to you or your doctor's office,
- Medicine- and disease-specific education and counseling, and
- Online support at **cvsspecialty.com**, including disease-specific information and interactive areas to submit questions to pharmacists and nurses.

Certain brand medications are subject to the Step Therapy Program, which means a more cost-effective generic drug must be tried first before the plan will cover the brand-name medication. The list of brand medications that require step therapy can be found on **caremark.com**. This list is periodically updated, based on new generic drug availability.

Questions? Call CVS Caremark at **1.866.339.0593** to get connected to this program. This phone number is also on the back of your insurance ID card.

About Generic, Preferred Brand, and Non-Preferred Brand Drugs

Your prescription drug coverage includes coverage for generic drugs and drugs listed on the formulary (preferred drug guide) for both the retail and mail-order programs.

- A generic drug is a chemical copy of a brand-name prescription drug. It must contain the same active ingredients and be equivalent in strength and dosage to its brand-name counterpart. It is subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength, and purity as its brand-name counterpart. Generally, generic drugs cost 30% to 60% less than their brand-name counterparts because manufacturers of generic drugs don't have to pay for research and development or marketing and advertising.
- A formulary (preferred drug guide) is a list of frequently prescribed preferred brand medications for which the program has negotiated preferred pricing. As a result, prescriptions for preferred brand medications are more cost-effective. Physicians and pharmacists develop and evaluate the formulary list. Visit **caremark.com** to find the formulary. The formulary may change from time to time.

If your doctor wants your prescription to be filled only with a brand-name drug, he or she must indicate that by writing "Dispense as Written" (DAW) on the prescription slip. If your doctor has not written DAW on the prescription slip, but you choose the brand-name drug when a generic is available, you will pay the cost difference between the generic and brand, plus any applicable Deductible, Coinsurance amount, or Copayment. For some medical options, the amount you must pay is limited by a maximum Copayment.

Accessing Network Pharmacies

You can select a Network pharmacy from the CVS Caremark Network Pharmacy Directory or by logging on to CVS Caremark's website at **caremark.com**. If you cannot locate a Network pharmacy in your area, you should call CVS Caremark member services at **1.866.339.0593**.

To be eligible for Network benefits, you must present your CVS Caremark ID card to the Network pharmacy every time you get a prescription filled. The Network pharmacy will calculate your claim online. You will pay any Deductible, Coinsurance percentage, or Copayment directly to the Network pharmacy.

CVS Caremark will pay the Network pharmacy the Plan share for a covered expense. You do not have to complete or submit claim forms. The Network pharmacy will take care of claim submission.

Covered Charges – Prescription Drug Program

The Prescription Drug Program covers drugs and medications that are Medically Necessary and prescribed by a physician, such as insulin and diabetic supplies, cholesterol and legend drugs. For proton pump inhibitors (PPI – prescribed to reduce gastric acid), a Step Therapy Program requires you to try a lower-cost generic drug first and progress to other more costly brand-name drugs only if necessary.

The Prescription Drug Program pays benefits based on the formulary. **Note:** Out-of-Network prescriptions are not covered except in case of an emergency.

Fact Sheet: Overview of the HSA and HRA Prescription Drug Coverage Options

The Copayments and maximums for specific types of medication are subject to change. Refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information.

Prescription Drug (Rx) Coverage	HSA Medical Option In-Network You Pay	HRA Medical Option In-Network You Pay
Rx Deductible		
> You Only	Included in medical Deductible	Refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information.
> Family		
Coinsurance/Copayment Maximum		
> You Only	Included in medical Out-of-Pocket Maximum	Refer to *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment for specific information.
> Family		
Retail (up to a 30-day supply)		
> Value/preventive generic	$5 Copay(1)	$5 Copay(1)
> All other generic	20% after annual option Deductible	$10 Copay(1)
> Preferred brand name(2)	20%, up to $75 max per Rx after annual option Deductible	30%, up to $100 max per Rx after Rx Deductible
> Non-preferred brand name(2)	20%, up to $120 max per Rx after annual option Deductible	40%, up to $120 max per Rx after Rx Deductible
Mail Order (up to a 90-day supply)		
> Value/preventive generic	$10 Copay(1)	$10 Copay(1)
> All other generic	20% after annual option Deductible	$20 Copay(1)
> Preferred brand name(2)	20%, up to $150 max per Rx after annual option Deductible	30%, up to $200 max per Rx after Rx Deductible
> Non-preferred brand name(2)	20%, up to $240 max per Rx after annual option Deductible	40%, up to $240 max per Rx after Rx Deductible
Lifetime Maximum Medical and Rx Benefit	Unlimited	

(1) No Deductible.

(2) If you are taking a brand prescription with a generic equivalent and do not switch to the generic, you will pay the generic Copayment, plus the difference between the price of the generic and brand name drug.

What the Prescription Drug Benefits Do Not Cover

Although prescription drug benefits can help you pay many of your prescription drug expenses, certain types of expenses are not covered. Here are some examples of specific types of prescription drug expenses the program does not cover:

- The amount above the option share of the Allowed Amount for emergency services,
- A diagnosis of gender dysphoria is required to receive certain prescription drug benefits based on medical necessity,
- A drug labeled "Caution – limited by federal law to investigational use" or an experimental drug, even though a charge is made to the individual,
- All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a prescription drug,
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order,
- Biological sera, blood, blood plasma, blood products or substitutes, or any other blood products,
- Certain immunizations (which may be covered under the Oncor medical option),
- Charges for the administration or injection of any drug (may be covered under the Oncor medical option),
- Dental fluoride products,
- Drugs, services, and supplies provided in connection with treatment of an occupational injury or occupational illness,
- Drugs used for the purpose of weight gain or reduction, including but not limited to, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants, and other medications,
- Drugs used for the treatment of obesity,
- Durable medical equipment, monitors, and other equipment,
- Embryo transfer procedures,
- Experimental or investigational drugs or devices; this exclusion will not apply with respect to drugs that:
  - Have been granted treatment investigational new drug (IND) or group/treatment IND status; or
  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
  - CVS Caremark determines, based on available scientific evidence, that the drugs are effective or show promise of being effective for the illness.
- Food items, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods, and other nutritional items,
- Homeopathics,
- Immune/gamma globulins,
- Infertility services, treatments, procedures, or supplies that are designed to enhance fertility or the likelihood of conception have a lifetime limit of $15,000 medical and $5,000 prescription drug expenses,
- Inhaler spacers,
- Levonorgestrol (Norplant®),
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals,
- Mifeprex®,
- Minoxidil (Rogaine®) for treatment of alopecia, or any drugs whose sole purpose is to promote or stimulate hair growth, or is for cosmetic purposes only,
- Needles and syringes (these are covered under the Oncor medical option rather than the Prescription Drug Program),
- Non-legend drugs other than insulin,
- Ostomy supplies (covered under the Oncor medical option),

What the Prescription Drug Benefits Do Not Cover *(continued)*

- Over-the-counter contraceptive supplies, including but not limited to, condoms, foams, jellies, and ointments, and services associated with the prescribing, monitoring, and administration of contraceptives,
- Prescription drugs, medications, injectables, or supplies provided through a third-party vendor contract with the contract holder,
- Prescriptions that an eligible person is entitled to receive without charge, including but not limited to, those paid under workers' compensation laws,
- Replacement of lost or stolen prescriptions,
- Strength and performance drugs, preparations, devices, and supplies to enhance strength, physical condition, endurance, or physical performance, including performance-enhancing steroids,
- Sexual dysfunction supplies or supplies to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ,
- Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of their intended use, and
- Tretinoin, all dosage forms (e.g., Retin-A) for individuals age 36 and older.

If You Have Questions

Contact CVS Caremark at **1.866.339.0593** or **caremark.com** to:

- Find a participating retail pharmacy,
- Replace your ID card,
- Check whether a drug is a preferred brand drug, or
- Ask any other questions about the program.

The estimated cost of a particular drug can be obtained by accessing the CVS Caremark website at **caremark.com**.

SPECIAL MEDICAL BENEFIT FEATURES

Reconstructive Surgery After Mastectomy

Participants in All Medical Options

If you or your Dependent receives medical benefits for a mastectomy, coverage will include reconstructive surgery after the mastectomy, as follows:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

Authorization must be secured with the Claims Administrator for certain reconstructive procedures. Deductibles, Coinsurance amount, and Copayments are the same as those for other medical and surgical benefits under your medical option.

Health and Wellness Programs

If you participate in a BCBSTX medical option, you can access Health Advocacy Solutions (HAS) by calling **1.877.213.6898**. The HAS Customer Service Representatives can assist you with your questions using a holistic approach to health management, and they will help you use the appropriate Oncor programs that are available to you, including:

- Medical and Surgical Decision Support Services, an enhancement to Consumer Medical,
- MDLIVE, which allows you to access care for non-emergency medical issues, 24 hours a day, seven days a week through a convenient virtual service,
- Tobacco cessation program, which helps you quit using tobacco for good, and the Live Well Program explained in your Annual Enrollment materials,
- Weight management program, which gives you tips and resources to maintain a healthy weight,
- BCBSTX Nurseline, which provides answers to your health questions 24 hours a day, seven days a week, and
- Women's and Family Health Program.

Information about additional programs available through HAS can be accessed online at **bcbstx.com**.

About Medical and Surgical Decision Support Services

With these services, you can access expert medical opinion assistance through Consumer Medical.

Consumer Medical can help you understand your medical condition and treatment options, recommend the best doctors and hospitals in your area, and assist you in getting a second opinion.

If you participate in the Scott & White Health Plan (SWHP) Option, you can access the Vital*Care* Program, combining individual health support with personalized lifestyle management programs and vital information to help you take charge of your health. Vital*Care* is available to all employees and Dependents enrolled in the SWHP Option. Services available through this program include:

- Access to a Health Coach 24 hours a day, 7 days a week to answer questions and provide you with health information on more than 65 diseases and conditions,
- Nurse Advice Line,
- Dialog Center, an online health and wellness site that complements personal health coaching,
- Vital*Care* Health Risk Assessment (Succeed®), designed to identify basic information about your health, providing you with a personalized report that consists of explanations and advice, based on your responses, to help you with your health choices, and
- Lifestyle Management Programs, individual personalized plans that fit your life. Choose from a variety of programs, including Relax®, Nourish®, Breathe®, Balance®, Care for Your Back®, and more.

Home Health Care

Participants in HSA and HRA Medical Options

Home health care is care you receive at home, usually following a hospitalization. The medical options cover home health care expenses if all of the following requirements are met:

- Charges are made by a home health care agency,
- Care is provided according to a home health care treatment plan, and
- Care is provided to a covered patient in his or her home.

Home health care charges include the following services and supplies:

- Part-time or intermittent care by an RN, or by an LPN if an RN is not available,
- Part-time or intermittent home health aide services for patient care,
- Physical, occupational, respiratory, and speech therapy, and
- Medical supplies, drugs, and medicine provided by a physician, and lab services provided by the home health care agency (note that these services and supplies are covered only if they would have been covered by the option during inpatient hospital or convalescent facility confinement).

Home health care benefits do not cover services or supplies that are not part of the home health care treatment plan. They also do not cover services provided by family members, persons who usually live with the patient, social workers, or homemakers. Transportation expenses also are not covered. Note that other medical services and supplies used during home health care (for example, durable medical equipment) may be covered under the provisions in other parts of the medical options.

Hospice Care

Participants in HSA and HRA Medical Options

Hospice care is intended for patients whose life expectancy is six months or less. It is directed at providing comfort and relief (not treatment or a cure) for a terminal illness.

Hospice care may be provided in a patient's home or in a special hospice facility. However, it must be provided through a licensed hospice care agency under a formal program prescribed by a physician. Covered services include patient comfort, psychological counseling for patients and their families, and medication administration.

You must precertify hospice care before services begin.

Services and supplies typically billed through a hospice include the following:

- Inpatient care,
- Nutritional counseling and special meals,
- Part-time nursing,
- Homemaker services, and
- Bereavement counseling for immediate family members during the six-month period following the patient's death. (Immediate family members include husband, wife, and children.)

These options cover the following hospice services provided at home:

- Part-time or intermittent nursing care by an RN, APN, or LVN,
- Part-time or intermittent home health aide services,
- Physical, speech, or respiratory therapy by licensed therapists, and
- Homemaker and counseling services routinely provided by the hospice agency, including bereavement counseling.

These options cover the following hospice services provided by a hospice care facility:

- Room and board, equipment, routine services and supplies, and usual nursing care by RNs, APNs, and LVNs, and
- Physical, speech, and respiratory therapy by licensed therapists.

The following items, while possibly part of hospice services, are NOT eligible for separate coverage:

- Food or home-delivered meals, such as Meals on Wheels,
- Homemaker or housekeeping services,
- Transportation services,
- Respite Care services, such as hospitalization to provide caregivers with a rest period, and
- Traditional curative care services for treatment of the terminal illness, condition, disease, or injury.

Organ Transplants

Participants in HSA and HRA Medical Options

You must precertify an organ or tissue transplant before you start treatment. The medical options pay benefits for human organ transplants listed in the chart below.

What's Covered

- Bone marrow,
- Heart,
- Kidney,
- Liver,
- Pancreas,
- Bone marrow/stem cell,
- Heart/lung,
- Kidney/pancreas, and
- Lung.

What's Not Covered

The medical options do not cover:

- Experimental or investigational treatments,
- Expenses related to maintaining the life of a donor for purposes of organ or tissue donation,
- Organs obtained from other species, and
- Acquisition costs of organs.

Benefits include evaluation and surgical removal of the donated organ from a living or non-living donor. If a living donor is not covered by your option, the option covers remaining charges after any benefits are paid from the donor's group or individual insurance. Covered expenses include the following:

- Organ or tissue procurement from a cadaver, consisting of removing, preserving, and transporting the donated part,
- Services and supplies furnished by a facility provider,
- Treatment and surgery by a professional provider,
- Drug therapy treatment to prevent rejection of the transplanted organ or tissue, and
- Donor search and acceptability testing of potential live donors.

When bone marrow transplants are covered, the medical options pay benefits for the following services related to the bone marrow transplant, provided the services are performed to treat a covered condition and there is the right match of genetic markers:

- Services to transplant the bone marrow of another person into the patient or to transplant the patient's own bone marrow and/or peripheral blood stem cells,
- Blood tests for family members who are approved by your medical option to evaluate potential donors (provided the donor's plan does not cover the tests), and
- The harvesting of marrow and/or blood stem cells.

Note to BCBSTX participants: When transportation and lodging expenses are paid, the option will reimburse these costs for the patient and one companion, as shown in the chart below.

Travel and Lodging Benefits	BCBSTX
Required distance from transplant facility	No requirements/limitations
Number of companions	One
Maximum daily lodging benefit per person	$50 (lodging only)
Maximum travel benefits per surgery	$10,000

Covered expenses include the following:

- Transportation for the patient and one companion traveling on the same day(s) to or from the site of the transplant for the evaluation, transplant procedure, or necessary post-discharge followup, and
- Reasonable and necessary expenses for lodging for the patient (while not hospitalized) and one companion, as shown in the chart above.

MANAGING MEDICAL COSTS

The medical options have a number of features that help Oncor manage medical costs.

Mandatory Precertification Review of Hospital Stays and Other Treatment

Before you or a covered Dependent receives certain types of treatment (such as an overnight hospital admission), you may be required to have the treatment reviewed in advance by the Claims Administrator.

Terminology

Depending on your medical option, the precertification process may be referred to as preauthorization, preadmission review, or preservice claims.

You or your provider must precertify the following:

- All inpatient hospital stays,
- All inpatient mental health and chemical dependency hospital stays (you or your provider should precertify these stays through the mental health/chemical dependency administrator – BCBSTX or Scott & White),
- All skilled nursing facility stays,
- Hospice care,
- Home health care,
- Home infusion therapy,
- All organ and tissue transplants, and
- Weight reduction and bariatric surgery.

Claims Review Process

To ensure that you receive the care you need on a timely basis, precertification reviews and concurrent reviews have special timing requirements under the claims review procedures, as described in the **Plan Administration** section of this handbook. Claims subject to precertification are also called "preservice claims."

How to Precertify

To precertify, you or your provider must call the Claims Administrator for your Network. If you or your provider do not precertify a hospital stay or other stay or treatment when required, your benefits may be reduced or denied, as shown in the chart below.

How Precertification Affects Your Benefits

	BCBSTX Medical Options
BCBSTX provider is required to precertify	
If you call and the Claims Administrator determines that treatment is Medically Necessary	Option pays benefits at regular rates.
If you call and the Claims Administrator determines that treatment is not Medically Necessary	No benefits are paid without additional information from your physician that supports a determination by BCBSTX of medical necessity.
If you do not call and the Claims Administrator determines that treatment is Medically Necessary	Option pays benefits at regular rates.
If you do not call and the Claims Administrator determines that treatment is not Medically Necessary	No benefits are paid without additional information from your physician that supports a determination by BCBSTX of medical necessity.

Note: If you do not precertify inpatient services that are Out-of-Network, you will be charged a penalty.

Emergency Hospitalization – All Participants

In order to receive full benefits paid at the In-Network level with no precertification penalty for emergency admissions, you must contact the Claims Administrator for your option as soon as possible following the emergency admission. Precertification for an emergency admission is not required. Note that you also don't need to precertify a hospital stay following the birth of a newborn, as long as the stay does not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section. Remember, however, that expenses associated with a pregnancy and birth of a child that you birth as a surrogate for another individual are not covered under the Plan.

Concurrent Review – All Participants

If a stay needs to be extended beyond the number of days originally certified, the additional days must be approved before your hospital stay that was originally certified ends. This is called concurrent review. When you use In-Network providers, your doctor is responsible for making sure that a concurrent review occurs.

Preadmission review and concurrent review are intended to help you make informed decisions about health care costs and treatment alternatives. These services also can help you understand how to use your medical benefits to your best advantage and monitor the quality of care being provided.

- When your doctor recommends hospitalization, you or the doctor should call the toll-free number on your medical ID card for preadmission review. In an emergency, it is your responsibility to contact your doctor or the Claims Administrator as soon as possible following your admission.
- The Claims Administrator compares information about your admission with nationally accepted medical standards, including the treatment and expected length of stay. If there is any question, a physician from the Claims Administrator's office will review your admission and either approve it for benefit payment purposes or discuss it further with your doctor, perhaps suggesting an alternative such as outpatient treatment or a shorter stay. Whatever the outcome, you, your doctor, and the hospital will be notified.
- On the day before you are expected to leave the hospital, the Claims Administrator will call your doctor or hospital to ask about discharge plans. If your doctor wants to lengthen your stay, the nurse reviewer will ask for medical information to support the request. If the nurse reviewer cannot approve an extended stay, a physician from the Claims Administrator's office will talk with your doctor. You, your doctor, and the hospital will be told whether the extra days are eligible for reimbursement from the option.

Medical Case Management

If you have a serious illness or injury that is likely to require complex or long-term health care, the medical options may offer the services of a medical case manager. The case manager's role is to give you information about treatment alternatives and plan benefits, to help you to get quality care, and to effectively manage your benefits dollars.

The Claims Administrator will have a medical case manager contact you after becoming aware of a situation in which you could benefit from case management. Patients and families facing treatment for the following conditions can often benefit from this service.

Examples of Conditions Where Case Management Is Recommended

- AIDS,
- Alzheimer's disease,
- Brain tumor,
- Burns,
- Cancer,
- Hemophilia,
- Kidney problems/ dialysis,
- Complicated heart attacks,
- Respirator dependency,
- Major organ transplants,
- Multiple sclerosis,
- Premature births,
- Severe accidents with injury to head or spinal cord, and
- Strokes.

You also could be referred to a case manager when:

- The length of a hospital stay exceeds certain maximums,
- The doctor's diagnosis indicates complications,
- You have a repeat admission in a given time period, and
- More than one kind of treatment or therapy is needed after you or a Dependent leaves the hospital.

Second Surgical Opinion

Participants in HSA and HRA Medical Options

A second surgical opinion helps ensure that surgery is best for you. It also helps to control the expense of unnecessary surgery. Second surgical opinions for elective (non-emergency) surgery are paid according to the ***Fact Sheet*** in this section for your medical option. The second opinion must be from a surgeon who specializes in your injury or illness. This surgeon must not be in practice with the first surgeon.

Following is a list of surgeries for which a second opinion is commonly recommended.

Examples of Conditions in Which a Second Opinion is Recommended

- Back (disc surgery),
- Breast,
- Bunion,
- Cataract,
- Dilation and curettage (except elective abortion),
- Heart bypass,
- Hemorrhoid,
- Hysterectomy,
- Intestine,
- Knee,
- Nose,
- Pacemaker insertion,
- Prostate,
- Thyroid,
- Tonsil/adenoid, and
- Varicose vein.

If the second opinion conflicts with the first, you can obtain a third opinion. This third opinion will be covered in the same way as the second opinion.

APPLYING FOR BENEFITS

When You Use In-Network Providers

You don't need to file a claim when you use In-Network providers. In most cases, the providers will file the claim for you. After the Claims Administrator has processed your claim, you will receive an Explanation of Benefits (EOB) statement that shows the amounts paid and any amounts you owe.

If You Use Out-of-Network Providers

You will need to file a paper claim when you use Out-of-Network providers.

Note: If you are enrolled in the Scott & White Health Plan (SWHP) Option, you only have coverage when you use an In-Network provider, except in the case of a medical emergency. For more information, refer to your SWHP Summary of Benefits or contact SWHP Option Customer Service at **1.800.321.7947**.

How to File a Claim: In- and Out-of-Network

Save your bills. Save all health care bills for you and your covered family members. Each bill should include the following:

- The full name of the person being treated,
- The diagnosis of the illness or injury,
- The date and type of service received,
- Any itemized charges, and
- The name, address, and tax ID number of the provider performing the service.

Keep a record of expenses. Keep separate records of your expenses and those of each of your Dependents, because benefits, Deductibles, and maximum payments apply separately to each of you.

For HSA participants, it's important that you keep a record of expenses and save your bills or EOBs for tax purposes.

Obtain claim forms. To get claim forms, call the Claims Administrator or print out the form from the Claims Administrator's website. Claim forms need to be filed separately with the appropriate Claims Administrator.

Determine the type of claim. There are four types of health care claims, and the claims process varies with each type. The four types of claims are:

- **Concurrent care claim.** A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim for a course of treatment involving urgent care. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.
- **Preservice care claim.** A preservice care claim is a claim for a benefit for which the medical option requires approval before you receive the medical services or treatment (for example, preadmission review or precertification).
- **Post-service care claim.** A post-service care claim is a claim for a benefit that is made after you receive health care services.
- **Urgent care claim.** An urgent care claim is any claim for health care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of you or your covered Dependent. The determination of the claim as an urgent care claim is made at the discretion of the Claims Administrator or may be characterized as such by the treating physician. This type of claim generally includes Emergency Care claims.

  If you have an urgent care claim, you can initiate the claim yourself if you are able to do so, or your physician can file for you. An urgent care claim can be made orally, but you will be responsible for completing a written claim form in support of your claim, as required by the Claims Administrator.

Make copies of your claim forms and bills. The Claims Administrator cannot return original claims to you.

