ONCOR
LIVE WELL

ONCOR BENEFIT HANDBOOK

Oncor Electric Delivery Company LLC
For Retirees and Long-Term Disability Participants

Summary Plan Description

Effective April 1, 2019

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Overview

ONCOR RETIREE WELFARE PLAN

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.

For information about eligibility for your Dependents, refer to ***Dependent Eligibility*** in the **Plan Participation** section of this handbook.

The Oncor Retiree Welfare 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
- 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.

Thank you for your hard work and dedication that have contributed to Oncor's success!

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.

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

This handbook summarizes the primary provisions of the Oncor Retiree Welfare Plan (the "Plan") effective July 1, 2019. 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 document. **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.

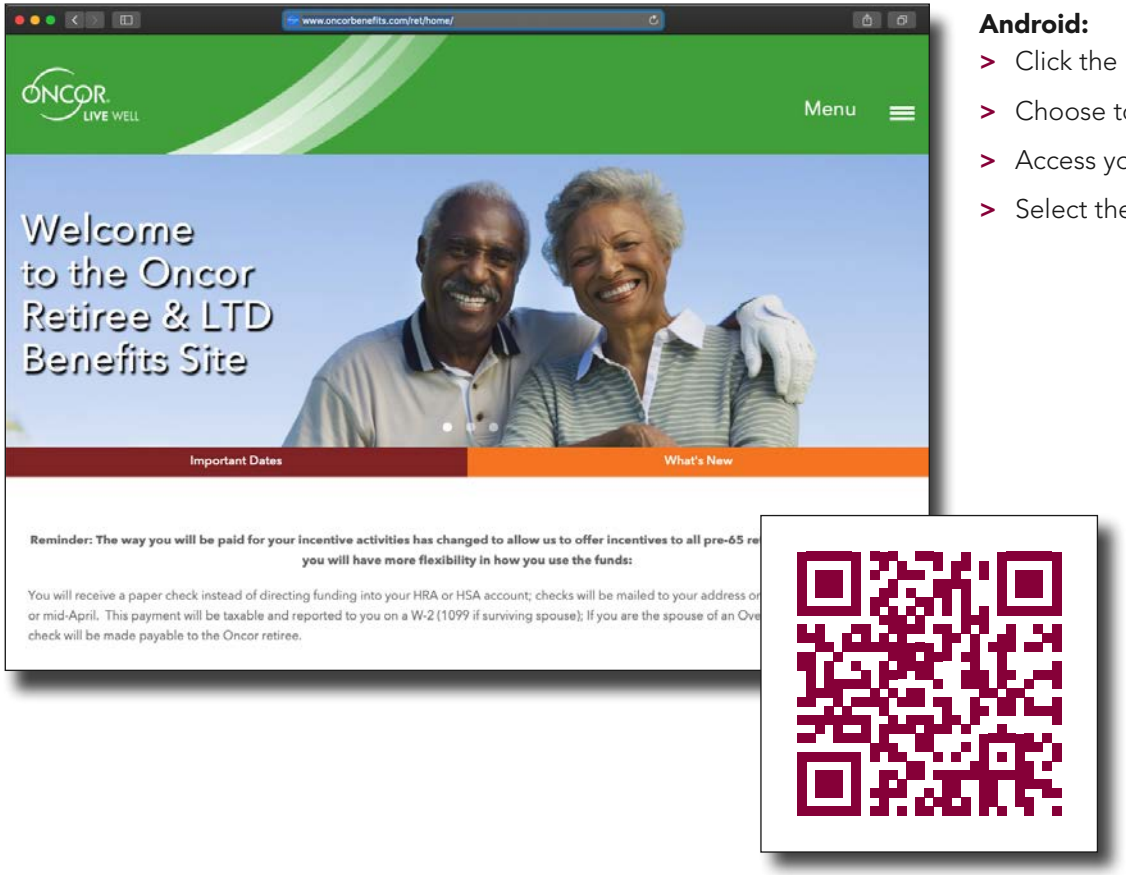
When the Plan's benefits are changed, you will be notified by the Plan Administrator. If the Plan is terminated, in whole or in part, or terminated as to any group, benefits will be paid only for eligible expenses incurred up to the date of the Plan's termination. No benefits will be paid for expenses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