Submit the claim. Submit the claim to the Claims Administrator. Make sure you are submitting bills for which benefits are payable. Before submitting the claim, make sure that the claim form is complete and has an original signature, and that all bills are attached. Benefits for services received by an In-Network provider are generally paid directly to the provider. However, in other circumstances, benefit payments are paid to you, and you are responsible for paying the provider.

Important!

Be sure to file your claims within 90 days after you incur health care expenses. The medical options won't pay benefits if you don't submit your claims within 12 months.

Prescription Drug Claims

You pay for your prescriptions when you pick them up from a retail pharmacy or send in your order to the mail-order program, so you don't need to file claims for prescription drug benefits unless you need to use an Out-of-Network pharmacy. In this case, you can get a claim form from CVS Caremark, the prescription drug administrator. Complete the form and return it to CVS Caremark. Benefits will be paid directly to you.

Reimbursement from HSA, HRA, and Health Care Flexible Spending Account (HCFSA) Options

Certain expenses that are not covered by medical options or that are not fully reimbursed may be Eligible Charges under other benefit features. These charges might include Deductibles, Copayments, charges that are over and above option limits, and charges not covered by the options.

- **If you participate in an HSA Medical Option**, charges can be reimbursed under your HSA. In this case, you may also have an HRA which you can use to help pay eligible dental and vision expenses, but not medical expenses.
- **If you participate in an HRA Medical Option,** charges can be reimbursed under your HRA or your HCFSA Option.
- **If you participate in any other option,** charges that are not covered by the medical option may be eligible for reimbursement under your HCFSA.

HSA Claims

You do not need to submit claims for the HSA. You are responsible for determining if withdrawals are for qualified medical expenses. If the IRS questions any withdrawals, it is your sole responsibility to prove those expenditures were for qualified medical expenses.

You can choose to purchase eligible products or services using out-of-pocket dollars. A reimbursement can be requested from Fidelity by submitting an online transfer from your HSA, or you can call Fidelity at **1.800.544.3716** to get a check mailed to you or to transfer money to another account.

For IRS purposes, be sure to save your receipts as documentation of expenses.

HRA Claims

When you incur an eligible expense at a qualified provider, you can either use your payment card or file a claim for reimbursement later.

- You can pay with your HRA debit card that you received from **ConnectYourCare**. Be sure to save your receipts. When you swipe the card, a claim is created for you so you do not need to complete a claim form. If a receipt is needed, you will be notified by email or letter within two weeks of your payment card swipe. To see if a receipt is required, log on to your online account.
- You can file a claim through:
  - **CYC Mobile.** To use this fastest way to submit a claim, download CYC Mobile to your Android, iOS, Windows, or Windows device. Use your existing ConnectYourCare website user name and password. Click ***"Add new claim"*** from the main screen and follow the steps.
  - **Online claim submission.** Visit ConnectYourCare.com and follow the instructions.
  - **Paper claim submission.** If you didn't use your payment card and are unable to access the Internet, complete the Manual Claim Form and fax it with itemized receipts or other documentation to **1.433.681.4602**. Keep the original claim form and documents for your records; you do not need to submit a hard copy through the mail.

If you prefer, you can mail your claim form and documents to:
Claims Department, P.O. Box 622317, Orlando, Florida 32862-2317.

If a Claim Is Denied

There is a procedure to follow to obtain a full and fair review if a claim is denied and you believe it should be paid. See ***Claim Review and Appeal Process*** in the **Plan Administration** section of this handbook.

Coordination of Benefits

Your medical option benefits are coordinated with benefits from other group health care plans that cover you or your Dependents. When benefits are coordinated, the benefits from all plans cannot be greater than your allowable health care expenses. For information about how coordination works, see ***Coordination of Benefits*** in the **Plan Administration** section of this handbook.

Subrogation Rights

Subrogation rights apply when another party may be responsible for your injury or illness or your enrolled Spouse's or Child's injury or illness (for example, in the case of an automobile accident) and the Oncor Plan pays benefits relating to that illness or injury. By participating in the Plan, you agree that if you or your enrolled Spouse or Child are injured by a third party, the Plan will be subrogated to any rights that you or your Spouse or Child may have against the third party, and/or the third party's insurance carrier, and will be entitled to full reimbursement for any benefits paid by the Plan that are related to the injury. The Plan has the right to recover benefit amounts from funds that you or your Spouse or Child receive from the responsible third party, whether through a judgment, settlement, or otherwise (including, but not limited to, an uninsured motorist award or settlement from your own or another's insurance, Med-Pay, or PIP coverages, and any other first- or third-party coverages not specifically referenced herein) whether or not you have been fully compensated for your losses, and without offset for any costs of recovery. This means that the Plan may sue the third party and/or its insurance carrier and recover any and all amounts paid by the Plan from the third party or its insurance carrier, up to the total amount that the Plan paid, or may pay, for expenses related to the injury. The Plan's right of recovery is without any reduction for attorney fees or court costs, and without regard to whether (i) you and/or your enrolled Spouse or Child would be fully compensated or made whole by the amount recovered, (ii) the third party admits causing the injury, (iii) the amount recovered is awarded specifically for medical expenses, or (iv) if a "make whole" doctrine applies under state law. The Plan will have a lien on any and all amounts you recover up to the full amount paid by the Plan, and that amount will be held in trust for the Plan's sole benefit until delivered to the Plan.

If the Plan advances payment for any benefits, the Plan may require that you (or the injured person) execute a subrogation agreement that requires you to acknowledge, among other things, (i) the conditional nature of the Plan's payment, (ii) the Plan's right to subrogation and full reimbursement, and (iii) your obligation to cooperate in protecting the Plan's rights, (iv) your waiver of any defense that you have been reimbursed in full, and that your attorneys' fees and costs must be paid from any recovery, and (v) that your legal counsel will hold any amount recovered in trust for the Plan. The subrogation agreement may contain additional terms and conditions determined by the Plan Administrator to be necessary or appropriate. Additionally, you and/or your enrolled Spouse or Child must, as a condition to receiving Plan benefits, assist with the Plan's recovery. In this connection, you must provide the Plan Administrator with information about the facts surrounding your injury, your future medical needs, and any claim you may have against a third party, sign and deliver any necessary documents, provide advance notice of any litigation or settlement negotiations with third parties, and notify relevant parties of the Plan's subrogation and reimbursement rights, among other things. The Plan has the right to withhold benefits that you or your enrolled Spouse or Child may be entitled to receive under the Plan unless (and until) you fully comply with all the obligations explained, including executing a subrogation and reimbursement agreement. The Plan also has the right to reduce future payments payable to or on behalf of you and/or your enrolled Spouse or Child by the amount that the Plan is entitled to reimbursement until the time that the entire amount has been recouped in full, including any costs of collection.

You and/or your enrolled Spouse or Child must contact the Plan Administrator and obtain the Plan Administrator's consent before settling any claim against a third party and may not pay any attorneys' fees or other amounts before the Plan is fully reimbursed. You and/or your enrolled Spouse or Child and your attorney will hold any amounts recovered from a third party in constructive trust to satisfy the Plan's lien. If the Plan must take legal or other action due to your failure to reimburse the Plan or otherwise cooperate, you will be responsible for the cost of collection. Note that the subrogation provisions of the Plan may be administered on behalf of the Plan Administrator by a third party. Review the **Plan Administration** section of this handbook, as well as Annual Enrollment materials, to see who is responsible for administering the subrogation provision. You should coordinate with the subrogation administrator as described in this section. Failure to do so could affect your benefits under the Plan.

The Plan's subrogation and reimbursement rights do not limit your right or your Spouse's or Child's right to take legal action against the person who caused your (or your enrolled Spouse's or Child's) injury. You can pursue legal action to recover medical expenses and other damages. Again, however, you must obtain the Plan Administrator's consent before you settle any claim or release any third party from liability. The Plan will not be responsible for attorney fees or court costs that you and/or your Spouse or Child incur and will not reduce the amount of the required reimbursement by the amount of your attorney fees or court costs.

Recovery of Overpayments

If the Plan or Blue Cross and Blue Shield of Texas (in its capacity of Claims Administrator) pays benefits for eligible expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or it was made in error ("overpayment"), the Plan or Blue Cross and Blue Shield of Texas has the right to obtain a refund of the overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) the Network providers or Out-of-Network providers that received the overpayment.

If no refund is received, the Plan and/or Blue Cross and Blue Shield of Texas (in its capacity of Claims Administrator) has the right to deduct the unrecovered overpayment amount from any future benefit payment, or other payment, otherwise payable under this Plan to any person to, or for whom, the overpayment was paid, including any Network providers or Out-of-Network providers that received the overpayment.

Coordination with Medicare

If you are actively employed, you and your Spouse (if age 65 or older) have primary coverage under the Oncor medical option. Medicare coverage may be secondary for you or your Spouse.

When you retire and you or your Dependents are under age 65 and not eligible for Medicare, the Oncor medical option is the primary plan. However, when you or your Dependents become eligible for Medicare, whether or not covered by another group health plan, the Oncor medical option may provide supplemental benefits for expenses that are not covered or fully paid by Medicare. These supplemental benefits are calculated as if you receive a Medicare benefit, even if you actually don't (for instance, because of your failure to enroll for Medicare). You are responsible for reporting when a Dependent becomes eligible for Medicare, through age or disability criteria, and for selecting the appropriate Medicare Coordination Plan.

Coordination of benefits rules, which prohibit you from receiving a "double payment" of benefits for the same illness or injury, apply while you are covered by both an Oncor medical option and Medicare.

Dental

DENTAL BENEFITS

Getting regular dental care is an important part of taking care of our health. The options encourage regular checkups and treatment by paying a high percentage of preventive and diagnostic expenses.

If you are eligible for the Plan, you may elect dental coverage. This section of your handbook describes how the dental options work. Note that you will not receive an ID card for dental benefits.

Dental Coverage Decisions

When you enroll for coverage each year, you choose a coverage category and a dental option that best fit your situation.

Your Dental Options

If you are eligible for the Plan, you can enroll in one of two dental options:

> Dental Option A (enhanced coverage) or

> Dental Option B (comprehensive coverage).

Dental Option A provides a higher level of benefits than Dental Option B. Both options are administered by Aetna.

About the Networks

The Oncor dental options operate through a Network. A Network is a group of dentists and dental care providers who contract with Aetna, the Claims Administrator, to offer discounted rates to their participants.

When you need dental care, you have the freedom to choose any dentist you want. However, In-Network dentists have agreed to provide services to Oncor employees at negotiated rates. This can result in significant cost savings for you.

HOW THE DENTAL OPTIONS WORK

See the ***Dental Options Fact Sheet*** in this section for Coinsurance percentages. The dental option you choose determines the Deductible you pay, the option's Coinsurance, the annual dental maximum, and the orthodontia maximum. The Deductibles and annual and lifetime maximums are found in *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment. You can also access the guide at **oncorbenefits.com/ee**.

For most dental expenses, the options work like this:

1. Each year, you must satisfy a Deductible before the option starts to pay benefits. However, a Deductible is not required for preventive/diagnostic care or orthodontia services.
2. Once you meet the Deductible, the percentage the option pays is based on the option you choose and the type of dental expense incurred. Your Coinsurance is the remaining charge.
3. Each year, you and each covered Dependent can receive dental benefits up to an annual maximum. If you or a Dependent reaches the annual maximum during the year, no further benefits are paid for that person for the rest of that calendar year. However, this annual maximum does not apply to preventive/diagnostic care or orthodontia services.
4. The orthodontia benefits have a lifetime maximum for each covered person.
5. You and each covered Dependent who receive at least one cleaning per calendar year will receive an increase in his or her maximum annual benefit payable for the following year for basic and major services (does not apply to orthodontia). The incentive is $250 per person with a cap of $500 per year.

Types of Expenses

Dental expenses are generally divided into the following four categories. The options pay different benefits for each category of expenses.

- Diagnostic and preventive services,
- Basic services,
- Major services, and
- Orthodontia services.

Examples of services in each of these categories can be found in the ***Dental Options Fact Sheet*** in this section of the handbook.

Deductible

The Deductible is the amount of covered basic and major dental expenses you pay each year before the option starts to pay benefits. You don't need to meet the Deductible before preventive and diagnostic expenses or orthodontia expenses are paid.

Each covered person must satisfy the annual Deductible each year before the option starts paying expenses for benefits other than preventive and diagnostic expenses and orthodontia expenses. Once an individual has met the Deductible, that person does not have to meet any additional Deductibles for the calendar year.

The option also has a maximum family Deductible. The maximum family Deductible is three times the individual Deductible. All covered family members can contribute to the family Deductible limit. Once three people in your family meet the individual Deductible, no further Deductibles will be required from your family for the rest of the year.

All eligible dental charges count toward the Deductible, with these exceptions:

- Preventive care expenses,
- Orthodontia expenses, and
- Any charges that are not covered by the option or that exceed Reasonable and Customary Charges or other option limits.

Coinsurance

Coinsurance is the portion of charges that you and the option each pay for covered services. The Coinsurance for your dental option is the percentage of covered charges shown on the ***Dental Options Fact Sheet***. Your Coinsurance is the remaining portion of covered charges.

In-Network Benefits Based on Discounted Rates

The Coinsurance is based on the discounted rates that have been negotiated with In-Network providers.

When you receive care from In-Network providers, the provider bills the option at the provider's regular rate. Then, Aetna reduces the bill to the discounted rate. (The provider has agreed to accept the discounted rate as payment.) The option then pays its Coinsurance (for example, 80%) based on the discounted rate for that type of dental expense, and you pay the remaining Coinsurance (for example, 20%) based on the discounted rate.

Out-of-Network Benefits Based on Recognized Charges

When you receive care from Out-of-Network providers, the provider bills the option at the provider's regular rate. Aetna calculates the Recognized Charge based on the Reasonable and Customary Charges. You are responsible for paying the entire remaining amount of the provider's regular rate.

Here's an example: Say you and your family have dental care charges of $1,000 during the year. The In-Network rate for those expenses is $700. Assuming you've satisfied any Deductible requirements and that the option pays 80% of charges for those expenses, payments would be:

	In-Network	Out-of-Network
Full charge	$1,000	$1,000
In-Network rate	$700	N/A
Recognized Charge	$700	$700
Option pays percentage of Network discounted rate	80% of $700 = $560	80% of $700 = $560
You pay remainder	$700 – $560 = **$140**	$1,000 – $560 = **$440**

In this example, you pay $140 if you receive services from In-Network providers, or you pay $440 if you receive services from Out-of-Network providers. Note that this is a very simple example to show how the concept works. The actual negotiated Network discounted rates may vary depending on the Network, the physician's billing practices, and the geographic area. The percentage the option pays also may vary, depending on the type of expense and on the Network you choose.

Benefit Maximums

The annual maximum for basic and major services applies to each covered person during each calendar year. Benefit payments for preventive and diagnostic services do not count against this annual maximum.

A separate lifetime maximum applies to orthodontia services for each covered person.

Important Reminder

Your dental services and supplies must meet the following rules to be covered by the Plan:

- The services and supplies must be Medically Necessary,
- The services and supplies must be covered by the Plan, and
- You must be covered by the Plan when you incur the expense.

DENTAL OPTIONS FACT SHEET

	Dental Option A (Enhanced Coverage)	Dental Option B (Comprehensive Coverage)
Deductible for Basic and Major Services	**You Pay**	
> You Only > Family	Annual Deductibles can be found in *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment.	
Individual Annual Maximum Benefit for Basic and Major Services	**Option Pays**	
	Annual maximum benefit amounts can be found in *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment.	
	An additional $250 incentive for payment of basic and major services the following year can be earned by you and each covered Dependent who receives at least one cleaning per calendar year. The maximum individual incentive in any calendar year is $500.	
	Option Pays	
Diagnostic and Preventive Care		
> Routine dental exams > Prophylaxis (teeth cleaning) > Bitewing X-rays (one set per year) > Vertical bitewing X-rays (one set every 3 years) > Full-mouth X-rays (one set every 3 years) > Periapical X-rays > Periodontal cleaning (active perio therapy is a prerequisite) > Fluoride treatments (twice each year) > Space maintainers > Emergency treatment to relieve pain (charges count toward annual maximum) > Sealants > Appliances to correct harmful habits (charges count toward orthodontia lifetime maximum) > Consultations (charges count toward annual maximum)	100% (no Deductible) Charges do not count toward annual maximum unless specifically noted.	

	Dental Option A (Enhanced Coverage)	Dental Option B (Comprehensive Coverage)
	Option Pays	
Basic Services		
> Fillings (amalgam and resin composites only) > Endodontic treatment, including root canal therapy (except for molar root canal therapy) > Periodontal treatment, including surgery and scaling of teeth > Rebasing and relining of dentures > Tooth extractions > Treatment of bruxism (grinding of the teeth) > Oral surgery (except those procedures covered by a medical option) > Anesthetics in connection with covered surgery or other dental treatments > Accidental injury to sound natural teeth (when not covered under a medical option)	80% after Deductible, up to annual maximum	60% after Deductible, up to annual maximum
Major Services		
> Inlays and onlays > Crowns (once each 5 years) > Molar root canal therapy > Initial installation of complete and partial removable dentures > Initial installation of fixed bridgework, including removable dentures and inlays and crowns as abutments. The options also cover adjustments following installation. > Repairing and recementing crowns, inlays, bridgework, and dentures > Replacement of existing dentures and bridgework when they are: – Needed to replace natural teeth extracted while you are covered by a dental option, – Needed to replace congenitally missing teeth, – At least 5 years old and cannot be made serviceable, or – Damaged because of an accident occurring while the patient is covered by a dental option. > Dental implants > Treatment and appliances for temporomandibular joint disorder (TMJ), other than surgery. (Surgery is covered under the medical options.)	50% after Deductible, up to annual maximum	
Orthodontia		
Orthodontia treatment	50% (no Deductible), up to lifetime orthodontia maximum	
Lifetime orthodontia maximum	Lifetime orthodontia maximum benefit amounts can be found in *Your Guide to Benefits* that you receive as a new hire and each year during Annual Enrollment.	

MORE ABOUT ORTHODONTIA SERVICES

Orthodontia coverage provides benefits for teeth straightening. Benefits are 50% of Reasonable and Customary Charges with no Deductible requirement.

Orthodontia expenses do not count toward the per-person annual benefit maximum for other dental services, but are limited to the lifetime orthodontia maximum for the dental option you choose.

Before treatment begins, you can file an orthodontia Treatment Plan with Aetna. The orthodontia Treatment Plan is a report that describes what treatment is needed, the length of treatment, and the cost. You are not required to submit any further claims for benefits for your orthodontia treatment. After you submit your orthodontia Treatment Plan, Aetna calculates your benefits for the entire treatment and pays benefits directly to your orthodontist under an assignment of benefits.

If your dentist does not submit an orthodontia Treatment Plan, you must submit the following information to Aetna in order for them to process an orthodontic claim:

- Date of service (banding date),
- Assignment of benefits,
- American Dental Association Code,
- Total case fee,
- Number of months of treatment, and
- If applicable, an Explanation of Benefits (EOB) from the primary insurance (if the patient has other dental coverage).

How the Payment Plan Works

Regular, fully banded orthodontia is paid over the entire length of time services are received. When the appliances are first installed, the dental option pays an initial benefit of 20% of the total cost at the 50% benefit rate. As treatment continues, the option pays 50% of the remaining expenses up to the lifetime maximum. You are responsible for the remaining 50% of the expenses not covered by the option. Payments are made monthly. Here is an example of how orthodontia benefit payments work.

Orthodontia Benefit Payment Plan Example	
Total fee	$2,500
Initial benefit (20% of total fee)	$2,500 x 20% = $500
Initial payment (50% of initial benefit)	$500 x 50% = **$250**
Remaining balance	$2,000
Payable over 2 years (24 monthly installments)	$2,000 ÷ 24 = $83.33
Monthly installment x 50%	$83.33 x 50% =
Monthly payment amount	**$41.67***

*Subject to the lifetime maximum benefit for orthodontia services

Benefits for fixed or removable appliance therapy (interceptive orthodontia) are not paid under the payment plan procedure, but are paid as services are rendered.

Orthodontia Expenses Not Covered

The dental options will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the options.

The options do not cover the following orthodontic services and supplies:

- Replacement of broken appliances,
- Re-treatment of orthodontic cases,
- Changes in treatment necessitated by an accident,
- Maxillofacial surgery,
- Myofunctional therapy,
- Treatment of cleft palate,
- Treatment of micrognathia,
- Treatment of macroglossia,
- Lingually placed direct bonded appliances and arch wires (i.e., "invisible braces"), or
- Removable acrylic aligners (i.e., "invisible aligners").

SPECIAL DENTAL BENEFIT FEATURES

Predetermination of Benefits

If you expect charges for planned dental work to be $350 or more, a predetermination of benefits (pretreatment estimate) is recommended to be filed with Aetna before treatment begins, unless Emergency Care is necessary. Your dentist should submit a completed claim form that itemizes the services to be performed and their costs.

Predetermination works like this: Your dentist decides what treatment is needed and describes it on the claim form along with an estimate of treatment charges. Your dentist also should attach X-rays and other supporting records with the form.

Aetna will review the claim to make sure the charges are Reasonable and Customary and the proposed services are within the option's guidelines. You and your dentist will be notified of what portion of the charges will be paid by your option.

Benefits Based on Professionally Acceptable Treatments

Be aware that many dental problems can be treated in more than one way. The dental options cover the least expensive procedure that is effective in providing a professionally satisfactory result, as determined by Aetna.

For example, if you have a cavity in a tooth and you have the tooth crowned for the sake of appearance instead of simply having the cavity filled, your benefit will be based on the cost of the filling. If, however, because of the condition of the tooth, a crown is necessary to provide a professionally satisfactory result, your benefit will be based on the cost of the crown.

Accidents to Teeth

If you injure your teeth as a result of an accident, all necessary dental treatments will be covered as follows:

- Claims for injury to natural teeth need to be submitted to your medical option first. If the claims are not covered by medical, dental will consider the service based on whichever category the service falls under.
- All covered dental services would count toward the annual maximum.

Dental Medical Integration (DMI)

The following additional dental expenses will be considered covered expenses for you and your covered Dependents if you have medical coverage and have at least one of the following conditions:

- Pregnancy,
- Coronary artery disease/Cardiovascular disease,
- Cerebrovascular disease, and/or
- Diabetes.

Additional Covered Dental Expenses

- Scaling and root planing (four or more teeth); per quadrant,
- Full mouth debridement,
- Periodontal maintenance (one additional treatment per year), and
- Localized delivery of antimicrobial agents (not covered for pregnancy).

Payment of Benefits

- The option Coinsurance applied to the other covered dental expenses described above will be 100%. These additional benefits will not be subject to any frequency limits except as shown above or any calendar-year maximum.
- Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement of covered expenses.

WHAT THE DENTAL BENEFITS DO NOT COVER

Although the dental options cover you and your covered Dependents against many dental care expenses, certain services are not covered. You and your dentist should consult the following list when you are planning a course of treatment.

The dental options do not cover:

- Any work not done by a dentist, except X-rays ordered by a dentist and services by a dental hygienist performed under the dentist's supervision,
- Appliances, if an impression was made before the patient was covered by a dental option,
- Appliances or restorations for the purpose of crowns or splinting, to change vertical dimension, or to restore occlusion,
- Charges incurred before coverage begins or after coverage ends,
- Charges over the Reasonable and Customary Charge amount,
- Charges that you are not legally obligated to pay,
- Cost of a more expensive or elaborate course of treatment in excess of a less expensive procedure that would have produced a professionally satisfactory result,
- Crown, gold restoration, or bridge if the tooth was prepared before the patient was covered by a dental option,
- Crowns, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material, or
  - The tooth is an abutment to a covered partial denture or fixed bridge,
- Dentures, bridgework, or implants if the work involves existing dentures, bridgework, or implants that were installed in the last five years,
- Dentures, bridgework, or implants if the work involves natural teeth extracted within six months before a person's effective date, unless the denture or bridgework also includes a natural tooth extracted while the person is covered by a dental option,
- Drugs or medicines,

- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace teeth, all of which were lost while the person was not covered,
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply,
- Orthodontic treatment except as covered in the ***More About Orthodontia Services*** in this section of the handbook,
- Orthognathic surgery,
- Pontics, crowns, cast, or processed restorations made with high noble metals (gold or titanium),
- Prescribed drugs, premedication, or analgesia,
- Replacement of a device or appliance that is lost, missing, or stolen, or for the replacement of appliances that have been damaged due to abuse, misuse, or neglect, or for an extra set of dentures,
- Root canal therapy if the pulp chamber was opened before the patient was covered by a dental option,
- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services,
- Services and supplies provided for your personal comfort or convenience or for the convenience of any other person, including a provider,
- Services and supplies provided in connection with treatment or care that is not covered under the option,
- Services for cosmetic purposes, unless it is cosmetic dentistry made necessary by an accident that happened while the patient was covered by a dental option; facings on molar pontics are always considered cosmetic,
- Services not Medically Necessary or usually provided for dental care,
- Services or supplies for any illness or accidental injury in connection with any employment for wage or profit,
- Services or supplies furnished or payable by any government or governmental agency, or any governmental program or law under which you could be covered, unless payment is legally required,
- Services or supplies received as a result of war or an act of war, declared or undeclared, including resistance to armed aggression,
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth,
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, and
- Treatment by someone other than a dentist; however, the option will cover some services, such as scaling and cleaning of teeth provided by a licensed dental hygienist under the supervision and guidance of a dentist.

Rules and Limits That Apply to the Dental Options

Several rules apply to the dental options. Following these rules will help you use the options to your advantage by avoiding expenses that are not covered by the options.

Orthodontic Treatment Rule

The options do not cover the following orthodontic services and supplies:

- Replacement of broken appliances,
- Re-treatment of orthodontic cases,
- Changes in treatment necessitated by an accident,
- Maxillofacial surgery,
- Myofunctional therapy,
- Treatment of cleft palate,
- Treatment of micrognathia,
- Treatment of macroglossia,
- Lingually placed direct bonded appliances and arch wires (i.e., "invisible braces"), and
- Removable acrylic aligners (i.e., "invisible aligners").

The options will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the option.

Replacement Rule

Crowns, inlays, onlays, and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services are subject to the options' replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures, or bridges are covered only when you give proof to Aetna that:

- While you were covered by the options, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least five years before its replacement and cannot be made serviceable.
- You had a tooth (or teeth) extracted while you were covered by the options. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges, or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the options, and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior five years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the options' coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Coverage for Dental Work Begun Before You Are Covered by the Options

The options do not cover dental work that began before you were covered by the options. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the options,
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the options, and
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the options.

APPLYING FOR DENTAL BENEFITS

When You Use In-Network Providers

You typically don't need to file a claim when you use In-Network dental providers. In most cases, the providers will file the claim for you.

If You Use Out-of-Network Providers

If you use Out-of-Network providers, you will usually need to file a claim to receive benefits. To file a claim, follow these instructions:

- **Save your bills/receipts.** Save all dental bills for you and your covered family members. Each bill/receipt should include:
  - The full name of the person being treated,
  - The diagnosis,
  - The date and type of service received,
  - Any itemized charges, and
  - The name, address, and tax ID number of the provider performing the service.
- **Keep a record of expenses.** Keep separate records of dental expenses for yourself and your Dependents because benefits, Deductibles, and maximum payments apply separately to each of you.
- **Obtain claim forms.** To get claim forms, call Aetna or print out the form from their website.
- **Determine the type of claim.** There are two types of claims under the dental options:
  - *Post-service care claim.* A post-service care claim is a claim for a benefit that is made after you receive care services.
  - *Urgent care claim.* An urgent care claim is any claim for care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of you or your covered Dependent. The determination of the claim as an urgent care claim is made at Aetna's discretion or may be characterized as such by the treating dentist or physician. This type of claim generally includes Emergency Care claims.

If you have an urgent care claim, you can initiate the claim yourself, or your dentist or physician can file for you. An urgent care claim can be made orally, but you will be responsible for completing a written claim form in support of your claim as required by Aetna.

- **Make copies of your claim forms and bills.** Aetna cannot return original claims to you.
- **Submit the claim.** Submit the claim to Aetna. Make sure you are submitting bills for which benefits are payable. If a Deductible has to be met, you are encouraged to accumulate enough expenses to satisfy the Deductible before submitting the claim. Before submitting the claim, make sure that the claim form is complete and has an original signature, and that all bills are attached. Benefits for services received by an In-Network provider are generally paid directly to the provider. However, in other circumstances, benefit payments are paid to you and you are responsible for paying the provider. To have benefits paid directly to the provider, complete the assignment of benefits statement on your claim form.

Be sure to file your claims within 90 days after you incur the expenses. If, through no fault of your own, you are not able to meet the 90-day deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 12 months after the date of service.

Don't Forget the HSA, HRA, and HCFSA Advantages

If you have dental expenses remaining after the options pay benefits, you can use your HSA, HRA, or Health Care FSA (HCFSA) debit card and pay expenses from your HSA, HRA, or HCFSA. This includes Deductibles, Coinsurance, expenses that exceed option limits, and expenses that are not covered by the option. However, keep in mind that teeth whitening is not covered under the HCFSA option because it's considered a cosmetic procedure.

If a Claim Is Denied

There is a procedure to follow to obtain a full and fair review if a claim is denied and you believe it should be paid. See ***Claim Review and Appeal Process*** in the **Plan Administration** section.

Subrogation Rights

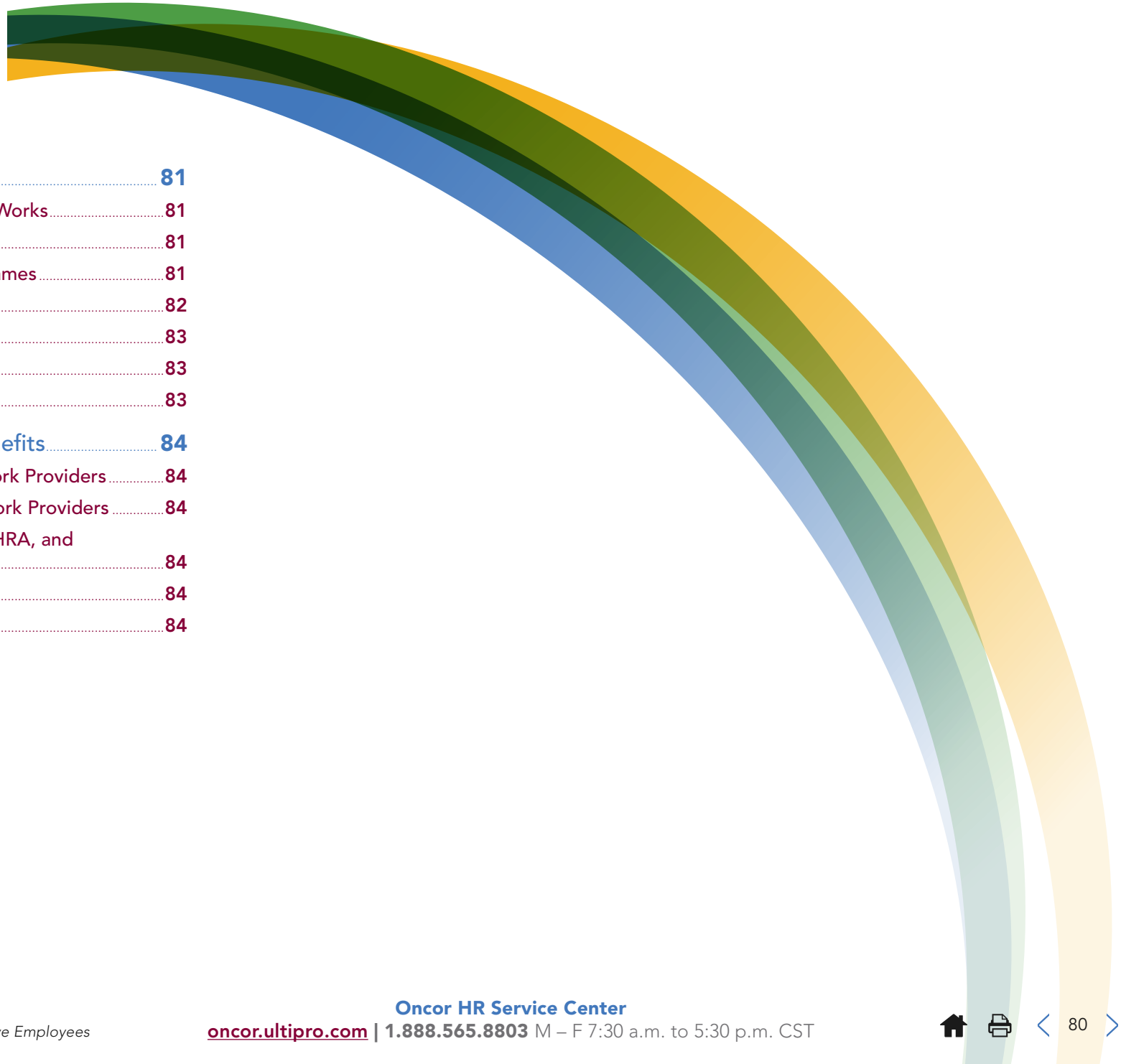
The ***Subrogation Rights*** information in the **Medical** section of this handbook also applies to dental benefits.

Recovery of Overpayments

If a benefit payment is made by the Plan, to you or on your behalf (for example, if a benefit payment is made directly to one of your health care providers) and the amount paid exceeds the benefit amount that you are entitled to receive (an "overpayment"), the Plan has the right to require the return of the overpayment. Additionally, the Plan has the right to reduce, by the amount of the overpayment, any future benefit payment made to you or on your behalf. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or, if the overpayment was made to an In-Network provider, other dental plans for which Aetna acts as the Claims Administrator.

Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount back to the Plan or, if the overpayment is recovered from an In-Network provider, to the plan that overpaid the provider. Payments to In-Network providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Vision



VISION BENEFITS

The Vision Option covers expenses for routine eye exams, eyeglass lenses or contact lenses, and frames. It also provides discounts on laser eye surgery and online shopping options. Benefits are provided through an insurance contract issued by UnitedHealthcare Vision℠, the insurance carrier.

If you are eligible for the Plan, you may elect vision coverage. This section of your handbook describes how the Vision Option works.

How the Vision Option Works

If you elect vision coverage, the option covers a portion of the costs of eye exams and contacts (including up to six boxes or 12 pairs of certain disposable contacts) or eyeglass lenses and frames instead of contacts. There are also discounts on special features such as progressives and transition lenses.

When you need eye care services, you choose whether or not to use an In-Network provider that has contracted with the insurance carrier. Similar to the medical options, you receive a higher benefit when you use the services of an In-Network provider. You can get a list of participating providers at UnitedHealthcare's website at **myuhcvision.com** or by calling UnitedHealthcare Vision at **1.800.638.3120**.

If you use an Out-of-Network provider, you pay the full cost at the time you receive care, and you must submit your receipts to the insurance carrier to receive the appropriate reimbursement.

Coverage includes benefits for an eye exam, lenses, and frames once per calendar year.

Eye Exams

In-Network Providers

If you use In-Network providers, you pay a $10 Copayment for an eye exam and the option pays the remaining costs.

Out-of-Network Providers

If you use Out-of-Network providers, the option will reimburse you up to $40 for the exam.

Eyeglass Lenses and Frames

In-Network Providers

After you pay the eye exam Copayment, you do not pay an additional fee for standard, clear, single-vision lenses, lined bifocals or trifocals, lenticular lenses, or for polycarbonate lenses for participants up to age 19. Standard scratch-resistant coating, UV coating, and tints are also covered in full.

You can purchase elective eye care materials, such as progressive lenses, transition lenses, and antireflective coatings at a preferred discounted price. If you purchase elective eye materials, you pay the discounted cost offered by In-Network providers for lenses and frames.

- Vision benefits include 100% coverage for a variety of selected frames.
- If you use a private practice provider or retailer, you receive an allowance of $150. You are responsible for paying the difference between $150 and the cost of the frames.
- The UnitedHealthcare Children's Eye Care Program includes coverage for a second eye exam each Plan Year for members up to age 13 – at no additional premium cost; standard Copayments apply. Employees have coverage for a new pair of glasses (frames and lenses) for a covered child up to age 13 at no additional premium cost if the vision prescription changes 0.5 diopter or greater in a Plan Year. (A diopter is the unit used to measure the optical power of the lens an eye requires.)

Out-of-Network Providers

If you use Out-of-Network providers, the Vision Option pays the following amount for eyeglasses:

	Out-of-Network Benefit
Lenses	
Single vision	Up to $40
Lined bifocal	Up to $60
Lined trifocal	Up to $80
Lenticular	Up to $80
Frames	Up to $45

Contact Lenses

In-Network Providers

You can choose contact lenses instead of eyeglasses if you wish. However, if you purchase contact lenses, you will not be able to purchase eyeglasses under the Vision Option until the next calendar year.

When you use In-Network providers, the option covers the full cost of many different types of contact lenses (including up to six boxes, or 12 pairs, of disposable contact lenses) from the provider's covered-in-full selection. The option also covers the full cost for fitting, evaluation, and two follow-up visits with In-Network providers. These are generally referred to as the "covered-in-full selection."

If you choose contacts that are not part of the covered-in-full selection, such as toric or bifocal contacts, you pay the difference between the benefit of $150 and the cost of the fitting and contacts. Be sure to ask your provider which contacts are covered in full.

Out-of-Network Providers

If you use Out-of-Network providers, the option covers up to $150 toward the cost of contacts.

Necessary Contact Lenses

If your provider determines that contact lenses are necessary, the Vision Option pays the full cost if you use In-Network providers. It pays up to $210 toward the contacts if you use Out-of-Network providers. Situations where contacts may be necessary include cataract surgery without intraocular lens implant, to correct extreme vision problems that cannot be corrected with eyeglasses alone, certain conditions of anisometropia and keratoconus. Before you purchase the contacts, you should have your provider contact UnitedHealthcare Vision to be sure these benefits are payable.

Vision Fact Sheet

Service	In-Network	Out-of-Network
Benefits Frequency: Once Per Calendar Year		
Professional Fees(1)		
Vision exam	You pay $10	Option reimburses up to $40
Eyeglasses(1)		
Single vision lenses	You pay $0(2)	Option reimburses up to $40
Lined bifocal lenses	You pay $0(2)	Option reimburses up to $60
Lined trifocal lenses	You pay $0(2)	Option reimburses up to $80
Lenticular lenses	You pay $0	Option reimburses up to $80
Polycarbonate lenses for up to age 19	You pay $0	Not covered
Frames	Option pays up to $150 allowance per year	Option reimburses up to $45
Scratch-resistant coating and ultraviolet coating	You pay $0	Not covered
Tinted lenses	You pay $0	Not covered
Contact Lenses		
Medically Necessary(3)	You pay $0	Option reimburses up to $210
Elective(4)	Up to 6 boxes (12 pairs) of disposables from the provider's covered-in-full selection. If you choose contacts not included in the covered-in-full selection, such as bifocal contacts, you pay anything over $150.	Option reimburses up to $150

(1) Enrolled children up to age 13 are eligible for a second exam, and are also eligible for replacement frames and lenses if they have a prescription change of 0.5 diopter or more. The second exam and replacement benefits are the same as the initial exam, frame, and lens benefits.

(2) Popular lens upgrades (such as no-line bifocals and anti-reflective coating) are available at a discount to you.

(3) Contact lenses are considered Medically Necessary if your eyesight cannot be corrected with eyeglasses or as determined by your provider. If you select contacts for any other reason, they are considered elective.

(4) If you choose contact lenses under this option, you will not be eligible for frames until the next calendar year.

Laser Eye Care Surgery

The Vision Option offers participants a discount on laser eye care surgery through QualSight LASIK to provide savings on LASIK evaluation and surgery. QualSight, a part of GlassesUSA.com, operates the largest network of LASIK eye surgeons in the United States and offers:

- Free LASIK consultation,
- Contracted set price of up to 35% below national average,
- Convenient access to experienced laser surgeons at more than 900 locations nationwide, and
- Personal QualSight Care Manager for one-on-one help throughout the process.

Online Shopping

UHC offers online shopping options for members through **glassesusa.com**.

You have:

- Access to over 7,000 styles of glasses and sunglasses,
- Easy-to-use online shopping experience, including a virtual mirror (try-on) feature and transparent pricing,
- Risk-free shopping with free shipping and returns, and
- 24/7 customer support.

To reach GlassesUSA.com and QualSight, call **1.800.525.4170** or access **glassesusa.com** to learn more about these benefits.

APPLYING FOR VISION BENEFITS

When You Use In-Network Providers

You typically don't need to file a claim when you use In-Network vision providers. In most cases, the providers will file the claim for you.

If You Use Out-of-Network Providers

If you use Out-of-Network providers, you will usually need to file a claim to receive benefits. To file a claim, follow these instructions:

- **Save your bills/receipts.** Save all vision bills for you and your covered family members. Each bill/receipt should include:
  - The full name of the person being treated,
  - The diagnosis,
  - The date and type of service received,
  - Any itemized charges, and
  - The name, address, and tax ID number of the provider performing the service.
- **Keep a record of expenses.** Keep separate records of vision expenses for yourself and your Dependents because benefits, Deductibles, and maximum payments apply separately to each of you.
- **Obtain claim forms.** To get claim forms, call UnitedHealthcare Vision or print out the form from their website.
- **Make copies of your claim forms and bills.** UnitedHealthcare Vision cannot return original claims to you.
- **Submit the claim.** Submit the claim to UnitedHealthcare Vision. Make sure you are submitting bills for which benefits are payable. Before submitting the claim, make sure that the claim form is complete and has an original signature, and that all bills are attached. Benefits for services received by an In-Network provider are generally paid directly to the provider. However, in other circumstances, benefit payments are paid to you and you are responsible for paying the provider. To have benefits paid directly to the provider, complete the assignment of benefits statement on your claim form.

  Be sure to file your claims within 90 days after you incur the expenses. If, through no fault or neglect of your own, you are not able to meet the 90-day deadline for filing a claim based on circumstances beyond your control, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 12 months after the date of service.

Don't Forget the HSA, HRA, and HCFSA Advantages

If you have vision expenses remaining after the option pays benefits, you can use your HSA, HRA, or HCFSA debit card and pay expenses from your HSA, HRA, or HCFSA. This includes expenses that exceed option limits and expenses that are not covered by the option.

If a Claim Is Denied

There is a procedure to follow to obtain a full and fair review if a claim is denied and you believe it should be paid. See ***Claim Review and Appeal Process*** in the **Plan Administration** section.

Subrogation Rights

The ***Subrogation Rights*** information in the **Medical** section of this handbook also applies to vision benefits.

Flexible Spending Accounts

HOW THE FLEXIBLE SPENDING ACCOUNT (FSA) OPTIONS WORK

This section provides a summary of Oncor's FSA options. Oncor has contracted with an administrator to provide certain administrative services for the FSAs.

If You Choose the HSA Option

Under this medical option, you have access to a Health Savings Account (HSA). If you are enrolled in an HSA medical option, you may not participate in a Health Care FSA. You can contribute pre-tax money into your HSA to be reimbursed for eligible health care expenses.

Overview

The FSA options allow you to set money aside on a tax-free basis to pay health care and Dependent care expenses. By paying expenses through your FSA options, you save money by lowering your taxable federal income and Social Security taxes. You get the full buying power of every dollar you spend for these expenses, because taxes are not deducted from the money you contribute to these accounts.

Here's how it works:

- There are two FSA options: the Health Care Flexible Spending Account (HCFSA) Option and the Dependent Care Flexible Spending Account (DCFSA) Option.
- Every year you decide how much you want to contribute to each FSA option on a pre-tax basis up to the maximum allowable under the Internal Revenue Service (IRS).
- When you make pre-tax contributions, you authorize Oncor to reduce your pay by the amount of your contributions. Since your pay is lower, you pay lower federal income taxes, lower Social Security taxes and, in most areas, lower state and local taxes, if applicable.
- If you have available funds in your HCFSA, your HCFSA will pay first, before your HRA funds are accessed. When you have eligible health care expenses incurred for a medical, prescription drug, dental, or vision provider, regardless of whether the provider is In-Network or Out-of-Network, first show the appropriate medical or prescription drug ID card so that the provider can verify your coverage and benefit. Then present your FSA debit card. If HCFSA funds are available, the card's embedded technology will first withdraw payment automatically from your HCFSA. Once your HCFSA funds are exhausted, swiping the same FSA debit card will withdraw payment from your available HRA funds. (**Note:** When you use your FSA debit card, you need to save your receipts and may need to submit them to the HRA/FSA administrator, because the IRS requires substantiation for purchases made with your card.) You're reimbursed with tax-free dollars.
- When you have eligible Dependent care expenses, you pay the expenses and file a claim for reimbursement from your DCFSA Option. You are reimbursed up to the amount in your DCFSA with tax-free dollars.
- In exchange for the significant tax advantages that your FSA options can provide, the IRS requires that you forfeit any money that remains in your accounts at year-end. However, you have until March 31 of the next year to turn in claims for expenses you incurred through December 31 of the previous year. Because of this rule, it's important that you estimate your eligible expenses carefully and don't contribute any more than you expect to use during the year.

For FSA Resources

You can take full advantage of the administrator's interactive website to learn about eligible expenses, estimate your FSA needs for the coming year, and complete a variety of self-service transactions online.

Note: If receipts are not submitted, the monies will be taxable the following year.

Call **1.877.292.4040** or visit **ConnectYourCare.com** to reach ConnectYourCare, the FSA administrator.

MAKING CONTRIBUTIONS TO YOUR FSA OPTIONS

Contribution Amount

When you enroll, you decide how much you want to contribute to your Health Care FSA (HCFSA) Option and/or your Dependent Care FSA (DCFSA) Option. Contributions to your FSAs are subject to annual minimum and maximum amounts, which are determined each year by the IRS and will be specified each year in the Plan's Annual Enrollment materials.

> You can get additional information about eligible health care expenses from **IRS Publication 502, Medical and Dental Expenses**, and about Dependent care expenses from **IRS Publication 503, Child and Dependent Care Expenses**. You can also visit the IRS website at **irs.gov** for these documents.

Making a Mid-Year Change in Your FSA Contribution

You may be able to change your FSA contribution amount during the year if you have an eligible qualified life event, as long as your change is consistent with the qualified life event.