GETTING STARTED

How to Access Benefit Materials

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

- Going directly to **oncorbenefits.com/ret**.
- Calling ePeople at **1.888.812.5465** *(select option '0')* to request a hard copy of any of the materials posted on the Oncor Retiree benefits site, free of charge. Service Center Representatives are available Monday through Friday from 7:30 a.m. to 6:00 p.m. Central time.



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/ret**, 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.

TOOLS AND RESOURCES CONTACT INFORMATION

Topic	Provider/Administrator	Contact Information
Benefit Guides and Other Benefits Information	**Oncor**	The Oncor benefits site at **oncorbenefits.com/ret**.
Enrollment and General Information	**ePeople HR Service Center**	> Log onto: **www.connect2epeople.com** to enroll. > Call: **1.888.812.5465 *(select option '0').*** Representatives are available Monday through Friday from 7:30 a.m. to 6:00 p.m. Central time.
Telemedicine	**MDLIVE**	> Log onto: **www.mdlive.com/bcbstx** > Call: **1.888.680.8646**
Premium Payments	**Chard Snyder**	> Log onto: **www.chard-snyder.com** > Email: **cobra_retiree@chard-snyder.com** > Call: **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)**	> Log onto: **www.bcbstx.com** to find Network providers, check claims, and access cost estimators. > Call: Customer Service at **1.877.213.6898** to speak to your Health Advocate.
	Scott & White Health Plan Option	> Log onto: **www.swhp.org** to find a Network provider, and review claims and Explanations of Benefits (EOBs). > Call: **1.800.321.7947**
	CVS Caremark *(if you are not eligible for Medicare)*	> Log onto: **www.caremark.com** > Call: **1.866.339.0593**
For Medicare-Eligible Participants Only	**Via Benefits** *(helps you find medical, pharmacy, dental, and vision insurance plans)*	> Log onto: **my.viabenefits.com** > Call: **1.844.498.5563**
	SilverScript *(if you are eligible for Medicare and are covered under the Indemnity with Rx or the Indemnity with Legacy Rx Option)*	> Log onto: **www.caremark.com** > Call: **1.800.706.9346**

Topic	Provider/Administrator	Contact Information
Health Reimbursement Account (HRA) Claims	**ConnectYourCare (CYC)** *(does not apply to participants in Scott & White)*	> Log onto: **www.ConnectYourCare.com** > Call: **1.877.292.4040**
Health Savings Account (HSA) Claims	**Fidelity** *(does not apply to participants in Scott & White)*	> Log onto: **www.netbenefits.com** > Call: **1.866.602.0629**
Concierge and Advocacy Services (For Non-Medicare Eligible Participants Only)	**Health Advocacy Solutions**	> Log onto: **www.bcbstx.com** > Call: **1.877.213.6898**
Incentive Information	**Evive Health** *(does not apply to participants in Scott & White)*	> Log onto: **Oncor.myevive.com** > Email: **questions@evivehealth.com** > Call: **1.800.475.8205**
Diabetes Support (For Non-Medicare Eligible Participants Only)	**Livongo**	> Log onto: **www.welcome.livongo.com/oncor** Registration Code: **ONCOR** > Call: **1.800.945.4355**
Tobacco Cessation and Weight Management Programs (For Non-Medicare Eligible Participants Only)	**Blue Cross and Blue Shield of Texas (BCBSTX)**	> Log onto: **www.bcbstx.com** > Call: **1.877.213.6898** (Once enrolled, call **1.866.412.8795**.)
Dental Benefits	**Aetna Dental**	> Log onto: **www.aetna.com** > Call: **1.877.238.6200**
Vision Benefits	**UnitedHealthcare Vision**	> Log onto: **www.myuhcvision.com** > Call: **1.800.638.3120**
Life Insurance	**MetLife Life Insurance**	> Call: **1.800.638.6420**
Will Preparation	**Hyatt Legal Services** *(available to participants covered under Oncor's life insurance benefits)*	> Call: **1.800.821.6400**
Retirement Benefits (Pension and Thrift)	**Fidelity**	> Log onto: **www.netbenefits.com** > Call: **1.866.602.0629**
Social Security Benefits	**The Social Security Administration**	> Log onto: **www.ssa.gov** > Call: **1.800.772.1213** (TTY: 1.800.325.0778)
Medicare, Medicaid, and the Children's Health Insurance Program	**Centers for Medicare and Medicaid Services (CMS)**	> Log onto: **www.cms.gov** > Call: **1.800.Medicare** (1.800.633.4227) (TTY: 1.877.486.2048)