> **Important!**
>
> On or after October 1, only qualified life event status changes resulting in a decrease in the annual election will be considered. Qualified life event status change requests resulting in an increase in the annual election or a first-time enrollment will not be accepted due to the limited number of pay periods remaining in the calendar year.

Keeping this rule in mind, examples of qualified life event status changes for FSAs may include:

Health Care FSA (HCFSA) – You may:

- **Begin or increase your contribution amount** if you marry, have a baby, adopt, or have a child placed with you for adoption.
- **Stop or decrease your contribution amount** if a Dependent child loses coverage or no longer meets eligibility requirements; you divorce, legally separate, or have your marriage annulled; or if your spouse or Dependent dies. You may not stop or reduce your total contribution to an amount less than the amount already reimbursed from your HCFSA or the amount in your HCFSA.

Dependent Care FSA (DCFSA) – You may:

- **Begin or increase your contribution amount** if you gain an eligible Dependent child or elder through marriage, have a baby, adopt, or have a child placed with you for adoption.
- **Stop or decrease your contribution amount** if your eligible Dependent child or elder no longer meets the eligibility requirements, or if your spouse or Dependent dies. You may not reduce your total contribution to an amount less than the balance in your DCFSA.

If you want to make a change in your FSA contribution amount mid-year, contact the FSA administrator to confirm that your qualified life event allows for such a change. Call **1.877.292.4040** or visit **ConnectYourCare.com** to reach ConnectYourCare, the FSA administrator.

Avoiding Forfeitures

You will forfeit any money that remains in your Health Care FSA (HCFSA) Option or Dependent Care FSA (DCFSA) Option at the end of each year. However, you have until March 31 of the next year to submit claims for expenses you incurred through December 31 of the previous year. To avoid forfeitures, it's important that you carefully estimate your eligible expenses and don't contribute any more than you expect to use during the year. ConnectYourCare, the FSA administrator, has helpful online tools that you can use to estimate your expenses.

Additional Considerations for Dependent Care Contributions

- If your spouse also makes deposits into a DCFSA where he or she works, your combined Dependent care deposits cannot be more than the IRS annual maximum contribution limit.
- You cannot contribute more than your earned income. If you're married, you cannot contribute more than your own earned income or your spouse's earned income – whichever is less. For example, if you earn $25,000 per year and your spouse earns $4,000 per year, the maximum amount you can contribute is $4,000.
- If your spouse does not work because he or she is disabled, or if your spouse is a Full-Time Student for at least five months during the year, you can contribute up to the following amounts, even if your spouse's income is less than these amounts:
  - Up to $250 for each month your spouse doesn't work, if you pay for day care for one qualified Dependent, or
  - Up to $500 for each month your spouse doesn't work, if you pay for day care for two or more qualified Dependents.

Coordinating Contributions With Tax Credits and Deductions

When you use pre-tax dollars from the FSA options, you cannot also take a tax deduction or credit on your federal income tax return for the same expenses. Whether you would be better off using the FSA options or taking deductions and credits on your federal income tax return depends on your personal situation. Following are some general guidelines to keep in mind as you make your decisions. However, the tax rules relating to medical expense deductions are complex; you are encouraged to consult your personal tax advisor.

Health Care Expenses

You may deduct from your federal income tax return the amount of the total unreimbursed allowable medical care expenses for a year that exceed 10% of your adjusted gross income (7.5% of your adjusted gross income if you are over age 65). In addition, you must itemize all your deductions in order to be eligible for this deduction.

In contrast, the HCFSA gives you a tax break beginning with your first $1 of expense, but only up to the maximum contribution. You do not have to report the expenses or the reimbursements on your income tax returns. So, if your medical, dental, and vision expenses are less than the minimum allowable income tax deduction for medical expenses, you will probably be better off using the HCFSA.

> **Defining a Dependent**
>
> The FSAs define "Dependent" differently than the Oncor benefit options. See ***Dependent (for FSAs)*** in the **Glossary** section of this handbook for details.

Dependent Care Expenses

By using the Dependent Care FSA (DCFSA), a tax break is available to any taxpayer with qualifying Dependent care expenses. You can claim reimbursement of up to the annual maximum of eligible expenses (i.e., $5,000 total for 2020) for any number of eligible Dependents.

A dependent care tax credit for Dependent care expenses is available to taxpayers when filing annual federal income tax returns. The maximum tax credit for 2020 is 35% of eligible expenses for families with adjusted gross income of $15,000 or less. As adjusted gross income increases, the tax credit percentage decreases to a minimum of 20% of eligible expenses for taxpayers whose adjusted gross income is more than $43,000. The tax credit is also subject to an annual dollar limit ($3,000 for one dependent; $6,000 for two or more dependents).

You may be able to use a combination of the dependent care tax credit and the DCFSA Option. For example, assume you contribute $3,000 to the DCFSA Option for two or more Dependents, but your eligible expenses are $3,500. You may be able to take a tax credit on the remaining $500 of child care expenses when you file your income tax return.

Each dollar you contribute to your DCFSA Option reduces the maximum child care expenses available for the tax credit by a corresponding dollar. So, if you contribute $3,000 to the DCFSA Option, but your eligible expenses are actually $3,500 for one Dependent, you would not be able to count the remaining $500 in expenses toward the tax credit.

Also, you cannot claim a dependent care tax credit for any expenses that were reimbursed to you through the DCFSA Option.

You should consult with your tax advisor to determine which option is best for you.

Defining a Dependent

The FSAs define "Dependent" differently than the Oncor benefit options. See ***Dependent (for FSAs)*** in the **Glossary** section of this handbook for details.

Planning Contributions to Your FSAs

You can contact ConnectYourCare, the FSA administrator, by visiting **ConnectYourCare.com** or calling **1.877.292.4040**. To decide how much to contribute to one or both FSA options, start with estimating your health care and Dependent care expenses expected for the coming year.

As you plan, keep in mind that:

- The funds in each option must remain separate.
- You cannot shift money from one option to the other.
- Expenses you incur before your participation starts or after December 31 of each Plan Year are not eligible for reimbursement.

Generally, you will want to estimate how much you expect to spend on the following expenses and any other costs you anticipate.

Health Care FSA (HCFSA) Option

Estimate out-of-pocket expenses for doctor and hospital bills, prescription drugs, dentistry and orthodontia, and vision care, including the Deductibles and Coinsurance you pay, as well as expenses (other than over-the-counter drugs and medications that have not been prescribed by your physician) that may not be covered by your health care plans.

Include expenses for everyone who is an eligible Dependent.

Dependent Care FSA (DCFSA) Option

Day care expenses usually are predictable. Estimate the weekly charge for your eligible Dependents and multiply it by the number of weeks that each Dependent will receive care.

Be sure to exclude vacations, holidays, and other periods when you will not be charged for day care.

This option cannot be used for child care expenses after your child reaches age 13.

If you participate in the HSA option, you may not participate in an HCFSA, but you can participate in a DCFSA.

ELIGIBLE HEALTH CARE EXPENSES

You can use your Health Care FSA (HCFSA) for medical (except if enrolled in the HSA Option), dental, vision, and hearing expenses that are not covered by the Plan or by other plans in which you or your Dependents participate.

Eligible Dependents for Your HCFSA Option

For your HCFSA Option, your eligible Dependents include any person who qualifies as your Dependent for income tax purposes. This generally includes anyone who depends on you for at least half of his or her financial support. (In other words, a Dependent does not have to meet the requirements for Dependent coverage under the Plan in order to qualify under the HCFSA Option.)

In addition, eligible Dependents include all children up to age 26. If the definition of Dependent in the Plan document provides coverage for a child beyond age 26 (Dependent who is mentally or physically disabled), the provision and all restrictions will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child will start at age 26.

Eligible Health Care Expenses

Eligible health care expenses include your medical and dental Deductibles, your share of other expenses covered by the Oncor health care options, as well as certain additional medical, prescription drug, dental, and vision expenses that are not covered or fully reimbursed by any employer-provided plans.

In general, expenses that qualify as itemized deductions on your federal income tax return are eligible for reimbursement through the HCFSA Option. Contact ConnectYourCare, the FSA administrator, by visiting **ConnectYourCare.com** or calling **1.877.292.4040** for a complete and up-to-date list of eligible expenses.

> You can get additional information about eligible health care expenses from **IRS Publication 502, Medical and Dental Expenses**. You can also visit the IRS website at **irs.gov** for these documents.

Listed below are a few examples of eligible expenses:

- Any Deductibles and Copayments you pay for medical, dental, or vision coverage through Oncor or other health care plans in which you or your Dependents participate,
- Your Coinsurance – that is, the portion of medical, dental, or vision expenses you pay under your health care options,
- Medical, dental, and vision expenses that exceed your health care option's maximums – for example, charges that exceed reasonable and customary* limits, and charges that exceed annual or treatment limits,
- Expenses that are not covered by health care options, such as private hospital room charges, eye exams, eyeglasses, special features for eyeglasses, contact lenses and supplies, and laser eye surgery to the extent these charges are not covered by other medical or vision options,
- Insulin,
- Fertility enhancement,
- Psychiatric care, psychoanalysis, and psychologist's fees that are not covered or that exceed medical option limits,
- Stop-smoking programs and medications, if prescribed by a physician,
- Weight-loss programs for the treatment of an existing disease, including weight-loss medications, if prescribed by a physician,
- Special education or learning disability fees for the treatment of a specific medical condition,
- Transportation expenses for medical care, and cost of meals and lodging at a hospital or similar institution,
- Nursing-home care and long-term care to the extent charges do not constitute *qualified long-term care services* under Section 7702B of the Internal Revenue Code (**https://irs.gov/pub/irs-regs/td8792.pdf**),
- Fees for special homes for the mentally handicapped if recommended by a psychiatrist,

*See ***Reasonable and Customary Charges (for the Dental options)*** in the **Glossary** section of this handbook.)

- Capital expenses for special medical equipment installed in your home or for certain improvements made to your home to accommodate your or your Dependents' disabled condition,
- Lead-based paint removal to prevent a child who has (or has had) lead poisoning from ingesting paint,
- Special equipment for disabled persons, such as special hand controls and other equipment installed in a car in order for a disabled person to operate a car,
- Hearing aids, the cost and repair of special telephone equipment for the hearing-impaired, and the cost of equipment that displays the audio part of television programs for the hearing-impaired, and
- Guide dogs and Braille books and magazines.

Ineligible Health Care Expenses

Listed below are examples of expenses that are not eligible for reimbursement from your Health Care FSA (HCFSA). Contact ConnectYourCare, the FSA administrator, by visiting ConnectYourCare.com or calling **1.877.292.4040** for a complete list of ineligible expenses.

- Marriage or family counseling,
- Custodial Care in an institution or a nursing home,
- Cosmetic treatments or surgery (including face-lifts, liposuction, electrolysis, and hair transplants), unless for correction of disfigurement due to an accident or a birth defect, and
- Over-the-counter medicines or drugs for which you have not received a prescription.
- Expenses for general well-being, such as health club dues, YMCA dues, exercise classes, swimming lessons, dancing lessons, steam baths, vitamins (unless prescribed by a physician for a specific health problem), nutritional supplements, and personal use items. Items such as these are covered only when you submit with your claim a letter of medical necessity from the prescribing physician.
- Costs associated with weight loss or stop-smoking programs, unless prescribed by a physician for a specific health problem. These costs are covered only when you submit with your claim a letter of medical necessity from the prescribing physician.

ELIGIBLE DEPENDENT CARE EXPENSES

You can use your Dependent Care FSA (DCFSA) Option for child care expenses for your children under age 13 or for day care expenses for a disabled spouse or other Dependent who is incapable of self-care.

Eligible Dependents for Your Dependent Care FSA Option

The purpose of the DCFSA is to reimburse you for day care that is needed to allow you, and your spouse if you are married, to work. You also can be reimbursed for day care while your spouse is actively looking for work, attending school as a Full-Time Student, or if your spouse is incapable of self-care due to a mental or physical condition.

For this option, a qualifying Dependent is either of the following:

- A Dependent child who is under age 13 years at the time the care is provided and for whom you can claim an exemption on your federal income tax return or
- A mentally or physically disabled child or adult, if he or she lives with you, depends on you for at least half of his or her financial support, and is incapable of caring for himself or herself.

If you're divorced or legally separated and have custody of your children, but your former spouse claims them as Dependents for income tax purposes, you can be reimbursed for their Dependent care expenses if you have custody of them for more than six months during the year.

A Dependent does not need to meet the definition of a qualified Dependent under other company plans to qualify as a Dependent under the DCFSA. See ***Dependent (for FSAs)*** definition in the **Glossary** section of this handbook.

Information About Your Day Care Provider

You'll need your day care provider's name and address as documentation when you file a claim for Dependent care expenses. You'll also need your provider's tax ID number when you file your taxes each year. (Note that a tax ID number is not required for a tax-exempt church day care provider.)

Eligible Dependent Care Expenses

Generally, any expense that qualifies for inclusion under the *Credit for Child and Dependent Care Expenses* section on your federal income tax return also qualifies for reimbursement from the Dependent Care FSA (DCFSA) Option.

For a complete and up-to-date list of eligible expenses, contact ConnectYourCare, the FSA administrator, by visiting **ConnectYourCare.com** or calling **1.877.292.4040**.

Listed below are a few examples of eligible expenses:

- Over-the-counter medications per the CARES Act,
- Care provided in your home by a babysitter or nurse (if a nurse is providing medical services, those expenses do not qualify under the DCFSA Option, but may qualify under the Health Care FSA (HCFSA) Option),
- Care provided in your home (such as bathing and preparing meals) for a disabled person or an elderly Dependent living with you,
- Day care given outside your home by a Qualified Child Care Provider,
- Before-school and after-school care,
- School tuition, up to and including prekindergarten, and
- Dependent day care expenses incurred while your spouse either is disabled or is a Full-Time Student – even though your spouse does not work.

> You can get additional information about Dependent care expenses from **IRS Publication 503, Child and Dependent Care Expenses**. You can also visit the IRS website at **irs.gov** for these documents.

Ineligible Dependent Care Expenses

For a complete list of ineligible expenses, contact ConnectYourCare, the FSA administrator, by visiting **ConnectYourCare.com** or calling **1.877.292.4040**.

Examples of Dependent care expenses that are not eligible for reimbursement are:

- Services provided for a child who is age 13 or older unless the Dependent is mentally or physically disabled,
- Any expenses reimbursable through any other benefit plans, including your spouse's employer-provided plans, a separate individual insurance policy, and coverage under any government programs,
- School tuition for first through twelfth grades,
- Fees charged by an overnight camp,
- Any expenses that are claimed as a deduction on your income tax return,
- Services provided by your child under age 19 (even if you do not claim that person as a dependent on your income tax return),
- Services provided by your spouse or a person you claim as a dependent on your tax return (such as a relative who lives with you),
- Any expenses that could not be claimed as a deduction on your federal income tax return, and
- Charges for nursing home care.

HOW TO RECEIVE FSA BENEFITS

The benefit of your FSA options is to pay your health care and Dependent care expenses with tax-free dollars. During the Plan Year, as you incur eligible expenses, you can receive benefits:

- By having eligible expenses automatically drawn from the Health Care FSA (HCFSA) (by using your FSA debit card) for any medical, prescription drug, dental, or vision provider, and
- By paying for eligible expenses yourself and submitting claims for reimbursement.

For More Information

Contact ConnectYourCare, the FSA administrator, by visiting **ConnectYourCare.com** or calling **1.877.292.4040** to:

- Find out about card transaction limits for various services and provider categories,
- Get more information about your card and how to use it,
- Access forms to complete online, or
- Print forms for filing paper claims.

Claim Submission Deadline

Be sure to submit claims for all expenses incurred while you are a participant in the options. If you participate in an FSA this year, you must submit your claims for expenses incurred this year before the claim submission deadline ends on March 31 of next year. Any amounts from the prior year remaining in your account after March 31 will be forfeited.

Having Eligible Expenses Paid Automatically

You can use the HCFSA to pay your Copayments or Coinsurance at your pharmacy, hospital, and doctor's or dentist's office. If you are an FSA participant, simply present your FSA debit card and the payment will be automatically drawn from your HCFSA first (if sufficient funds remain in the FSA to fully cover the cost) and then your HRA if you participate in an HRA and have funds available.

If you are in the Scott & White Health Plan (SWHP) Option or any other medical plan, you can use the FSA debit card to pay many of your own eligible health care expenses and those of your eligible Dependents. You use the card just like an ordinary credit card, but you still need to save your receipts and submit them to the FSA administrator for substantiation of your purchases.

Paying Eligible Expenses Yourself and Submitting Claims for Reimbursement

You have the option of paying for some eligible expenses yourself and then filing your claims for reimbursement. You can:

- Use the online claim submission process through the FSA administrator's employee site, or
- Submit a paper claim form with your itemized receipts or other required expense documentation. You can obtain a paper claim form by contacting ConnectYourCare. Follow the instructions to submit your signed claim form.

If You Do Not Provide Required Expense Documents

If you do not provide documentation of expenses that are reimbursed through your FSA debit card, your debit card may be suspended and you will not be able to use it for expenses. In addition, unverified expenses may become taxable to you the following tax year.

Save All Bills, Receipts, and Other Documentation

Whether you pay expenses with your FSA debit card or you submit a claim for reimbursement by fax or mail, you must get itemized receipts or other required documentation for products purchased or services rendered. You'll need to turn in these receipts when you file a claim, and you may need to provide this documentation for validation purposes when using your card. If you don't provide this supporting documentation, your claim will not be processed and you won't be reimbursed.

Participants in the HSA Option

With an HSA, you **may not** participate in a Health Care FSA (HCFSA) Option.

Participants in Other Medical Options

You may participate in an HCFSA even if you do not enroll in an Oncor medical option. You will receive an FSA debit card that you can use for reimbursements from your HCFSA.

Documents You'll Need to Provide for Claim Processing

You must provide proper supporting documentation to ConnectYourCare so that your claim can be approved. This includes itemized receipts or other documentation, such as an Explanation of Benefits (EOB) statement from your health plan if you do not have a BCBSTX medical option.

Defining a Dependent

The FSAs define "Dependent" differently than the Oncor benefit options. See ***Dependent (for FSAs)*** in the **Glossary** section of this handbook for details.

Your Receipts Should Include This Information:

Health Care Claims	Dependent Care Claims
An itemized receipt must include: > Date of service, > Name of service provider, > Name of patient (not required for over-the-counter drugs), > Name of drug, product, or service, and > Amount paid.	If you use a care provider or day care service, your receipt must contain: > Dates of service, > Name of service provider, > Name of Dependent receiving services, and > Amount paid.

If the receipt is handwritten, it must include the service provider's signature. For prescription drugs, submit the receipt that the pharmacist attaches to the prescription – don't submit the cash register receipt.

If you have medical insurance, proof (such as an EOB) of any amount paid by other coverage is required.

If you've lost a receipt, contact your doctor or pharmacy to request a copy, or call your health plan for an EOB. If you don't provide the necessary information, the processing of your claim may be delayed. Visit the FSA administrator for more documentation requirements concerning medical necessity, orthodontia, and other services.

Refer to ConnectYourCare, the FSA administrator, by visiting ConnectYourCare.com or calling **1.877.292.4040**.

Information Required for Dependent Care Providers

Federal tax rules require you to report the care provider's name and address for any Dependent care expense claims. This applies both to expenses reimbursed from your Dependent Care FSA option and to expenses you claim as a tax credit on your federal income tax return. If you do not include this information when filing your federal income tax return, any DCFSA Option reimbursements that you received for payment of that provider's services may become taxable income to you.

Payment of FSA Reimbursements

Your claim will be processed as soon as administratively practical – usually within three to five days after the FSA administrator receives your paperwork. For faster processing, log on to your account with the FSA administrator and submit your claims online.

If you participate in direct deposit with your bank, reimbursements are deposited directly to your bank account; otherwise, a check is mailed to your home.

How Much You Can Receive

Health Care FSA (HCFSA)

At any time during the Plan Year, you can be reimbursed for up to the total amount of your HCFSA election. Your ongoing contributions will fund the deficit in your account for the remainder of the year.

Dependent Care FSA (DCFSA)

If the balance in your account is enough to reimburse your entire claim, you will be reimbursed for the full amount of eligible expenses. If the claim is for more than your current balance, you will be reimbursed for the amount of your current balance. The remaining claim will automatically be recorded and paid to you as additional contributions are made.

Account Balance Information

You can contact ConnectYourCare, the FSA administrator, by visiting ConnectYourCare.com or calling **1.877.292.4040**. to verify the amount of your annual contribution elections, obtain a summary of account transactions, and confirm current account balance(s) for each FSA option in which you are participating.

If a Claim Is Denied

There is a procedure to follow to obtain a full and fair review if a claim is denied and you believe it should be paid. See ***Claim Review and Appeal Process*** in the **Plan Administration** section of this handbook.

SITUATIONS AFFECTING YOUR FSA PARTICIPATION

Participation in the FSA options stops automatically if your paycheck from Oncor stops for any reason (for example, when you leave the company or take an unpaid leave of absence).

Participation also stops every December 31. If you want to participate in an FSA option during the next calendar year, you need to enroll during the Annual Enrollment period. Claims for the current year will be accepted through the claims submission deadline of March 31 of the following year.

Health Care FSA (HCFSA)

If your contributions to this account stop during the year for any reason, only expenses you have incurred up to the date of termination are eligible for reimbursement. Any remaining balance is forfeited. Claims for expenses in the current year incurred on or before the date of the last deduction will be accepted through the claims submission deadline of March 31 of the following year. Your participation may continue under COBRA, as described in the **Qualified Life Events** section of this handbook.

Dependent Care FSA (DCFSA)

If your contributions to this account stop during the year for any reason, you can continue to submit claims for expenses incurred before your participation ended, up to the remaining balance. Claims for the current year will be accepted through the claims submission deadline of March 31 of the following year.

Life and AD&D Insurance

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OPTIONS

Life insurance pays a benefit to your beneficiary(ies) in the event of your death. AD&D insurance provides a benefit to your beneficiary(ies) if you die or to you if you suffer certain types of injuries as a result of an accident. The Spouse Life and Child Life Options and/or AD&D Options pay a benefit to you if your spouse or child dies, or if they suffer certain types of injuries as a result of an accident.

This section provides a summary of the life and AD&D insurance coverage available to eligible employees and their Dependents. If you have any questions about the information in this section, contact the Oncor HR Service Center.

Coverage for a newly hired eligible part-time employee is based on 20 hours of work each week. Your annual base pay is calculated by multiplying your hourly rate of earnings by 1,040 hours. If your annual base pay changes during the year, your costs for life insurance will not change until the next Annual Enrollment period.

When moving from:

- **A full-time to an eligible part-time employment status,** you may maintain the coverage you had as a full-time employee until the next Annual Enrollment period or lower your life insurance within 30 days of the status change.
- **A part-time to an eligible full-time employment status,** you may maintain the coverage you had as a part-time employee until the next Annual Enrollment period or increase your life insurance within 30 days of the status event. Note that Statement of Health (SOH) rules may apply.

Group Term Life Insurance

All of the life and AD&D insurance currently offered is group term insurance. There is no cash accumulation for term life insurance. However, when you retire or leave Oncor, the Employee Life, Spouse Life, and Child Life Options may be portable. AD&D insurance is not portable.

In the event of an accidental death of a person covered by both Life Insurance and AD&D Insurance Options, both options pay a benefit.

Life Insurance Program A

Program A is a closed legacy Life Insurance Option. If you chose to keep your Program A coverage, your coverage is different from that currently offered under the Plan.

If you were eligible and chose to remain in Program A, you can elect to transfer to the current Plan Life Insurance Options during any Annual Enrollment period or when you have a qualified life event status change. However, you cannot transfer back to Program A at a later date.

For a description of that coverage, refer to the ***Life Insurance Program A*** information in this section of the handbook.

YOUR LIFE INSURANCE AND AD&D INSURANCE OPTIONS FACT SHEET

Oncor provides:

- **Basic Life Insurance** for you equal to one times your annual base pay up to a maximum benefit of $1 million.
- **Basic AD&D Insurance** equal to two times your annual base pay up to a maximum benefit of $2 million.

In addition, you may elect:

- **Optional Life Insurance** for yourself and Life Insurance for your spouse and children.
- **Optional AD&D Insurance** for yourself and your family.

This Fact Sheet provides an overview of these optional coverages.

More Information About Life Insurance Program A

If you are an employee who chose to continue life insurance under Program A, see ***Life Insurance Program A*** later in this section of the handbook for a description of coverage under that program.

Options	Coverage Choices
Optional Employee Life Insurance Options	1, 2, 3, 4, 5, 6, or 7 times your annual base pay, up to $2 million in optional coverage
Spouse Life Insurance Options (Available if you are enrolled in Optional Life Insurance for yourself in an amount at least equal to your spouse's coverage)	1, 2, 3, 4, 5, 6, or 7 times your (the Oncor employee's) annual base pay Maximum coverage is equal to either employee coverage or $250,000, whichever is lower.
Child Life Insurance Options	$10,000, $15,000, or $20,000
Optional Employee AD&D Insurance	1, 2, 3, 4, 5, 6, or 7 times your annual base pay, rounded up to the nearest $1,000, up to $2 million
Dependent AD&D Insurance (Family coverage)	• If you have a spouse only (no children), your spouse's coverage is equal to 60% of your optional family AD&D coverage amount. • If you have children only (no spouse), each child's coverage is equal to 15% of your optional family AD&D coverage amount. • If you have a spouse and children, your spouse's coverage is equal to 50% of your optional family AD&D coverage amount and each child's coverage is equal to 10% of your optional family AD&D coverage amount.

EMPLOYEE LIFE OPTION

Employee Life Option Coverage Choices

The company provides Basic Life Insurance equal to one times your annual base pay up to $1 million.

You can choose employee-paid coverage of one up to seven times your annual base pay, up to $2 million in Optional Life Insurance. If the resulting coverage amount is not an even multiple of $1,000, it is rounded to the next higher $1,000. (See the example on this page.)

Employee Life Option Coverage Choices

- 1 times annual base pay
- 2 times annual base pay
- 3 times annual base pay
- 4 times annual base pay
- 5 times annual base pay
- 6 times annual base pay
- 7 times annual base pay

Your annual base pay does not include overtime or any other form of extra pay. If your annual base pay changes during the year (for example, when you get a raise), your costs for life insurance will not change until the next Annual Enrollment period; however, the benefit paid would include any salary increase as of the day your new pay rate goes into effect.

At each Annual Enrollment period, you can increase your Optional Life coverage by one coverage level (for example, from one times pay to two times pay, or from three times pay to four times pay) without providing a Statement of Health (SOH).

An Example

Here's an example of how coverage is calculated for Optional Employee Life Insurance:

Optional Employee Life Insurance Coverage Example	
Annual base pay	$42,500
Coverage election of 3 times annual base pay	$42,500 x 3 = $127,500
$127,500 is not an even multiple of $1,000. It is rounded up to:	**$128,000**

Plus, this employee would have $43,000 ($42,500 rounded up to the next $1,000) in Basic Life Insurance.

Statement of Health (SOH)

You must provide an SOH and receive approval from the insurance company if you:

- Didn't enroll in optional coverage when you were first eligible and choose to do so at a later date,
- Choose to increase your coverage during Annual Enrollment by:
  - One times your pay if your total elected coverage will exceed four times pay, or
  - More than one times your annual base pay, or
- Are a new employee and you elect Optional Life Insurance greater than four times your annual base pay.

The SOH may also apply to spouse coverage elected or increased after the spouse is first eligible.

Any requested coverage that requires an SOH will not take effect until MetLife provides approval.

The maximum Optional Employee Life coverage available is $2 million.

For more information about making your Plan elections, see ***Enrolling for Coverage*** in the **Plan Participation** section of this handbook.

Premiums Based on Tobacco-User Status

Your premiums for the Employee Life Option and the Spouse Life Option are based on whether or not you use tobacco products. You are considered to "use tobacco products" if, in the previous two years, you smoked cigarettes, pipes, or cigars, and/or you used snuff and/or chewed tobacco. It is your responsibility to notify Oncor if you or your covered spouse has a change in tobacco user status. Rates are announced each year during the Annual Enrollment period.

Beneficiary

Benefits are paid to the beneficiary you designate (see ***Designating a Beneficiary*** in the **Plan Participation** section of this handbook). Make sure to designate both a primary beneficiary and contingent beneficiary who will receive your Life Insurance proceeds if your primary beneficiary should die before you. You must designate a beneficiary for Basic Life, Optional Life, and AD&D insurance.

Accelerated Death Benefits Option

If you have a terminal illness with a life expectancy of 24 months or less, you can elect to receive a portion of your life insurance benefit before your death.

You may be able to receive up to 80% of your insurance coverage before you die. The minimum payout is $20,000. The maximum payout is $500,000. For details, call the Oncor HR Service Center.

The benefit payable to your beneficiary upon your death is reduced by the amount of the accelerated benefit.

All claims for this option must be certified by a licensed physician and approved by the insurance carrier. You may be asked to have a physical exam by a doctor chosen by the insurance carrier.

See ***When Employee, Spouse, or Child Life Insurance Benefits Are Not Paid*** in this section of the handbook for exclusions under this benefit.

SPOUSE LIFE OPTION

Eligibility

You can enroll for the Spouse Life Option if you are enrolled for Optional Life Insurance for yourself in an amount at least equal to your spouse's coverage (maximum of $250,000).

For more information about eligibility, see ***Dependent Eligibility*** in the **Plan Participation** section of this handbook.

Eligible Spouse

For this option, your spouse is eligible for coverage if you are legally married, and if your spouse lives in the United States and is not serving in the armed forces.

If you are married to another Oncor employee or Retiree, you must each be insured as an employee or Retiree (not as a Dependent) under the Life Insurance Program.

Spouse Life Option Coverage Choices

You can choose any of the Spouse Life coverage choices available through the Plan.

The coverage choices are based on the annual base pay of you, the Oncor employee. If the result is not an even multiple of $1,000, it is rounded up to the next higher $1,000.

You cannot choose Spouse Life coverage that is greater than your Optional Employee Life coverage, and there is a maximum coverage limit of $250,000 for the Spouse Life Option.

Spouse Life Option Coverage Choices

- 25% times annual base pay *(no longer available as of January 1, 2021)*
- 50% times annual base pay *(no longer available as of January 1, 2021)*
- 1 times annual base pay
- 2 times annual base pay
- 3 times annual base pay
- 4 times annual base pay
- 5 times annual base pay
- 6 times annual base pay
- 7 times annual base pay

Beneficiary

You are automatically the beneficiary for the Spouse Life Option and any benefits are paid to you. No additional paperwork is required to be completed.

Accelerated Spousal Death Benefits Option

If your spouse has a terminal illness with a life expectancy of 24 months or less, you can elect to receive a portion of the Spouse Life Option benefit before your spouse's death.

You can receive up to 80% of the value of your spouse's coverage. The minimum payout is $20,000 and the maximum payout is $200,000. For details, call the Oncor HR Service Center.

The benefit payable to you upon your spouse's death is reduced by the amount of the accelerated benefit.

All claims for an accelerated benefit payment must be certified by a licensed physician and approved by the insurance carrier. Your spouse may be asked to have a physical exam by a doctor chosen by the insurance carrier.

See ***When Employee, Spouse, or Child Life Insurance Benefits Are Not Paid*** in this section of the handbook for exclusions under this benefit.

CHILD LIFE OPTION

Eligibility

You can enroll your children for the Child Life Option if you are enrolled for the Employee Life Option. **Note:** If you are married to another Oncor employee or Retiree, only one of you can cover your Dependent children. Also, if your Dependent child works for Oncor and is eligible for coverage as an employee, you cannot also cover that child as a Dependent.

For more information about eligibility, see ***Dependent Eligibility*** in the **Plan Participation** section of this handbook.

Child Life Coverage Choices

You can choose any of the Child Life Option coverage choices available through the Plan. When you elect the Child Life Option, all of your eligible Dependent children are automatically covered. The cost of the coverage is the same, regardless of the number of eligible children you have.

Child Life Coverage Choices

- $10,000
- $15,000
- $20,000

Beneficiary

You are automatically the beneficiary for the Child Life Option, and any benefits are paid to you.

Note that the accelerated benefits option does not apply to the Child Life Option.

WHEN EMPLOYEE, SPOUSE, OR CHILD LIFE INSURANCE BENEFITS ARE NOT PAID

Benefits are not paid for suicide committed within two years after coverage starts. Additionally, benefits for any coverage increase are not paid for suicide committed within two years after the coverage increase goes into effect.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OPTIONS

AD&D provides a benefit if you die or suffer certain types of injuries as a result of an accident. The amount of benefit paid is based on the severity of the accidental loss.

Oncor provides you with Basic AD&D Insurance at no cost to you equal to two times your annual base pay up to a maximum of $2 million.

Optional AD&D for You and Your Family

You can choose any of the Optional Employee AD&D coverage choices available through the Plan.

You can choose coverage for yourself from one up to seven times your annual base pay. If the result is not an even multiple of $1,000, it is rounded up to the next higher $1,000.

AD&D Insurance Options

Optional AD&D Coverage Choices

- 1 times annual base pay
- 2 times annual base pay
- 3 times annual base pay
- 4 times annual base pay
- 5 times annual base pay
- 6 times annual base pay
- 7 times annual base pay

The maximum AD&D you may elect is $2 million of coverage.

Dependent AD&D Option Coverage Benefits

If you choose the Dependent AD&D Option, these are the benefit levels that would be paid for each family member:

> If you have a spouse only (no children): 60% of your optional family AD&D coverage amount,

> If you have children only (no spouse): 15% of your optional family AD&D coverage amount, or

> If you have a spouse and children: Spouse coverage is 50% of your optional family AD&D coverage amount, and each child's coverage is 10% of your optional family AD&D coverage amount.

For more information about making your Plan elections, see ***Enrolling for Coverage*** in the **Plan Participation** section of this handbook.

Eligible Dependents

Your eligible Dependents for AD&D coverage are defined in the same way as for Dependent Life Insurance coverage.

What AD&D Covers

AD&D benefits are payable if you or your Dependents die or suffer certain losses as the result of an accident.

AD&D covers certain losses of body parts, and it covers death caused by accidental injuries. If your death or loss occurs within 12 months of the accident, you or your beneficiary will receive a predetermined amount based on your annual base pay.

AD&D benefits are paid according to the following schedule:

Accidental Loss	Percentage of Benefit Paid
Loss of life	100%
Loss of two or more: hand, foot, or sight of eye	100%
Loss of one: hand, foot, or sight of eye	50%
Thumb and index finger of same hand	25%
Speech and hearing	100%
Speech or hearing in both ears	50%
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%

- **Loss of hands and feet** means permanently severed at or above the wrist or ankle.
- **Loss of thumb and index finger** means permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
- **Quadriplegia, paraplegia, and hemiplegia** mean the total paralysis, or permanent and complete loss of use of a limb, as determined by a physician, of both upper and lower limbs (quadriplegia), both lower limbs (paraplegia), or upper and lower limbs on one side of the body (hemiplegia).
- **Loss of sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
- **Loss of speech** means the entire and irrecoverable loss of speech that continues for six consecutive months following the accidental injury.
- **Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for six consecutive months following the accidental injury.

Only the loss providing the highest amount of insurance is paid for each accident. Once benefits for one loss have been paid, you cannot submit claims for later losses caused by the same accident.

Beneficiary

The Employee AD&D Option pays a benefit to the beneficiary you designate if you die in an accident. Refer to ***Designating a Beneficiary*** in the **Plan Participation** section of this handbook.

You are the beneficiary for AD&D benefits if you are injured (but do not die) in an accident, or if your covered spouse or child dies or is injured in an accident.

When AD&D Benefits Are Not Paid

Some losses are not covered. AD&D benefits are not paid for a loss if it in any way results from, or is caused or contributed to, by:

- Physical or mental illness, diagnosis of or treatment for the illness,
- An infection, unless it is caused by an external wound that can be seen and which was sustained in an accident,
- Suicide or attempted suicide that occurs within two years from the date AD&D insurance takes effect,
- Self-inflicted injury,
- The voluntary intake or use by any means of:
  - Any drug, medication, or sedative unless it is taken or used as prescribed by a physician,
  - An over-the-counter drug, medication, or sedative unless it is taken as directed, and
  - Alcohol in combination with any drug, medication, or sedative,
- A war or warlike action in time of peace, including terrorist acts,
- Committing or trying to commit a felony or other serious crime or an assault,
- Any poison or gas, voluntarily taken, administered, or absorbed,
- Service in the armed forces of any country or international authority, except the United States National Guard,
- While in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self-preservation), and/or
- Driving a vehicle while intoxicated, as defined by the laws of the jurisdiction in which the vehicle was being operated.

LIFE INSURANCE PROGRAM A

Eligibility

If you previously elected Life Insurance Program A and have not dis-enrolled, you have the Employee and Dependent Life Insurance described on this page instead of the ***Employee Life Option***, ***Spouse Life Option***, and ***Child Life Option*** described earlier in this section of the handbook. Program A is closed to new entrants.

You can change to the Employee Life Option currently available under the Plan during any Annual Enrollment period or if you have a qualified life event status change. Refer to ***Changing Your Coverage*** in the **Plan Participation** section of this handbook. However, once you move out of Program A, you cannot re-enroll in Program A.

Program A Coverage

Type of Coverage	Coverage Amount
Employee Life Insurance	
> Company-paid coverage	First $20,000
> Employee-paid coverage	2 times annual base pay (less $20,000 company paid)
Spouse Life Insurance	$15,000
Child Life Insurance	$5,000

Employee Life Insurance Options

Under Program A, you have coverage of two times your annual pay, of which the company pays for the first $20,000.

Dependent Life Insurance

You can elect Dependent Life Insurance of $15,000 for your spouse and $5,000 for each child.

Accelerated Benefits Option

If you have a terminal illness with a life expectancy of 24 months or less, you can elect to receive a portion of your life insurance benefit before your death.

You can receive up to 80% of the face value of your insurance coverage. The minimum payout is $20,000 and the maximum is $500,000 for you. For your spouse the payout is $12,000.

The benefit payable to your beneficiary upon your death is reduced by the amount of the accelerated benefit.

All claims for an accelerated benefit payment must be certified by a licensed physician and approved by the insurance carrier.

FILING A CLAIM

In the event of your death, ensure that your beneficiary knows to contact the Oncor HR Service Center as soon as possible.

If a Dependent dies or has a covered AD&D loss, or if you have an AD&D loss other than death, you should notify the Oncor HR Service Center as soon as possible.

A death certificate or proof of other loss will be required when the claim is filed. The claim should be filed as soon as possible after the death or loss.

Source of Payments

All of the benefits described in this section are paid through insurance policies with MetLife.

Benefits usually are paid in a single sum. However, other payment methods may be available upon request.

If a Claim Is Denied

If a claim is denied but you or your beneficiary believes it should be paid, you can request a full and fair review of the claim. For more information, see ***Claim Review and Appeal Process*** in the **Plan Administration** section of this handbook.

PORTABILITY AND CONVERSION

When you leave Oncor, you can continue the Employee Life Option coverage through portability or by converting your contributory coverage to an individual policy. With both options, you can continue coverage without providing a Statement of Health (SOH) that would be required if you were applying for an individual policy.

Rates for the portability provision are set by MetLife. If you choose, you can elect to provide an SOH to potentially reduce the premiums you pay.

If you elect the portability provision, you can convert any remaining amount that exceeds the portability maximum.

If you are enrolled in the Company Paid Life under Life Insurance Program A (Program A), you can only convert, not port, your coverage.

Portability

Under most circumstances, you can continue the Employee Life Option (not including Program A), the Spouse Life Option, and the Child Life Option through the Plan's portability provisions if your employment ends or you are no longer eligible for coverage. Your spouse can continue the Spouse Life Option and the Child Life Option in the event you die or you are divorced. A child cannot continue the Child Life Option unless you or your spouse is also continuing coverage.

Portability coverage is provided through an insurance policy with MetLife; however, the terms of that policy may be different from the coverage under the Plan.

To continue coverage, you (or your spouse) must, within 31 days after the date your coverage ends, give MetLife written notice of your intention to continue coverage. Conversion or portability should be applied for:

- Within 31 days from the date benefits are terminated, or
- Within 45 days from the date a notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated.

It is your responsibility to contact MetLife directly and complete the portability application process within the required time frame.

You can continue the same amount of coverage you had with the company on the date your coverage ends. You may contact MetLife Recordkeeping Center at **1.866.492.6983** for any additional questions regarding portability. You cannot continue a higher amount of coverage for your Dependents than you continue for yourself.

You pay the coverage premiums directly to MetLife. The continued policy is your individual policy and is not part of the Plan.

Converting Your Coverage

Under most circumstances, you can convert the Employee Life Option (including Program A), the Spouse Life Option, and the Child Life Option when coverage ends (for example, if your employment ends or if you or a Dependent is no longer eligible for coverage). If you choose the portability feature but are not able to port your entire amount of life insurance coverage, you can convert any remaining amounts to an individual policy.

When you convert coverage to one of the insurance company's individual life policies, you do not need to provide a Statement of Health (SOH) (proof of good health).

The benefits and provisions of the individual policy will be different from the policy under Life options under the Plan Life Insurance Options. For example, the individual policy will not be a term life insurance policy. You may be able to find better rates or coverage on your own through another insurance carrier.

To convert coverage, you must:

- Notify MetLife of your intention to convert coverage,
- Complete and submit an application within 31 days after coverage ends, and
- Pay the first premium within 31 days after coverage ends.

If you have questions about converting your coverage, contact MetLife directly. Note that special provisions and limits may apply if your coverage should end because of an amendment or termination of the Plan's Life Option. Since MetLife does not currently take responsibility for providing a conversion notice, terminated employees should first contact the Oncor HR Service Center as soon as possible for the conversion/portability form with completed Employer information.

Once a terminated employee is provided the form, he/she may contact MetLife directly at **1.877.ASKMET7** (**1.877.275.6387**). Note, however, that you must complete the conversion application process and pay the first premium with the 31-day period described in this section. It is your responsibility to meet this deadline.

You cannot convert AD&D coverage to an individual policy.

ADDITIONAL BENEFITS AND SERVICES

Survivor's Benefits

In the event of your death, your eligible beneficiary will be paid a benefit equal to one month of your base pay. This benefit is in addition to any other life insurance and retirement plan death benefits, if any.

Financial Consulting Services

In the event of your death, your surviving spouse, eligible beneficiaries, and/or other eligible Dependents can access free financial counseling services. This counseling is provided by an independent company. The counselors work on a fee-only basis (paid by Oncor) and do not sell commission products.

In the event of your spouse's death, you are also eligible to access free financial counseling services.

Funeral Planning Services and Grief Counseling

These services are available through MetLife.

Free Will-Writing Services

As an eligible employee or Dependent spouse, you have access to free will writing services through MetLife Legal Plans at **1.800.821.6400**. This service is not available for covered Dependent children.

In the event of your death, your surviving spouse and/or eligible Dependents may be eligible for continuation of certain health coverage. They may access information about this coverage in the ***Oncor Retiree Welfare Plan Summary Plan Description*** in the ***Oncor Benefit Handbook for Oncor Retirees and Long-Term Disability Participants*** by logging on to **oncorretirees.com**. Click ***Reference Center***.

To Reach MetLife

For claim-related information, you can call MetLife at **1.800.638.6420**, ***Option 2***.

Disability

LONG-TERM DISABILITY (LTD) BENEFITS

No one wants to be sick or injured. Besides the worry of medical expenses and getting back to good health, you still need to receive an income to pay the bills. That's what LTD is all about – coverage that provides an ongoing source of income if you are unable to work due to an extended illness or injury.

If you are an eligible employee, you have two types of disability coverage:

- Salary continuation to protect your income if you have a minor or short-term illness or injury. This coverage is described on the Oncor intranet under "Our Company and Our Policies and Procedures."
- Long-term disability (LTD) coverage to protect your income if you are disabled for an extended period of time. Oncor provides LTD coverage at no cost to you. The LTD benefits can replace up to 66⅔% of your base pay, up to a maximum $25,000 monthly benefit. Because Oncor pays the full cost of this benefit, you will pay taxes on LTD benefits you receive from the plan.

This section of your handbook describes LTD benefits.

Medical Coverage for Employees Receiving LTD Benefits

Refer to the ***Oncor Retiree Welfare Plan Summary Plan Description*** in the ***Oncor Benefit Handbook for Oncor Retirees and Long-Term Disability Participants*** for details about medical coverage for employees receiving LTD benefits.

Limited LTD Coverage for Pre-Existing Conditions

If you are disabled due to a pre-existing condition during the first 12 months you are covered by LTD, benefits are not paid for that disability. A pre-existing condition means a sickness or accidental injury for which you:

- Received medical treatment, consultation, care, or services or
- Took prescription medication or had medications prescribed in the six months before your insurance or any increase in the amount of insurance under this option takes effect.

MetLife will not pay benefits for a disability that results from a pre-existing condition, if you have been Actively at Work for less than 12 consecutive months after the date your LTD coverage under the Plan takes effect.

HOW YOUR LTD BENEFIT IS CALCULATED

If you become disabled, you may be eligible for income from several different sources (see *Other Sources of Disability Income*, in the right column). The LTD benefit options are designed to work with these other sources to continue a total of 66⅔% of your monthly pay up to a maximum monthly benefit of $25,000 (depending on your Plan election). In other words, the LTD benefit options are designed to make up the difference between the 66⅔% benefit level and any benefits payable from these other sources.

For the LTD benefit options, your "pay" means your regular pre-disability earnings. Pre-disability earnings means base salary or base wage rate you were earning from Oncor as of your last day of Active Work before your disability began. The term does not include:

- Commissions,
- Bonuses or any other incentive compensation,
- Overtime pay,
- Awards and the grant, award, sale, conversion, and/or exercise of shares of stock or stock options,
- Oncor's contributions on your behalf to any deferred compensation arrangement or pension plan, or
- Any other compensation from Oncor.

Other Sources of Disability Income

Examples of other sources of disability income that may be payable because of your disability include:

- Social Security disability or retirement benefits that you receive or are eligible to receive because of your disability,
- Workers' compensation,
- Any third-party award, settlement, or payment resulting from your disability, and
- Any other disability benefit you receive under any applicable federal, state, or local statute, rule, or ordinance.