Plan Participation

Plan Participation

RETIREE ELIGIBILITY

When you enroll for medical, dental, or vision coverage, you also choose the eligible family members you want to cover.

Retirees

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.

DEPENDENT ELIGIBILITY

You can also enroll your eligible Dependents for:

- Medical, dental, vision, and life insurance coverage:
  - Your legal spouse
- Medical, dental, and vision coverage:
  - Children up to age 26 and handicapped children (physically or mentally disabled) 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) before the Dependent reaches the maximum age of 26. This form must be completed by the covered Retiree and the child's regular attending physician, and sent to BCBSTX for their review and approval at least 30 days before coverage would end.
- Life Insurance:
  - If you are a Retiree, your children are not eligible for Life Insurance.
  - If you are an LTD participant in the Retiree Life Insurance Program, your covered children may continue Life Insurance coverage until age 26. However, for purposes of Life Insurance, your children are not eligible (regardless of their age) if they are married or are serving in the armed forces.

    Once you move from LTD-participant status to Retiree status, your Child Life Insurance coverage ends. Your child can continue Life Insurance coverage through a portability option or by converting to an individual policy.

Children

Your eligible children are your:

- Natural children,
- Legally adopted children (or children who have been placed with you for adoption),
- Stepchildren as long as you (the Oncor Retiree) 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 Retiree) 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 Retiree) 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 continue 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 his or her loss of coverage retroactive to the date he or she is deemed ineligible, to the extent permitted by applicable law. You may also be required to provide reimbursement for any claims paid for an ineligible Dependent.

See the Dependent Verification information in *Tools and Resources Contact Information* in the Overview section. Call for more information about the Dependent verification requirements or if you don't receive verification documents within three weeks of adding a Dependent. 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.

Eligibility Reviews

Oncor has full authority to administer all of the Plan's provisions, including eligibility provisions. 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 Worked for or Retired from Oncor

If you and your spouse are both eligible Retirees, 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 a Retiree, but Dependent children can be covered as Dependents by only one spouse. One spouse should elect Retiree and children coverage and the other spouse should elect Retiree only coverage. However, children for whom you have Legal Guardianship must be living with the Retiree electing coverage.

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

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 this medical option, confirm that you are eligible to make contributions to an HSA. You are personally liable for tax penalties if ineligible contributions are made to your HSA or HSA funds are used improperly. See **IRS Publication 969** 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,
- 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.

Oncor will set up an HSA for you to make contributions; however, Oncor does not make contributions to your HSA.

If your spouse enrolls in Medicare, you are still eligible to participate in the HSA.

Special Eligibility Rules for Vision and HMO Coverage

The Vision Plan Option, Via Benefits, and the Scott & White Health Plan Option are subject to insurance laws in the state of Texas. These laws allow you to cover:

- Your stepchildren, whether or not they are living with you, and
- Your grandchildren, provided the children are considered dependents for income tax purposes at the time you apply for coverage.

For more information, refer to documentation provided by these providers.