An Example

Following is an example to show how an LTD benefit might be calculated. Your annual pay is $36,000, so your monthly pay is $3,000. You are eligible for a monthly Social Security benefit of $1,200. Your benefit would be calculated like this:

LTD Benefit Example	
Monthly LTD benefit level equals 66⅔% of your $3,000 monthly pay	$2,000
Monthly Social Security pays this amount	$1,200
Monthly LTD benefit makes up remainder	$800

If you apply for, but are not eligible for, Social Security or other sources of income, the LTD benefit would be the entire amount or $2,000 a month.

WHEN CAN I RECEIVE LTD BENEFITS?

LTD benefits are payable if you have a disability that prevents you from working and you meet the Plan's disability requirements. The terms *Disabled* or *Disability* mean that, due to sickness or as a direct result of accidental injury, you are prevented from working and:

- You are receiving appropriate care and treatment and complying with the requirements of such treatment.
- During the Elimination Period (typically, 180 days after the date of your disability) and continuing for the first 24 months of sickness or accidental injury, you are unable to earn more than 80% of your pre-disability earnings at Your Own Job from any employer in your local economy; and unable to perform each of the material duties of Your Own Job. For the purposes of the Disability Plan, *Your Own Job* means the essential functions you regularly perform that provide your primary source of earned income.
- After 24 months of disability, the disability prevents you from working at any job for which you're qualified by education, training, or experience and unable to earn more than 60% of your pre-disability earnings from any employer in your local economy at any gainful occupation for which you are reasonably qualified taking into account your training, education, and experience.

In order to receive, and to continue to receive LTD benefits, you must be under the care or supervision of a physician for the disability at all times. To confirm your disability status throughout your leave, MetLife will ask you to have a physical exam by a doctor chosen by MetLife. To continue to receive LTD benefits, you must take these examinations and you must supply MetLife with the result, along with other requested information concerning your condition.

When LTD Benefits Are Not Paid

LTD benefits are not payable for a disability resulting from any of the following circumstances:

- War, whether declared or undeclared, or act of war or participation in an insurrection, rebellion, riot, or terrorist act,
- Intentional self-inflicted injury,
- Attempted suicide,
- Commission of or attempt to commit a felony, or
- A disability occurring due to any income-producing activity outside of Oncor's employment.

Responsibilities of a Participant

If you are disabled and eligible for disability benefits, it is your responsibility to cooperate with MetLife, to comply with all Plan provisions, and to effectively manage your period of disability to the extent that you are able. Your failure to do so may result in a loss of benefits. In addition to any other responsibilities described in this section, you are responsible for the following:

- You must obtain medical treatment and follow your doctor's medical advice.
- You must file a complete disability benefit application while you are still a regular full-time employee of Oncor and provide any medical information requested.
- You must apply for Social Security disability benefits and appeal any denial of these benefits.
- You must promptly notify MetLife of any Social Security benefits (including Social Security disability and retirement benefits), workers' compensation benefits, or third-party awards, settlements, or payments and provide the necessary documentation for these benefits or payments upon request.
- You must comply with MetLife's rehabilitation requests, including requests to participate in or pursue vocational and/or medical rehabilitation.
- You must make a diligent effort to return to work with Oncor or elsewhere – either as an employee or on rehabilitation status.
- You must notify MetLife of any and all information concerning your outside employment or income-producing activities.
- You must promptly notify the Oncor HR Service Center if your address changes while you are receiving benefits.

WHEN LTD BENEFITS START AND END

When LTD Benefits Start

If you are eligible, your LTD benefits start upon exhaustion of the required Elimination Period (typically, 180 days after the date of your disability). If approved, LTD benefits begin the day after completion of the Elimination Period.

When LTD Benefits End

As long as you remain disabled, LTD benefits may continue until you reach retirement age. If you become disabled before age 62, benefits are paid until you are no longer disabled, or to the later of Social Security Normal Retirement Age or age 65. If you become disabled on or after age 62, benefits may be paid for a specific number of months based on age at the time of disability, or until you are no longer disabled, whichever comes first, as shown in this chart.

Age at Date of Disability	Benefit Period for LTD Benefits	Age at Date of Disability	Benefit Period for LTD Benefits
Less than 62	Until you reach age 65	**66**	21 months
62	42 months	**67**	18 months
63	36 months	**68**	15 months
64	30 months	**69 and over**	12 months
65	24 months		

Rehabilitation Benefits

If, during the first 24 months of LTD, you are able to work at a job approved by the LTD insurance carrier, you may continue to receive your LTD benefits in addition to your pay from the approved job. However, if the income you receive from all sources during this rehabilitative employment exceeds your pre-disability earnings, your LTD benefit will be reduced.

If you participate in a Rehabilitation Program, your Monthly Benefit will be insured by an amount equal to 10% of the Monthly Benefit. The Plan will do so before your Monthly Benefit is reduced by any other income.

Work Incentive

A *Rehabilitation Program* is a program that has been approved by MetLife for the purpose of helping you return to work. It may include, but is not limited to, your participation in one or more of the following activities:

- On-site job analysis,
- Job modification/accommodation,
- Training to improve job-seeking skills,
- Vocational assessment,
- Short-term skills enhancement,
- Vocational training, or
- Restorative therapies to improve functional capacity to return to work.

If you work while you are disabled and receiving Monthly Benefits, your Monthly Benefit will be adjusted as follows:

- Your Monthly Benefit will be increased by Your Rehabilitation Program Incentive, if any, and
- Your Monthly Benefit will be reduced by ***Other Sources of Disability Income***, as defined in this section of the handbook.

Your Monthly Benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted Monthly Benefit plus the amount you earn from working and the income you receive from Other Income exceeds 100% of your pre-disability earnings as calculated in the definition of Disability. See ***Offset of Income from Other Sources*** in this section of the handbook for more information.

If Your Disability Recurs

If you return to work with Oncor after receiving LTD benefits and then become disabled again for the same cause within 90 days after returning to work, you may be eligible to have your LTD benefit resume in the same amount that was paid during the first disability.

If a different disability occurs at any time, or if the same disability recurs later than 90 days after you return to work, that disability will be considered a separate period of disability. Your LTD benefits will be based on your pay before you became disabled the second time. However, if the second disability is due to the same cause as the first, your benefit won't be less than the amount payable during the first disability.

If Your Disability Is Caused by a Mental or an Emotional Condition or by Chemical Dependency

You can receive LTD benefits for a maximum of two years if you are disabled due to a mental or an emotional condition or to chemical dependency. Disability benefit payments will end at the earliest of the date:

- You receive 24 months of disability benefit payments.
- You cease or refuse to participate in a recovery program.
- You complete a recovery program.

HOW TO FILE A CLAIM FOR LTD BENEFITS

If you are on Salary Continuation administered by Oncor, you must file an LTD claim with MetLife before the exhaustion of the six-month (180-day) Elimination Period. You should contact MetLife as soon as possible to initiate your LTD claim. Contact the Oncor HR Service Center for assistance in filing your claim.

Apply for Social Security Benefits

Social Security disability benefits, if approved, are payable after five months of disability. However, it can take several months to apply for Social Security benefits, so it's a good idea to apply as soon as you think your disability may last for more than five months. You should contact your local Social Security office to apply for these benefits.

When you know the amount of your Social Security benefit or if your claim for Social Security benefits is denied, contact MetLife. MetLife may be able to help you with your claim for Social Security disability benefits.

If you do not apply for Social Security benefits when eligible, MetLife may estimate the amount of your Social Security benefits and reduce your LTD benefits by that estimate. Your LTD benefits will be adjusted accordingly when you provide MetLife with required information concerning the approval or denial of your claim for Social Security benefits. See the section ***Offset of Income from Other Sources*** in this section of the handbook.

Payment of LTD Benefits

LTD benefits are normally paid near the end of each month. Federal taxes, where applicable, will be withheld from LTD Plan benefits payable to you.

Claims Administrator

MetLife administers claims for Oncor LTD benefits. You should send all claims, doctor's statements, and other information to MetLife. Only send address changes to the Oncor HR Service Center.

If Your Application Is Denied

If your application is denied, you are entitled to a full review. The steps in the review process are outlined in the ***Claim Review and Appeal Process*** explanation in the **Plan Administration** section of this handbook.

Offset of Income from Other Sources

Your disability benefits may be reduced by the amount of other income you, your spouse, or your children receive from other sources, including the following:

- Social Security or the Railroad Retirement Act retirement or disability benefits,
- Retirement or disability plan benefits of a state or local government or another country,
- A no-fault auto policy for loss of income (excluding supplemental disability benefits),
- A government benefit plan or program that provides benefits for loss of time from your job due to disability,
- Sick pay, vacation pay, or salary continuation paid by Oncor,
- Workers' compensation or similar benefits,
- Occupational disease laws or maritime maintenance and cure laws,
- Unemployment insurance,
- Any income (e.g., salary, commissions, overtime pay, bonuses) you receive from working while you are disabled, and
- Any recovery amounts you receive for loss of income (including future earnings) as a result of claims against a third party, whether you receive these amounts through a judgment, a settlement, or otherwise. (See ***Lien and Repayment – Third Party Payments*** in this section of the handbook.)

For a complete list of other income sources, contact MetLife.

Social Security Benefits

You are required to apply for Social Security benefits if there is a reasonable basis for you to receive such benefits. Starting after you have received 24 months of LTD benefits, the amount of your LTD benefits will be reduced by the amount of Social Security benefits that MetLife estimates you, your spouse, or your children are eligible to receive as a result of your disability or retirement, unless you provide MetLife with an approval of your claim for Social Security benefits or a notice of denial of Social Security benefits showing that you have exhausted your appeals.

Within six months after becoming disabled, you are required to:

- Provide MetLife with proof that you have applied for Social Security benefits,
- Sign a reimbursement agreement in which you agree to pay MetLife for any overpayments that they may make to you under the Plan, and
- Sign a release authorizing the Social Security Administration to provide information directly to MetLife regarding your eligibility for Social Security benefits.

If the above requirements are not met, MetLife may reduce your LTD benefits by your estimated amount of Social Security benefits starting with the first LTD benefit payment coinciding with the date you are eligible to receive Social Security benefits.

You are required to notify MetLife of final approval or denial of your claim for Social Security benefits. At that time, the amount of your disability benefit will be adjusted, if necessary, and you will be required to repay any overpayment.

Other Benefits

If you receive other benefits in the form of a single sum payment, you are required to give MetLife written proof within 10 days of the following:

- The amount of the payment,
- The amount of the payment that is attributed to income replacement, and
- The time period for which the payment applies.

Once this information is provided, the amount of your disability benefit will be adjusted. If you do not provide this information, MetLife may reduce your disability benefit by an amount equal to the amount of the benefit until the single sum amount is exhausted. The amount of any adjustment will not cause you to receive a total benefit less than the minimum amount taking into consideration the single sum payment and your LTD benefit payment, unless there has previously been an overpayment.

Lien and Repayment – Third Party Payments

If you receive disability benefits under this option and you receive payment from a third party for loss of income with respect to the same loss of income for which you received LTD benefits under this option (for example, a judgment, settlement, payment from federal Social Security, or payment pursuant to workers' compensation laws), you are required to reimburse the Plan from the proceeds of such payment up to an amount equal to the benefits paid to you under this option for your disability. The Plan's right to receive reimbursement from any such proceeds will constitute a claim or lien against the proceeds and the Plan has a first priority claim or lien over any such proceeds up to the full amount of the benefits paid to you under this option for your disability. You agree to take all action necessary to enable the Plan to exercise its rights under this provision, including, without limitation:

- Notifying the Plan and the disability insurance carrier under the Plan as soon as possible of any payment you receive or are entitled to receive from a third party for loss of income with respect to the same loss of income for which you received benefits under this option,
- Furnishing of documents (including an acknowledgment of the Plan's lien rights described above) and other information as requested by the Plan or any person working on behalf of the Plan (including the disability insurance carrier), and
- Holding in escrow, or causing your legal representative to hold in escrow, any proceeds paid to you or any party by a third party for loss of income with respect to the same loss of income for which you received benefits under this option, up to an amount equal to the benefits paid to you under this option for your disability, to be paid immediately to the Plan upon your receipt of said proceeds.

You are required to cooperate and cause your legal representative to cooperate with the Plan in any recovery efforts and to not interfere with the Plan's rights under this provision. The Plan's rights under this provision apply whether or not you have been or will be fully compensated by a third party for any disability for which you received or are entitled to receive benefits under this option.

Employee Assistance Program

OVERVIEW

The Employee Assistance Program (EAP) is a professional, confidential service to help employees and their eligible household members resolve personal or job-related concerns, such as:

- Family conflict,
- Drug or alcohol abuse,
- Stress,
- Marital discord,
- Personal finances, and
- Other personal matters.

Counselors are available 24 hours a day, seven days a week at **1.800.327.6608**. You can log on to **MagellanAscend.com** for assistance and information.

The EAP also offers these services:

- Legal assistance,
- Financial coaching,
- Identity theft resolution, and
- Work-life assistance.

Confidentiality

Discussions with an EAP Counselor are confidential. The EAP will not share information about your use of the EAP without your permission, except as required or permitted by law. You will have an opportunity to evaluate the services provided by the EAP by completing a confidential survey.

EAP Terms to Know

Brief Counseling
Brief Counseling is outpatient counseling that is problem-focused; emphasizes skills and strengths; encourages practicing new behaviors; involves setting goals that are achievable in a one- to five-month period; involves interpretation, suggestions, and a framework provided by a licensed professional counselor; and/or that you may utilize alone or together with others who are important to resolution of your problem.

EAP Counselor
An EAP Counselor is a psychologist; clinical social worker; marriage, family, child counselor or financial counselor; or other behavioral health professional who is licensed under state law to deliver counseling services and who is contracted with the EAP Administrator to provide EAP services.

EAP ELIGIBILITY AND COST

You and your eligible household members become eligible to participate in the EAP on the first day of active employment. You do not have to be enrolled in a medical option to participate in the EAP. Your coverage and coverage of your eligible household members is automatic; you do not need to take any steps to enroll.

Eligible Household Members

Eligible household members include your:

- Spouse,
- Dependent child(ren) (whether or not they reside with you), and
- Members of your household.

Cost

The company pays the full cost of participation in the EAP for you and your eligible household members (see ***Covered Services*** in this section). If you are on an approved FMLA leave, non-occupational medical leave, or workers' compensation leave, your EAP coverage will continue at no cost to you. You have no obligation to pay any amount for EAP coverage or to obtain EAP services; there are no premiums, Copayments, Coinsurance, or Deductible payments applicable to EAP services.

Important!

You will be financially responsible for costs:

- To retain a lawyer or a financial coach after the free consultations have been used, and
- For the work-life services you select, such as child care.

HOW TO OBTAIN EAP SERVICES

To obtain EAP services, simply call toll-free at **1.800.327.6608**. EAP representatives are available 24 hours a day, seven days a week. Spanish-speaking representatives and counselors are available.

When you call the EAP, a Magellan representative will:

- Ask you questions to help identify the problem and how it is affecting you,
- Find out what solutions you have tried and explore other solutions and resources, and
- Help you develop a plan to manage the situation.

You also can access information, self-help tools, and other resources through MagellanAscend.com.

COVERED SERVICES

The EAP provides confidential assessment and counseling services to improve your health, relationships, and job performance.

You and each of your eligible Dependents and household members are eligible to receive up to eight in-person sessions per situation each year (as considered clinically necessary by the EAP). If you obtain in-person counseling for a situation together with an eligible household member, such as your spouse, the total number of in-person sessions for which you and the other person are eligible for that situation is still eight. The number of sessions does not double simply because two covered persons participate in counseling together, nor does it triple because three covered persons participate.

The EAP will help you develop solutions for the following:

- Family conflict,
- Drug or alcohol abuse,
- Other personal matters,
- Stress, and
- Personal finances.

In addition, the EAP offers:

- Legal assistance: Free 60-minute consultation on the phone or in person; discounted fees for services after 60 minutes,
- Financial coaching: Two free 30-minute telephone consultations; discounted fees for services beyond initial consultations,
- Identity theft resolution: Free 60-minute telephone consultation with a Fraud Resolution Specialist™, and
- Work-life services to help you with:
  - Adult care and aging issues,
  - Pregnancy and adoption,
  - Child care and parenting,
  - Daily living (expert guidance on various topics such as home improvement, auto services),
  - Education,
  - Moving,
  - Pet ownership,
  - Relationships (wedding planning, marriage laws and licenses, separation/divorce support), and
  - Special needs support.

If you have questions or would like assistance with your EAP services, call Magellan at **1.800.327.6608**.

Reimbursement of Claims

Magellan pays EAP Counselors directly. You do not have to file EAP claims.

SERVICES NOT COVERED BY THE EAP

The EAP does not include any of the services listed below. Some of these services may be covered by your medical option.

- Acupuncture,
- Aversion therapy,
- Biofeedback and hypnotherapy,
- Charges for completing claim forms,
- Charges for failure to keep a scheduled visit,
- Court-mandated counseling, evaluations required by a state or federal judicial officer or other governmental agency, or to be used in legal actions of any kind (for example, child custody proceedings),
- Direct treatment for intellectual disabilities, learning disabilities, or autism,
- EAP services when you sue, or threaten to sue, the company,
- Evaluations for fitness for duty, excuses for leaves of absence, or time off,
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), obtaining any kind of insurance coverage,
- Inpatient treatment,
- Medication, medication management, or treatment of any condition for which medication is required, unless you are seeing a doctor who prescribes medication for that condition and oversees your use of the medication,
- More than eight in-person EAP sessions per problem per year,
- Psychiatric services or other medical care,
- Psychological, psychiatric, neurological, educational, or IQ testing,
- Remedial education services, such as evaluation or treatment of learning disabilities, developmental and learning disorders, behavioral training, and cognitive rehabilitation,
- Services or supplies for which there is no charge,
- Services or supplies not needed for treatment or not approved by your EAP Counselor,
- Services or supplies required or paid for under any government law, including workers' compensation or other federal, state, or local law,
- Services rendered before coverage became effective,
- Services rendered by a family member,
- Sleep therapy,
- Testimony in legal proceedings or preparation for legal proceedings,
- Treatment by someone other than an EAP Counselor to whom Magellan referred to you,
- Treatment for any physical illness,
- Treatments, procedures, or devices considered experimental or investigational in nature as determined by the EAP Administrator, and
- Treatment for any problem or condition that cannot be resolved in Brief Counseling (for example, a psychosis or any other condition that requires inpatient treatment or more than eight sessions).

Vacation Purchase

VACATION PURCHASE

We all need time away from work for rest and relaxation and for personal reasons. That's why Oncor offers the Vacation Purchase Option.

Eligibility

You can take advantage of the Vacation Purchase Option if you're a regular full-time employee. When you are hired by Oncor, you must complete six months of service before you are eligible for vacation. As a result, if you are hired after July 1, you cannot purchase additional vacation for the calendar year in which you are hired.

How the Vacation Purchase Option Works

You can purchase from one hour to 40 hours of additional vacation through a pre-tax option. You purchase this additional vacation in one-hour increments.

Your cost for the Vacation Purchase Option is based on your annualized base pay from Oncor on October 1 of the year in which Annual Enrollment is held for the upcoming year. The calculation is as follows:

Your adjusted annualized pay on October 1 divided by 2,080 **X** **The number of Vacation Purchase Option hours you choose**

Vacation Purchase Example	
Annual base pay on October 1	$31,164
Divide your annual base pay by 2,080	$31,164 ÷ 2,080 = $14.98
If you want to purchase 40 hours, your total cost would be	40 hours x $14.98 = **$599.20**

You can purchase additional vacation hours by using:

- Any medical and/or dental credits that are left over after you have purchased your other benefits coverage or
- Pre-tax dollars if you do not have medical and/or dental credits remaining.

Any hours that you purchase are in addition to the vacation days available to you under Oncor's vacation policy. See the "Vacation Policy" on the Oncor intranet under Our Company > Policies and Procedures > HR Policies > Vacation for more information about the company's vacation policy.

Vacation time must be taken in the following order:

- Vacation carry-over from previous year,
- Vacation earned in current year, and
- Purchased vacation.

Any purchased vacation days that you do not use during the year are forfeited and cannot be rolled over to the next year.

If You Are a New Hire

If you are a regular full-time employee hired between January and June 30, you can purchase vacation. Purchased vacation can be taken once you have completed six months of continuous service.

A Note About Unused Vacation Purchase

In light of the unprecedented circumstances surrounding the coronavirus pandemic, for the 2020 Plan Year, if you do not use all of your purchased vacation, your unused purchased vacation **will not be forfeited**. Instead, Oncor will reimburse you for any unused purchased vacation. This reimbursement will be paid to you in the last pay period of 2020, and will be subject to normal taxes and withholdings.

Qualified Life Events

HOW SOME MAJOR LIFE EVENTS AFFECT YOUR BENEFITS

When certain life events occur, your benefits may be affected. In some cases, you can change your elections to account for your new situation, or you can receive certain benefit payments. In other cases, your coverage may be continued or suspended. If your health care coverage ends, you may be able to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Changing Your Elections

During the Annual Enrollment period each fall, you have an opportunity to make your Plan elections for the next year. This includes your elections for medical, dental, and vision coverage; long-term disability (LTD); life insurance and accidental death and dismemberment (AD&D) coverage; and Flexible Spending Accounts (FSAs).

Your Plan elections go into effect on January 1 and remain in effect for the entire Plan Year. You cannot change your elections until the next Annual Enrollment period unless you have a qualified life event status change. (See the box to the right for examples of qualified life event status changes.)

To make a change:

- Contact the Oncor HR Service Center within **30 days** (60 days for the birth, adoption, or placement for adoption of a child) following the qualified life event status change.
- Any changes you make to your benefit options must be consistent with the qualified life event status change.

For more information about making changes to your benefit options, see ***Changing Your Coverage*** in the **Plan Participation** section of this handbook.

For information about each benefit option, see the corresponding section of this handbook. Any change is subject to the discretion of the Plan Administrator and must be permitted by the terms and conditions governing the applicable benefit option and relevant Internal Revenue Service (IRS) regulations.

Examples of Qualified Life Event Status Changes

- Your marriage, divorce, annulment, or legal separation,
- The birth, adoption, or placement for adoption of a Dependent child,
- The death of your spouse or a covered Dependent child,
- Your gain or loss of Legal Guardianship of an eligible Dependent,
- A child's gain or loss of status as an eligible Dependent,
- A change in your home address that causes you to lose eligibility for an option,
- A change in the employment status of you, your spouse, or your Dependent (part-time to full-time, etc.), resulting in gain or loss of coverage,
- Your or your covered Dependent's eligibility for Medicare or Medicaid, and
- A court order requiring a change in coverage (such as a Qualified Medical Child Support Order).

HEALTH CARE CONTINUATION COVERAGE (COBRA)

Coverage Continuation Rights Under the Consolidated Omnibus Budget Reconciliation Act of 1985

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) created the right to COBRA continuation coverage. This section contains important information about your right to COBRA continuation coverage. It explains when COBRA coverage may become available and what you need to do to protect your right to receive COBRA coverage. This section also contains other health coverage alternatives that may be available to you through the Health Insurance Marketplace.

For additional information about your rights and obligations under federal law and under the Oncor Plan – medical, prescription drug, dental, and vision coverage and the Health Care Flexible Spending Account (HCFSA) Option – contact the Oncor HR Service Center.