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 status change. However, you have 60 days to enroll new Dependents after birth, or adoption or placement for adoption.

ENROLLING FOR COVERAGE

When You First Retire

As an eligible new Retiree, you will be provided online enrollment information shortly after your retirement date. Be sure to carefully review these materials.

The medical options available to you and your covered Dependents are determined by Medicare eligibility. If you are Medicare eligible and your covered Dependents are not (or vice versa), you must make a separate medical election (called Med Separate).

You may elect a medical option at the time of your retirement or you may wish to postpone your participation in a medical option until a future date. Refer to ***Retiree Coverage and the Opt-Out Feature*** in this section for more information.

Once you make your coverage decisions, log on to the Service Center Website 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 Service Center to enroll. Refer to the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook.

If you don't enroll by the date shown on your enrollment materials, you will be automatically defaulted in the Indemnity with Rx Plan.

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.

For Service Center contact information, refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook.

Special Medical Coverage Enrollment Rules

You can enroll in a Via Benefits plan when you become eligible for Medicare and during the Annual Enrollment period. You cannot enroll in a Via Benefits plan during the year for other qualified life event status changes.

If you or a Dependent enrolls in a Medicare Prescription Drug plan (also called "Part D"), your Oncor medical option will change to the Indemnity Medical Only Option. This option does not include prescription coverage. The change occurs when Oncor is notified by Medicare of your enrollment in Part D. If you want to change to a medical option that provides Oncor prescription coverage at a later date, you will have a one-time opportunity to do so during Annual Enrollment.

Automatic Enrollment in the HSA – Wellness for Non-Medicare Eligible Participants

If you enroll for the HSA option, you are automatically enrolled in the Retiree Health Savings Account (HSA).

You will be paid for any incentives earned in the form of a paper check from Oncor. The incentive is subject to applicable income taxes and can be used for any expenses, not limited to health care expenses. Refer to ***About the Retiree HRA and Retiree HSA*** in the **Medical** section of this handbook. Also, see ***Special Eligibility Rules for HSA Medical Option*** in this section of the handbook.

You cannot contribute to an HSA after age 65. You can, however, at any time use funds deposited to an HSA that was established before you reach age 65.

When Coverage Begins

Subject to the one-time opt-out feature described under ***Retiree Coverage and the Opt-Out Feature*** found in this section of the handbook, your retiree health care and life insurance coverage starts on your first day of retirement.

ID Cards

You receive medical and prescription drug identification cards after enrolling for Retiree coverage. Carry your ID cards with you at all times. If a provider wants to verify coverage for you and your Dependents, have the provider call the number listed on the ID card. You will not automatically receive a dental ID card. If you want a dental ID card, you can log in to **www.aetna.com** to find and print a dental ID card.

ENROLLMENT TOOLS

Oncor provides numerous resources to help you enroll, including:

- **Benefits Site – oncorbenefits.com/ret.** Go to **oncorbenefits.com/ret** to explore this helpful benefits site. You will find:
  - Information about **Oncor medical options** and **Tools**,
  - **Important Dates** sections to alert you when an upcoming event is about to occur,
  - **What's New** where you will find information posted throughout the year, and
  - **QuickLinks** to additional information.
- **Health Advocacy Solutions for all non-Medicare eligible Oncor participants covered by a BCBSTX medical option** provides concierge and advocacy services. The Health Advocacy Solutions toll-free customer service number is on the back of your BCBSTX ID card. The 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, the Special Beginnings Program®, and Member Rewards.
- **Annual Enrollment information.** Each fall you will receive information about benefits for the coming year and instructions about how to enroll.

PAYING FOR COVERAGE

Every Oncor benefit option has a price tag that represents the cost of that benefit. During the Annual Enrollment period, you will receive information about the price tag for each option. The price you pay for a coverage option depends on the level of coverage that you choose for the option.