There may be other coverage options for you and your family. You are able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, Deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary continuation of health care coverage when it otherwise would end because of a life event, known as a "qualified life event." (Specific qualifying life events are listed under ***COBRA Qualifying Events and Qualified Beneficiaries*** below.)

After a qualifying life event, COBRA continuation coverage must be offered to each "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the health care benefits is lost because of the qualifying life event. Qualified beneficiaries who elect COBRA continuation coverage must pay for it.

Your COBRA continuation coverage rights under the Plan apply only with respect to Oncor's health care benefits (medical, prescription drug, dental, and vision coverage and the HCFSA Option).

COBRA Qualifying Events and Qualified Beneficiaries

Employees

You become a COBRA-qualified beneficiary if you lose your health care coverage because of either of the following qualifying life events:

- Your hours of employment are reduced below 20 hours per week or
- Your employment ends for any reason (other than your gross misconduct).

Spouse of the Employee

Your spouse becomes a COBRA-qualified beneficiary if he or she loses coverage under the health care benefits because of any of the following qualifying life events:

- You die,
- Your hours of employment are reduced below 20 hours per week,
- Your employment ends for any reason (other than your gross misconduct), or
- You become divorced or legally separated from your spouse.

Dependent Children

Your Dependent children become COBRA-qualified beneficiaries if they lose coverage under the health care benefits because of any of the following qualifying life events:

- You die,
- Your hours of employment are reduced below 20 hours per week,
- Your employment ends for any reason (other than your gross misconduct),
- You and your spouse become divorced or legally separated, or
- Your child loses eligibility for coverage as a "Dependent child" under the health care benefits (for example, he or she attains the maximum age).

Qualified beneficiaries also include any children born to you or placed with you for adoption during the COBRA continuation period.

Notification of Qualifying Life Events

The Plan offers COBRA when a qualifying life event has occurred. The company will issue a notification of eligibility in these cases:

- You die,
- Your hours are reduced,
- Your employment ends,
- You become entitled to Medicare benefits, or
- The commencement of a proceeding in bankruptcy with respect to the company.

You, your qualified beneficiary, or a representative must notify the Oncor HR Service Center in these cases:

- Your divorce or legal separation, or
- Your child's loss of eligibility for coverage under the health care plans (for example, he or she reaches the maximum age).

This notification must occur within 60 days from the latest of the following:

- The qualifying life event or
- The date you or your qualified beneficiary loses (or would lose) coverage as a result of the qualifying life event.

> This section of your handbook meets the Plan's initial COBRA notice requirement. However, you and your qualified beneficiaries will receive another notice if you have a qualifying life event.

How COBRA Coverage Is Offered

When the Oncor HR Service Center is notified of a qualifying life event, COBRA continuation coverage is offered to each qualified beneficiary.

Oncor's COBRA administrator will mail a COBRA continuation notice and a COBRA election notice within 14 days after receiving notice of the qualifying life event. This information is sent to the last known address that you provided to the Oncor HR Service Center. If your qualified beneficiary lives at another address, a separate information packet will be sent if that address is provided.

Notify the Oncor HR Service Center to give them the correct address for the qualified beneficiary.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees can elect COBRA continuation coverage on behalf of their spouses, and parents can elect COBRA continuation coverage on behalf of their children.

Be Sure to Keep Your Address and Your Dependents' Addresses on File with the Oncor HR Service Center

It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address to ensure that you receive COBRA election information following a qualifying life event, and that you receive all related information and billing notices while you are on COBRA. Be sure to update your address with the Oncor HR Service Center.

If COBRA Coverage Is Elected

You will have 60 days from the date of the COBRA election notice to elect COBRA continuation coverage. If you or your Dependent elects COBRA continuation coverage, you have the following options available to you:

- You or your Dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage.
- Your or your Dependent's coverage is effective as of the date of the qualifying life event, unless you or your Dependent waives COBRA coverage and then revokes the waiver within the 60-day election period. (In this case, your elected coverage begins on the date you revoke your waiver.)
- You or your Dependent can change coverage (if enrolled within the initial 60-day enrollment window) in either of the following circumstances:
  - During the Annual Enrollment period or
  - If you or your Dependent has a qualified life event status change or another change in circumstances recognized by the Internal Revenue Service (IRS) and the Plan.
- You can enroll any newly eligible spouse or Dependent child under the health care option's rules.

What COBRA Coverage Costs

COBRA participants must pay monthly premiums for their coverage category.

Premiums are based on the full cost of the coverage category, set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections (for example, a spouse following divorce, or a child upon reaching age 26) are charged the same rate as a single employee. In case of an extension of continuation coverage due to a disability, as explained below, you pay 150% of the cost.

Payment is due at election, but there is a 45-day grace period (from the date you send your election form) to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s), retroactively to the date benefits terminated under the Plan.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period. (For example, the June payment is due June 1, but will be accepted if postmarked by June 30.)

How Long COBRA Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. It can last up to a total of:

- 36 months when the qualifying life event is due to any of the following:
  - Your death,
  - Your divorce or legal separation, or
  - Your Dependent child's loss of eligibility as a Dependent child.
- 18 months when the qualifying life event is:
  - The end of employment or
  - A reduction of your hours of employment.

This 18-month period of COBRA continuation coverage can be extended in two ways:

> **Disability Extension of 18-Month Period of Continuation Coverage**
If a qualified beneficiary covered under the health care option(s) is determined by the Social Security Administration to be disabled and you notify Chard Snyder, the COBRA administrator for Oncor, in a timely fashion, you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage (for a total maximum of 29 months) if all of the following conditions are met:

- Your COBRA-qualifying life event was a termination of employment or a reduction in hours.
- The disability began at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the Oncor HR Service Center within 60 days of the date of the Notice of Award and before the end of the initial 18 months of COBRA coverage.

With respect to a disability determination, **you or your qualified beneficiary must notify the Oncor HR Service Center** of the disability determination, in writing, within 60 days after the latest of the following:

- The date of the Social Security Administration disability determination,
- The date the qualifying life event occurs, or
- The date you or your qualified beneficiary loses (or would lose) coverage due to the qualifying life event.

Note: You or your qualified beneficiary must provide notification of the disability determination, in writing, to the Oncor HR Service Center before the end of the initial 18 months of COBRA coverage.

If you or your qualified beneficiary is subsequently determined by the Social Security Administration to no longer be disabled, you or your qualified beneficiary must provide notification, in writing, to the Oncor HR Service Center within 30 days of the date of the final determination.

> **Second Qualifying Life Event Extension of 18-Month Period of Continuation Coverage**
If another qualifying life event occurs during the first 18 months of COBRA continuation coverage, your spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying life event is properly given to the Oncor HR Service Center.

This extension may be available to your spouse and any Dependent children receiving continuation coverage if you divorce or legally separate, or if your child is no longer eligible as a Dependent child under the health care plan(s), but only if the event would have caused your spouse or child to lose coverage under the plan(s) had the first qualifying life event not occurred.

Situations When COBRA Coverage May End Earlier

COBRA coverage under a group health care plan ends before the maximum continuation period if one of the following occurs:

> You or your covered Dependent does not make timely premium payments or contributions as required.

> Oncor stops providing any group health care option to all employees.

> After electing COBRA continuation coverage, you or any of your covered Dependents become covered under another health care plan not offered by Oncor.

> During an extended period of COBRA coverage based on the disability extension (and assuming there has not been a second qualifying life event), a final determination is made by the Social Security Administration that the qualified beneficiary is no longer disabled.

Continuation coverage also can be terminated for any reason the health care option would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, in the case of fraud or providing of false/inaccurate information).

Special Rules for the Health Care Flexible Spending Account (HCFSA) Option

Under certain circumstances, a qualified beneficiary can elect to continue benefits under the HCFSA by electing COBRA continuation coverage and continuing to make HCFSA contributions on an after-tax basis, but only for the period from the date of the qualifying life event through the end of the Plan Year in which the qualifying life event occurs. Further, COBRA continuation coverage will be available for the HCFSA only if you have a positive net balance in the account as of the date of the qualifying life event. This means that the amount of contributions to the HCFSA exceeds the qualified eligible expenses and reimbursements. Contributions to the HCFSA during the applicable COBRA period are made on an after-tax basis.

The use-it-or-lose-it rule will continue to apply, so any unused amounts at the end of the Plan Year will be forfeited. You will have until March 31 of the following year to seek reimbursement for expenses incurred during the Plan Year. Unless otherwise elected, all qualified beneficiaries who were covered under the HCFSA will be covered for this COBRA continuation coverage.

If You Have Questions

Questions concerning your Plan and your COBRA continuation coverage rights should be addressed with the Oncor HR Service Center.

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other laws affecting group health care plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at **dol.gov/agencies/ebsa** or call their toll-free number at **1.866.444.3272**. For more information about health insurance options available through a Health Insurance Marketplace, visit **healthcare.gov**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Oncor HR Service Center informed of any changes in your address or the addresses of family members. Also, for your records, you should keep a copy of any notices you send to the Plan Administrator or to the Oncor HR Service Center.

CONTINUATION OF HEALTH COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Health Care Coverage

If you are absent from work because of your service in the uniformed services (including Reserve and National Guard duty), you can continue health coverage (medical, dental, and vision) for yourself and your eligible Dependents under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Paying for Coverage

You may be required to pay all or a portion of the cost of your coverage.

- **If your military service is less than 31 days:** Your health care coverage is provided as if you had remained employed.
- **If your military service is more 30 days:** You may continue employer-sponsored health care for up to 24 months. You may be required to pay up to 102% of the full premium, similar to the manner in which the cost for COBRA continuation coverage is calculated.

Notification of Uniformed Service

You must notify your manager and the Oncor HR Service Center that you will be absent from employment due to military service (unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable). You also must notify the Oncor HR Service Center that you want to elect continuation coverage for yourself and/or your eligible Dependents under the USERRA provisions. Refer to Oncor's "Policy for Military Leave" for more details.

How Long Coverage Continues

Generally, your USERRA coverage continues for 24 months from the date your military leave starts.

When you are discharged, you are required to apply for a return to work within a certain period of time, depending on the length of your uniformed service. *If you don't apply for a return to work within these time frames, your coverage will end on the next day.*

Here are the time frames for applying for return to work:

- **If your uniformed service is less than 31 days:** You are generally required to return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service. (Your period of uniformed service ends after you return from your place of service to your residence.)
- **If your uniformed service is between 31 and 180 days:** You are generally required to return to work within 14 days of your discharge.
- **If your uniformed service is at least 181 days:** You are generally required to return to work within 90 days of your discharge.

AMENDMENT OR TERMINATION OF THE PLAN

Oncor reserves the right to amend, modify, or terminate all of its employee benefit plans, including the benefit options under this Plan, in whole or in part, at any time and for any or no reason, including but not limited to, by increasing, reducing, or terminating benefits for all employees or for any group of employees or Retirees; changing carriers, Network administrators, or benefits; increasing premiums, Deductibles, Copayments, or other payments; or any other changes. If a plan or benefit option is terminated or if material benefit changes are made, you will be notified.

Plan Administration

HOW THE PLAN IS ADMINISTERED

The information in this section is required by law. It includes information about how the Plan is administered and your legal rights.

Plan Sponsor and Administrator

Oncor Electric Delivery Company LLC
1616 Woodall Rodgers Freeway
Dallas, Texas 75202-1234

The company has also chosen outside administrators to help Oncor administer the Plan (see ***Claims Administrators, Third-Party Administrators, and Insurers*** on the following page). These organizations have been authorized to carry out certain administrative and fiduciary functions of the Plan.

Employer Identification Number

Oncor's employer identification number is 75-2967830.

Plan Year

The Plan is operated on a calendar-year basis, beginning January 1 and ending December 31.

Agent for Service of Legal Process

Service of legal process can be delivered to:

General Counsel
Oncor Electric Delivery Company LLC
1616 Woodall Rodgers Freeway
Dallas, Texas 75202-1234

Types of Plans/Plan Identification

The Plan provides a variety of health and welfare benefits including medical, prescription drug, dental, vision, flexible spending accounts, life and accidental death and dismemberment, disability, and other specified health and welfare benefits. The formal Plan name and Plan number are:

Plan Name: Oncor Electric Delivery Company LLC Employee Welfare Benefit Plan

Plan Number: 501

The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Privacy of Health Information

The Plan is required to comply with the Standards for Privacy and Security of Individually Identifiable Health Information (the "privacy standards") issued under the federal Health Insurance Portability and Accountability Act, commonly referred to as HIPAA. The privacy standards require the Plan to provide individuals who are enrolled in a health benefit option with a notice describing the Plan's policies and procedures with respect to a participant's health information.

The Notice of Privacy Practices is available online at any time through the Oncor HR Service Center. If you have any questions about the Notice of Privacy Practices or if you would like to request a paper copy, contact the Oncor HR Service Center. As further described in the notice, the privacy standards require the benefit administrators to take certain precautions in using and disclosing specified information about your health and that of your Dependents, and place limitations on the disclosure of such information to Oncor and other third parties.

CLAIMS ADMINISTRATORS, THIRD-PARTY ADMINISTRATORS, AND INSURERS

The chart below lists the organizations that provide day-to-day administrative and claims services for each benefit option. The Claims Administrators, third-party administrators, and insurers make benefit payments as authorized by the benefit option.

Options, Programs, and Networks	Claims Administrators, Third-Party Administrators, and Insurers
Medical Benefit Options	
HSA Option HRA Option	Blue Cross and Blue Shield of Texas P. O. Box 660044 Dallas, TX 75266–0044 **1.877.213.6898** bcbstx.com
Scott & White Health Plan (SWHP) Option	Scott & White Health Plan 1206 West Campus Drive Temple, TX 76502 **1.800.321.7947** swhp.org
Health Savings Account (HSA)	Fidelity *(does not apply to Scott & White or participants who waived medical coverage)* One Destiny Way Westlake, TX 76262 For mailing, add: MZ-WA4I **1.800.544.3716** netbenefits.com
Health Reimbursement Account (HRA)	ConnectYourCare P.O. Box 622317 Orlando, FL 32862-2317 **1.877.292.4040** connectyourcare.com
COBRA Administrators and Active COBRA Payment Collector	Chard Snyder 6867 Cintas Boulevard Mason, OH 45040 **1.513.459.9997** **1.800.982.7715** Fax: **1.513.459.9947** chard-snyder.com

Options, Programs, and Networks	Claims Administrators, Third-Party Administrators, and Insurers
Medical Benefit Options	
Flexible Spending Accounts (Health Care and Dependent Care FSA)	ConnectYourCare P.O. Box 622317 Orlando, FL 32862-2317 **1.877.292.4040** connectyourcare.com
MDLIVE Telemedicine: Phone-in Service for 24/7 Physician Access	**1.888.680.8646** MDLIVE.com/bcbstx
Prescription Drugs CVS Caremark (all medical benefits options)	Paper Claims: CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 **1.866.339.0593** caremark.com Mail Order: CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467 caremark.com
Confidential Counseling and Resources Employee Assistance Program (EAP)	Magellan Health 14100 Magellan Plaza Drive Maryland Heights, MO 63043 **1.800.327.6608** MagellanAscend.com
Tobacco Cessation and Weight Management Program	**1.877.213.6898** (Once enrolled, call **1.866.412.8795**) bcbstx.com

Options, Programs, and Networks	Claims Administrators, Third-Party Administrators, and Insurers
Dental Benefit Options	Aetna P.O. Box 14094 Lexington, KY 40512-4094 **1.877.238.6200** aetna.com
Vision Benefit Option	UnitedHealthcare Vision Attn: Claims Department P.O. Box 30978 Salt Lake City, UT 84130 **1.800.638.3120** myuhcvision.com
Life Insurance Options (include Employee Life Option, Spouse Life Option, and Child Life Option) **AD&D Insurance Options** (include Employee AD&D Option and Dependent AD&D Option) **Long-Term Disability (LTD) Benefit Option**	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 **1.800.638.6420** Fax: **1.570.558.8645**

COORDINATION OF BENEFITS

Your health care options are coordinated with other group insurance plans to which you or your covered Dependents belong. This means that all plans together pay no more than 100% of allowable health care expenses. An "allowable expense" is any expense covered at least in part by one of the health care plans.

Coordination of benefits does not apply to individual or private insurance policies maintained by you.

Here's how benefits are coordinated when a claim is made (unless documents for a particular benefit specify different rules):

- First, the primary plan pays its benefits without regard to any other plan.
- Then, the secondary plan calculates its benefits to the extent not paid by the primary plan, but only up to the allowable expense of the secondary plan.

No plan pays more than it would without the coordination provision.

The following provisions determine which plan is primary (and pays benefits first):

- A plan without a coordination provision is always the primary plan.
- If the patient is entitled to Medicare coverage, Medicare is the secondary plan with respect to (i) active employees and their spouses who are age 65 or older, (ii) active employees and their family members who are covered due to disability, and (iii) certain patients with end stage renal disease (to the extent provided in the Medicare secondary-payer regulations). Medicare is the primary plan with respect to other patients who are entitled to coverage under Medicare (regardless of whether they have enrolled in Medicare).
- The plan covering the patient as an employee rather than in any other capacity (e.g., as a Dependent or as a COBRA qualified beneficiary) will be the primary plan.
- Any plan that covers a patient in a capacity other than as a Dependent is a primary plan over a plan that covers a patient as a Dependent.
- Generally, (i) a plan that covers a patient as an employee rather than as a laid-off or retired employee is primary, and (ii) a plan that covers a person as a former employee or Dependent under COBRA (or a similar state program) is primary over a plan that covers a patient as a Dependent, unless the other plan does not include a similar rule.
- If a child or other Dependent is covered under two plans (e.g., one of each parent), the plan of the participant whose birthday is earlier in the year pays first. The plan of the participant whose birthday is second during the year pays second.
- If both birthdays fall on the same date, the plan that covered the participant longer is primary. This rule applies only if the other group health plan has a birthday rule. Otherwise, the other group health plan that covers a person as a Dependent of a male is primary.
- If a child's parents are divorced or separated and there is no court decree that establishes financial responsibility, (i) any plan covering the parent who has custody of the child is the primary plan; (ii) any plan covering the spouse of the parent with custody of the child is the first secondary plan; and any plan covering the parent without legal custody is secondary to both plans (i) and (ii). If the parents have joint custody, the birthday and gender rules described above are applied. If a court decree specifies that one of the parents is responsible for a Dependent child's health care expenses and the relevant plan has knowledge of this requirement, then that plan is primary.
- Any coverage under a no-fault auto insurance policy is primary.
- If these rules do not establish which plan is primary, then the plan that has covered the person the longest is primary.

When they are the primary plan, the medical options, dental options, and vision option will pay the benefits described in this handbook. When they are the secondary plan, they pay their benefits to the extent that the total benefit available is not greater than their allowable expense as a secondary plan. To the extent any amounts paid by the Plan as a secondary plan are more than what it should have paid, it may recover the excess from the person to whom or for whom the payment was made, or from the primary plan.

CLAIM REVIEW AND APPEAL PROCESS

When a request for benefits is denied, there is a formal claims review process established for a participant to appeal the denial. All appeals must be made in writing.

There are two types of "claims": an "eligibility claim" and a "benefit claim."

Eligibility Claim

An eligibility claim is a request to enroll, disenroll, or change participation in a specific benefit option (for example, a request to enroll a Dependent in one of the medical options).

Benefit Claim

A benefit claim is a request for a particular benefit under one of the benefit options (for example, a claim for a certain type of surgery under one of the medical options, or a request for a specific prescription drug that has been denied).

For both eligibility claims and benefit claims, there are up to two levels of review. If the first claim has been denied, a participant can appeal the initial claim and submit a request for a second review. If the appeal or the second review is denied, meaning the person has exhausted their administrative remedies, the participant has the right to file a civil action under Section 502(a) of ERISA.

Filing Claims

All eligibility claims are filed with the Plan Administrator (Oncor). Eligibility claims are filed by calling the Oncor HR Service Center.

Benefit claims are filed with the following entities, as specified in the table in the next column.

Benefit	Entity
Medical Options (except Scott & White Health Plan Option)	Blue Cross and Blue Shield of Texas*
Scott & White Health Plan Option	Scott & White Health Plan*
Prescription Drugs	CVS Caremark*
Dental	Aetna*
Vision	UnitedHealthcare Vision*
Health Savings Account	Fidelity
Health Reimbursement Account	ConnectYourCare
Flexible Spending Accounts	ConnectYourCare
Life Insurance/AD&D Insurance	MetLife*
Long-Term Disability	MetLife*

*These entities are the Plan's Claims Administrators for these benefits. The Claims Administrators are solely responsible for the claims decisions made for their particular benefits. The Plan Administrator (Oncor) has no responsibility for these claims decisions, nor is there any recourse for a participant to submit a claim directly to the Plan Administrator. When a claim is denied, the Claims Administrators will issue an Explanation of Benefits (EOB) statement, which will provide directions on the procedure for appealing the claim denial.

Oncor is the Claims Administrator for eligibility claims. All eligibility claims should be filed with the Senior Manager of Health and Welfare Benefits, 1616 Woodall Rodgers Freeway, Suite 7080, Dallas, Texas 75202.

When a Claim Has Been Filed

Benefit claims must be filed/submitted within 12 months following the service date in order to be considered timely.

When a claim has been filed, the applicable Claims Administrator will respond to you within certain prescribed time frames. In some situations, the Claims Administrator may need an extension of time to process your claim (for example, if additional information is needed to process your claim). In these cases, you will be notified of the extension.

The chart on the next page shows the various types of claims and the normal response time frames for each type of claim.

When You Receive the Initial Notification

Type of Claim	Notice of Claim Decision or Extension	Extension Rules
Health Care Benefit Claims (including Rx and Dental)		
Urgent Care Benefit Claim. An urgent care benefit claim is a claim for medical care or treatment where a delay in making a determination could result in any of the following: > Could jeopardize the life or health of you or your Dependent, > Could jeopardize the ability of you or your Dependent to regain the maximum function, or > In the opinion of your or your Dependent's physician, would subject you or your Dependent to severe pain that could not be adequately managed without the requested treatment.	As soon as possible, and, in any event, within 72 hours	None
Concurrent Care Health Care Benefit Claim Decisions. Concurrent care benefit claim decisions are decisions for treatment over a period of time or for a specified number of treatments. Examples include an extended number of days in a hospital, an extended number of physical therapy treatments, or a situation where the Plan reduces the number of treatments previously agreed upon.	Same as urgent care or preservice, as applicable	Same as urgent care or preservice, as applicable
Preservice Health Care Benefit Claim. A preservice benefit claim is a request for approval of a medical benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. Examples include preauthorization for hospital stays, second surgical opinions, etc.	Within 15 days	If necessary, the period can be extended for an additional 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll have 45 days to provide the information.
Post-Service Health Care Benefit Claim. A post-service benefit claim is any claim that is processed after a service is provided.	Within 30 days	If necessary, the period can be extended for an additional 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed and you'll have 45 days to provide the information.
Disability Benefit Claim (LTD Participants only)	Within 45 days	If necessary, the period can be extended two times for up to 30 days each. The extension notice(s) will explain the standards upon which eligibility is based, the unresolved issues that prevent a decision, and any additional information needed to resolve the issues. You'll have 45 days to provide the information.
All Other Benefit Claims (Life and AD&D Insurance and all eligibility claims)	Within 90 days	If special circumstances require an extension, the period can be extended for an additional 90 days.

Claim Denial Notice

If your claim is denied, you will receive a culturally and linguistically appropriate written notice from the Claims Administrator that includes:

- The specific reasons for the denial, including a reference to the specific Plan provisions on which the benefit determination is based.
- The Plan's provisions on which the denial is based. If an internal rule, guideline, or protocol was relied upon to determine a health or disability claim, you'll receive a copy of the actual rule, guideline, or protocol, or a statement that the rule, guideline, or protocol was used and that you can request a copy free of charge. If the denial is based on a provision such as medical necessity, experimental treatment, or a similar exclusion or limit, you'll receive an explanation of the scientific or clinical judgment for the determination, based on the terms of the Plan and your medical circumstances.
- A description of any additional material or information needed and an explanation of why it is necessary.
- An explanation of the Plan's internal and external claim review procedures, applicable time limits, and your rights to bring a civil action following a denial (if for an urgent care benefit claim under a health care plan, you'll receive an explanation of the expedited benefit claim review procedure).
- The date of service, the health care provider, the claim amount (if applicable), and any denial code and its corresponding meaning. You may also request, and receive free of charge, a statement of the applicable diagnosis code and treatment code, and their corresponding meanings.
- A statement indicating that you can have access to receive, upon request and at no charge, copies of all documents, records, and information relevant to your claim.
- A description of the available internal and external review process, including information regarding how to initiate an appeal.
- The availability of – and contact information for – any applicable office of health insurance consumer assistance or ombudsman established under the Act to assist individuals with the internal claims and appeals, and external review procedures.
- For a disability benefits claim denial, the notice shall be supplied in a culturally and linguistically appropriate manner and shall also include:
  - A discussion of the decision, including an explanation of the basis for disagreeing with or not following (i) the views you presented from your health care professionals who treated you and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan (without regard to whether the advice was relied upon in making the determination, and (iii) a disability determination you presented that was made by the Social Security Administration;
  - If an adverse determination is based on a medical necessity or experimental treatment or similar limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
  - Either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination or a statement that such criteria do not exist; and
  - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

In the case of an urgent care benefit claim, the Plan can notify you by phone or fax and follow up with a written notice.

Request for Review if Your Claim Is Denied

After receiving the notice, you, your beneficiary, or your legal representative can ask for a full and fair review of the decision by writing to the Claims Administrator. You must make this request within 180 days for a health care or disability claim or within 60 days for all other claims. During the 60-day or 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you can request copies free of charge. You can also submit written comments, documents, records, and other information to the Claims Administrator.

For an urgent care benefit claim, information can be provided by phone or fax.

Final Decision

The Claims Administrator will then review the claim again and make a decision based on all documents, records, and other information you've submitted. For a health care or disability claim:

- Deference will not be afforded to the initial claim denial or who was consulted in connection with the initial denial.
- A different person who is not a subordinate of the individual who made the initial denial will review the decision.
- If the denial was based on a medical judgment, the person will consult with a health care professional who has training and experience in the field involving the judgment. That professional cannot be the same person who made the initial decision of denial, or who was consulted in connection with the initial denial. Medical or vocational experts who are consulted in the claim process are identified in the final decision.
- For a claim involving disability benefits, before a denial on review is issued, you will be provided (free of charge) with (i) any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan, insurer, or other person making the benefit determination; and/or (ii) if the adverse benefit determination is based on a new or additional rationale, the rationale. Such evidence and/or rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination is required to give you a reasonable opportunity to respond before that date.

In most cases, you'll receive the Claims Administrator's final decision within the following time frames:

Type of Claim	Notice of Final Decision or Extension
Health Care	
Urgent Care Benefit Claims	As soon as possible, but not later than 72 hours after receipt of your request for review
Preservice Benefit Claims	As soon as reasonably possible, given the medical condition, but not later than 30 days after receipt of your request for review
Post-Service Benefit Claims	Within a reasonable time, but not later than 60 days after receipt of your request for review
Disability Benefit Claims	Within a reasonable time, but not later than 45 days after receipt of your request for review. If necessary, the period can be extended for an additional 45 days.
All Other Benefit Claims (Life and AD&D Insurance) and All Eligibility Claims	Within a reasonable time, but not later than 60 days after receipt of your request for review. If necessary, the period can be extended for an additional 60 days.

Appeal Denial Notice

If your appeal is denied, the Claims Administrator will send you a culturally and linguistically appropriate statement containing the following:

- Specific reasons for the denial,
- Specific references to pertinent Plan provisions,
- A statement indicating that you can have access to or receive, upon request and at no charge, copies of all documents, records, and information relevant to your claim, and
- A statement describing any voluntary appeal procedures offered by the Plan, including your right to receive information about such procedures and your right to bring an action in federal court under Section 502(a) of ERISA. Under the Plan, an action under Section 502(a) of ERISA must be filed no later than two years following the date of the final denial of a claim on appeal, or such action will be time-barred.
- For a claim involving disability benefits, the appeal denial notice shall be supplied in a culturally and linguistically appropriate manner and will also include:
  - A description of any applicable contractual limitations period that applies to your right to bring an action as described in the paragraph above, including the calendar date on which the contractual limitations period expires for the claim;
  - A discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views you presented from your health care professionals who treated you and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan (without regard to whether the advice was relied upon in making the determination), and (iii) a disability determination you presented that was made by the Social Security Administration;
  - If an adverse determination is based on a medical necessity or experimental treatment or similar limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
  - Either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon making the adverse determination or a statement that such criteria do not exist.

In addition to the information above, if your claim is a medical benefits or disability claim, the notice will contain details regarding the claim, any information regarding an internal rule, guideline, or protocol used in making the appeal decision, and an explanation of the scientific or clinical judgment used in the denial, and information regarding appeals and consumer assistance, as described in the section ***Your Rights Under ERISA*** later in this section of the handbook. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge.

Additional Requirements Related to External Review of Final Action on Internal Appeal for Health Care Claims

Different external review rules apply depending on whether the relevant health care coverage is subject to a state insurance law external review requirement that meets standards specified in federal regulations, or whether the coverage is not subject to such a state law.

Where the health care coverage is subject to a state standard that complies with applicable federal regulations, such state standard shall apply to the insurer (where the coverage is insured) or the Plan (where the coverage is self-insured). Where the relevant health care coverage is not subject to a state standard, or subject to a state standard that does not meet federal regulatory requirements (taking into account any period of deemed compliance during a transition period provided for under federal regulations), then the following rules apply to the Plan to the extent and as of the date required by applicable federal regulations:

(a) A claimant may file a request for external review within four months of receipt of notice of an adverse determination (to the extent permitted by applicable law, however, the Plan may require the claimant to exhaust any reasonable internal appeal process); for this purpose, and to the extent permitted by applicable federal regulations, an "adverse determination" means an adverse determination as defined elsewhere in these provisions, but only to the extent it involves medical judgment or a retroactive rescission of coverage.

(b) Within five business days following receipt of the request for external review, the Plan Administrator shall determine whether:

- The claimant was covered under Plan and applicable health care coverage when the health care item or service was requested (or provided, where the review is for a post-service claim);
- The adverse determination was not due to ineligibility of the claimant;
- The claimant exhausted any required internal appeal process; and
- The claimant provided all information required.

(c) The Plan Administrator shall issue notice to the claimant within one business day after the Plan Administrator's preliminary review of the request for external review. If the claimant is not eligible for external review, the notice must include reasons for ineligibility and contact information for the Employee Benefit Security Administration. If the request for external review is not complete, the notice must describe information that is needed and allow the claimant to complete or perfect his/her request within the four-month filing period described above or 48 hours, whichever is later.

(d) If the request for external review is appropriate, the Plan Administrator (or an entity on behalf of the Plan Administrator) shall refer the appeal to an Independent Review Organization (IRO), with which the Plan Administrator has contracted in accordance with applicable federal regulations. The IRO shall conduct its review and supply appropriate notices in accordance with applicable federal standards. If the IRO reverses the decision, the Plan shall without delay provide coverage or payment upon receipt of notice of the IRO's decision, without regard to the Plan's intention to seek judicial review of the IRO's decision.

(e) The Plan shall make available, to the extent required by and in accordance with applicable federal law, an expedited external review process where a claimant receives an adverse determination or final internal adverse determination under circumstances where completion of an expedited internal appeal or standard external review would seriously jeopardize the life or health of the claimant.

(f) No Conflicts of Interest: The Plan shall adjudicate claims in a manner ensuring the independence and impartiality of those involved in decision making. For example, the Plan may not hire, promote, provide incentives to, or terminate the employment of individuals based on their support of a denial of benefits or on the number of claims denied.

Legal Proceedings

You may not initiate a lawsuit regarding a claim denial under the Plan unless and until you have fully exhausted the claims review process described in this section. Additionally, a lawsuit regarding any claim denial must be brought within one (1) year from the date of the final denial of the claim.

Non-Assignment Provision

Your rights under the Plan and the rights of your eligible Dependents may not be assigned to any other person or entity, including any health care provider. Specifically, no benefit, right, or interest of any Plan participant, or any Dependent or other covered individual under the Plan, can be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities, torts or any other obligations of such Plan participant, Dependent or other covered individual, including in the event of the bankruptcy of any Plan participant, Dependent, or other covered individual, except as may be required by applicable law. Additionally, and for avoidance of doubt, no Plan participant, Dependent, or other covered individual may assign, or delegate any right or authority with respect to, any benefit, right, or other interest which such Plan participant, Dependent or other covered individual may have by virtue of, or as a result of his or her status under, the Plan, including any attempted assignment or delegation to a health care provider or other third party. The Plan Administrator may, on a case-by-case basis, agree to accept and recognize an assignment or delegation; however, the Plan Administrator shall not be under any obligation to do so, and any such acceptance and recognition shall not in any way limit the general prohibition against attempted alienations and delegations of authority as provided for above.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA), which are listed below.

Receive Information About Your Plan and Benefits

As a Plan participant, you are entitled to:

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated summary plan description. The administrator can make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

If you or your Dependents lose health coverage as a result of a qualified life event, you or your Dependents have the right to continue health care coverage. You or your Dependents may have to pay for such coverage. For rules governing your COBRA continuation coverage rights, see ***Health Care Continuation Coverage (COBRA)*** in the **Qualified Life Events** section of this handbook or the Plan documents governing the Plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals responsible for the operation of the Plan. The individuals 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, can fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Claim Review

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from a Plan and do not receive it within 30 days, you can file suit in a federal court. In such a case, the court can 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 administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court. In addition, if you disagree with a Plan's decision or lack thereof concerning the qualified status of a medical child support order, you can file suit in a federal court.

If it should happen that Plan fiduciaries misuse a Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court can order the person you have sued to pay these costs and fees. If you lose, the court can order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance With Your Questions

Oncor has established relationships with various organizations to provide assistance and answer questions related to the Oncor Plan. Refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook for a list of these organizations and their contact information.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact one of the following:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory (or call **1.866.444.3272** to obtain the address and phone number)
- Division of Technical Assistance and Inquiries
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue NW
  Washington, D.C. 20210

You can also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **1.866.444.3272**.

THE LEGAL DOCUMENTS AS FINAL AUTHORITY

This handbook is a summary of certain key provisions of the Plan. This summary is not intended to cover every Plan detail. The Plan is governed by the formal Plan document. If any conflict exists between this summary and the provisions of the Plan documents, the Plan documents, as they may be amended from time to time, shall govern. The Plan document is available for you to review by contacting the Plan Administrator or the Oncor HR Service Center during regular office hours.

Glossary

Active Work or Actively at Work

You are an active employee, or Actively at Work, if you are at work performing the essential functions of your job:

- On a full-time basis for regular, full-time employees or
- For at least 20 hours per week for part-time employees.

You also are Actively at Work if you are not disabled and are away from work due to a holiday, vacation, approved leave of absence, or due to a health-related reason.

Allowable Amount

The maximum amount determined by the Claims Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

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

- **For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan –** The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRGs), fee schedules, package pricing, global pricing, per diems, case-rates, discounts or other payment methodologies.
- **For Hospitals and Facility Other Providers not contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan outside of Texas –** The Allowable Amount will be the amount the Claims Administrator would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, based on a percentage of Medicare allowed charges in the region where services were received. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate (as determined by the Claims Administrator), the Allowable Amount will be the lesser of billed charge or a per diem established by the Claims Administrator.
- **For procedures, services, or supplies provided in Texas by Physicians and Professional Other Providers not contracting with the Claims Administrator –** The Allowable Amount will be the lesser of the billed charge or the amount the Claims Administrator would have considered for payment for the same covered procedure, service, or supply if performed or provided by a Physician or Professional Other Provider with similar experience and/or skill.
- **For procedures, services, or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with the Claims Administrator or any other Blue Cross and Blue Shield Plan –** The Claims Administrator will establish an Allowable Amount based on a percentage of Medicare allowed charges in the region where services were received.
- **For multiple surgeries –** The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus one-half of the Allowable Amount for each of the other covered procedures performed.

The Claims Administrator's determination of the Allowable Amount will be final and binding on all parties.

Claims Administrator

The company or other entity that is responsible for the review, processing, adjudication, and/or payment of claims for a benefit option under the Plan. The current Claims Administrators are shown in ***Claims Administrators, Third-Party Administrators, and Insurers*** in the **Plan Administration** section of this handbook.

Coinsurance

The percentages of the total cost of services that you pay when you receive care. For example, if the option pays 80% of a covered service, your Coinsurance is the remaining 20%. You need to meet the option's Deductible before the option pays its share of Coinsurance.

Copayment

The amount you are responsible for paying the provider at the time you receive certain health care services.

Custodial Care

Care that the Plan Administrator or Claims Administrator determines is provided mainly to help you with personal hygiene or the activities of daily living, or can, in terms of generally accepted medical standards, be safely and adequately given by people who are not nurses.

Deductible

When required by the option, the amount you are required to pay each year before benefit payments are made.

Dentally Necessary

The most appropriate and necessary service or supplies for the direct care and treatment of a dental condition in terms of generally accepted dental standards as determined by the Plan Administrator or Claims Administrator.

Dependent

Includes your spouse and your eligible children. For this purpose, your spouse is your legally recognized spouse under the applicable laws of the jurisdiction in which you and your spouse were married, as evidenced by a valid marriage certificate or other documentation filed with the applicable governmental authority evidencing the marriage. A domestic partner to whom you are not legally married is not considered your spouse and cannot, therefore, be your Dependent.

Your children, for purposes of determining Dependent eligibility status under the Plan, are your:

- Natural children (other than a child you birth as a surrogate for another individual),
- Legally adopted children (or children who have been placed with you for adoption),
- Stepchildren as long as you (the Oncor employee) are married to the children's parent,
- Foster children (as long as the children continue in the state foster care system and continue to be your foster children),
- Children for whom you (the Oncor employee) have Legal Guardianship,
- Children you are required to cover under a Qualified Medical Child Support Order (QMCSO), and
- Grandchildren, if the children live with you (the Oncor employee) and you claim the children as dependents on your federal income taxes.

For the Medical, Dental, Vision, Life Insurance, and AD&D Options, your eligible children can be covered until they reach age 26, regardless of their residence, student status, or federal income tax dependent status. Upon attaining age 26, your children are no longer eligible for coverage under these options except for handicapped children (physically or mentally disabled) over age 26 who were covered under the Plan before age 26. However, for purposes of the Life Insurance and AD&D options, your children are not eligible (regardless of their age) if they are married or are serving in the armed forces.

Note that, as a condition to covering your Dependents under the Plan, the Plan Administrator may require you to provide appropriate documentation to verify Dependent status and eligibility for the individuals you claim as Dependents.

See ***Dependent Eligibility*** in the **Plan Participation** section of this handbook for more information.

Dependent (for FSAs)

For purposes of the Dependent Care Flexible Spending Account (DCFSA) Option, a Dependent is either (i) a Dependent child who is under 13 years of age at the time the care is provided and for whom you can claim an exemption on your federal income tax return, or (ii) a spouse, or any other person that qualifies as your dependent for federal income tax purposes and for whom you can claim an exemption on your federal income tax return, who is incapable of self-care due to a mental or physical condition.

Under the Health Care Flexible Spending Account (HCFSA) Option, a dependent is anyone who qualifies as your dependent for federal income tax purposes, in accordance with Section 152 of the Internal Revenue Code (without regard to Section 152(b)(1) and (2) and Section 152(d)(1)(B)).

In general, a dependent for federal income tax purposes includes certain qualifying relatives who are dependent on you for at least half of their financial support. A dependent's eligible expenses can be reimbursed from the Dependent Care FSA Option even if he or she does not qualify as a Dependent eligible for coverage under other company-sponsored benefit options.

Eligible Charge

The reasonable and customary, or negotiated, fee for services and supplies prescribed by a covered health care provider. The services must be Medically or Dentally Necessary, covered under the option for the treatment of a non-work-related injury or illness, and not provided primarily for the convenience of you, your Dependent, the hospital, or the doctor.

For purposes of prescription drug benefits, an Eligible Charge is the negotiated charge for a prescription drug, specified as covered under the medical option. The fee must not be in excess of the charge for a generic drug, less the required Copayment when a generic drug is available but a brand-name drug is selected.

Emergency Care

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

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

Explanation of Benefits (EOB)

A statement from the Claims Administrator that shows certain information regarding a benefits claim, including the amount of the benefit paid, if any, and what you owe for a covered service.

Full-Time Student (for Dependent Care FSA (DCFSA))

For purposes of the DCFSA Option, anyone who is enrolled in a school or college on a full-time basis. You may qualify for reimbursement of expenses from the Dependent Care FSA Option while you are working and your spouse is a Full-Time Student.

Health Maintenance Organization (HMO)

A type of medical option offered through the Scott & White Health Plan that pays a portion of covered medical expenses only when you use In-Network providers (except in a medical emergency).

In-Network Services

Services or supplies provided by a doctor, hospital, or other health care provider who is part of the Network for a medical, dental, or vision option you select.

Legal Guardianship
Guardianship granted and documented by an appropriate court through appropriate legal processes, appointing an adult to exercise parental duties, rights, and responsibilities.

Life Insurance Program A
If you were employed when Oncor began offering a flexible benefits program, you had the option to keep your coverage under the frozen former life insurance program. This frozen coverage is called Program A. Only those employees currently participating in Program A are eligible to continue that coverage.

Medically Necessary
The most appropriate and necessary service, treatment, or supplies for the direct care and treatment of a medical condition as generally accepted by medical standards and known to be effective in improving health outcomes, all as determined by the Plan Administrator or the Claims Administrator.

Network
A select group of doctors, hospitals, and other health care providers that contract with the Plan's Claims Administrators to offer discounted rates to their participants. If you use an In-Network doctor, hospital, or other health care provider, you will not be charged more than the Network's discounted rate for a service.

Non-Contracting Allowable Amount
The amount the Claims Administrator would have considered for payment for the same procedure, service, or supply at an equivalent contracting hospital, physician, or supplier, based on a percentage of Medicare allowed charges in the region where services were received.

Oncor HR Service Center Website: oncor.ultipro.com
Use oncor.ultipro.com to make your benefit elections during Annual Enrollment and to access, learn about, and make changes to your benefits throughout the year. The site also includes helpful year-round resources with additional information about your benefits.

Out-of-Network Services
Services or supplies provided by a doctor, hospital, or other health care provider who is not part of the Network for the health care option you select.

Out-of-Pocket Maximum
The annual Deductible and Coinsurance maximums equal the Out-of-Pocket Maximum.

Participating Employer
Oncor Electric Delivery Company LLC

Plan Year
The calendar year.

Qualified Child Care Provider
Child care that is provided by either of the following:

- A Dependent care facility that maintains all required licensure under relevant state and local laws, regulations, rules, and ordinances applicable to those facilities, or
- An individual or facility not required to maintain licensure under relevant laws, regulations, rules, and ordinances to provide care for individuals.

Qualified Medical Child Support Order (QMCSO)
A medical child support order is a judgment, an order, or a decree that is made under state domestic relations law and provides for child support or health benefit coverage for an "alternate recipient." An alternate recipient is a child of a participant under a group health plan who is recognized under the order as having the right to enrollment under the Plan with respect to the participant. A medical child support order that is "qualified" creates or recognizes the right of the "alternate recipient" to receive benefits for which the participant is eligible under a group health plan. The order is recognized as "qualified" by the Plan Administrator of the group health plan when it includes certain information that meets the QMCSO statutory requirements. In addition, a properly completed National Medical Support Notice (NMSN) issued by a state child support enforcement agency must be treated as a QMCSO. The Plan Administrator is required by law to honor a QMCSO or an NMSN.

Reasonable and Customary Charges (for the Dental options)

The charge for dental services or supplies, determined by the Claims Administrator to be the lowest of the actual charge, the usual charge for the same or similar services or supplies charged by dentists, or the usual charge of most other dentists or other providers of similar training or experience in the same or similar geographic area for the same or similar services or supplies. You are responsible for paying charges above those determined by the Claims Administrator to be Reasonable and Customary.

Recognized Charge

The covered expense is only that part of a charge which is the Recognized Charge.

As to dental expenses, the Recognized Charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply, or
- A designated percentile of the Prevailing Charge Rate for the Geographic Area where the service is furnished.

Rehabilitation Benefit (for the Long-Term Disability Plan)

If, during the first 24 months of LTD, you are able to work at a job approved by the LTD insurance carrier, you may continue to receive your LTD benefits in addition to your pay from the approved job. However, if the income you receive from all sources during this rehabilitative employment exceeds your pre-disability earnings, your LTD benefit will be reduced.

If you participate in a Rehabilitation Program, your Monthly Benefit will be insured by an amount equal to 10% of the Monthly Benefit. The Plan will do so before your Monthly Benefit is reduced by any other income.

Retiree

If you retire from Oncor, you may be eligible for Oncor medical, dental, vision, and life insurance coverage if you were enrolled for coverage on the day before your date of separation, and:

- You are a Retiree of Oncor.
- Your employment ended after you reached at least age 55 with 16 years of service or after you reached at least age 65 (regardless of your years of service).

OR

- You were receiving disability benefits under Oncor's Long-Term Disability Program.

Skilled Nursing Care Facility

A licensed facility that provides skilled nursing care and treatment for you if you are recovering from an illness or injury. The facility must be approved by Medicare as a Skilled Nursing Care Facility.

Statement of Health (SOH)

Also known as proof of good health, this is a statement of your medical history or, in some cases, a medical exam. The Claims Administrator for the particular benefit option will specify the form of an SOH necessary to apply for the benefit, and will determine whether the information or medical exam establishes that you satisfy the applicable insurability requirement.

Surviving Dependent Coverage

Under the terms described herein, health care coverage that may be made available to your spouse and Dependents, if they are eligible and elect such continued coverage in the event of your death.

Treatment Plan (for the Dental options)

A treatment schedule for orthodontia services outlining orthodontia services to be provided, how long the services will take, and how much they will cost.

Your Own Job (for the Long-Term Disability Plan)

For purposes of the Disability Plan, Your Own Job means the essential functions you regularly perform that provide your primary source of earned income.