Two Ways to Pay for Your Coverage

You can pay for your coverage in one of two ways:

- **By direct debit.** If you choose this payment option, your contributions are automatically withdrawn from your checking or savings account each month. You can enroll for direct debit at any time during the year by calling the Service Center or the COBRA administrator. Once you enroll, the debits take effect the next billing cycle.
- **By monthly billing and payment by check.** If you do not choose direct debit, you will receive invoices each month. Your premium payment is due on the 1st of each month. There is a 30-day grace period after the premium payment is due. Therefore, you have until the end of each month to pay your premiums. If correct payment is not received within the 30-day grace period following the due date of your premium, your coverage under the Plan will terminate and you may not be able to re-enroll in the Plan in the future, nor will COBRA benefits be available to you or your Dependents.

How Costs Are Determined

Costs generally are based on the benefits coverage option and level of coverage. For some options, the costs are based on the demographics of the Oncor Retiree group, such as the number and age of covered Retirees. Costs are also based on the Retiree group's use of services (claims experience) in the option.

Insured and Self-Funded Options

Medical benefits (except those under the Scott & White Plan Option and a Via Benefits plan), 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, vision benefits, the Scott & White Health Plan Option, and a Via Benefits plan are provided through fully insured 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 disenroll Dependents when they are no longer eligible. If you fail to do so and you continue to pay premiums in error, you may be reimbursed for no more than three months' premiums.

> For Service Center contact information, refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook.

DESIGNATING A BENEFICIARY

Your Life Insurance Beneficiary

When you retire, the Service Center will automatically enroll you in the Optional Life Insurance coverage that you had as an active employee. You can only decrease the amount of coverage you had as an active employee.

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 Retiree Life Insurance Option. For the Spouse Life Insurance Option, 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 Service Center.

Changing Your Life Insurance Beneficiary

You can change your beneficiary designation at any time by updating it on the Service Center Website or by calling the 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.

CHANGING YOUR COVERAGE

Changing Your Plan Elections

Once you make your Plan elections during Annual Enrollment, they are effective for the next calendar year. 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 below.
- 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.

These special circumstances are described in more detail below.

Special Enrollment Rights

If you do not enroll in the medical option, dental option, or vision 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 employer that sponsors that coverage stops contributing toward the coverage). However, you must request enrollment within 30 days after your coverage or your Dependents' other coverage ends.

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 Dependent's 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 toward that coverage end, 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, or 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, or adoption or placement for adoption.

To request special enrollment or to obtain more information, contact the 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, vision, and life insurance coverage. Note: Any change in your optional life insurance benefits may only be a reduction in the coverage amount or cancellation of coverage. As a Retiree, you may never increase your life insurance coverage amount.

Eligible changes in qualified life event status include the following:

- You marry, divorce, legally separate, or have your marriage annulled.
- Your spouse or Dependent dies.
- You have a baby, you adopt, or you have a child placed with you for adoption.
- You, your spouse, or your Dependent starts or ends employment.
- The work schedule for you, your spouse, or your Dependent 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).
- A change in your home address causes you, your spouse, or your Dependents to lose eligibility for an option.

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, or 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).

Changing Coverage Categories

If you do not enroll your spouse under the Spouse Life Insurance Option at retirement or if you drop your spouse's coverage after retirement, you will not be allowed to re-enroll for this coverage at a later date.

Qualified Medical Child Support Order

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

You or your beneficiary can write to the 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 the Service Center Website or call the Service Center within 30 days (or 60 days for a birth, or adoption or placement for adoption) to make any changes in your benefit elections.

For Service Center contact information, refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook.

Changing Coverage Options

In addition to the special enrollment rights and qualified life event status changes described above, you can change your medical, dental, and vision options during the year at the following times:

- When you, your spouse, or your Dependent child becomes eligible for Medicare or Medicaid. Different medical options are provided, depending on whether you are eligible for Medicare, so you should notify the Service Center immediately when this happens.
- If you are covered by a Via Benefits plan and want to switch to the Indemnity with Rx option or the Indemnity Medical Only Option, you can switch during any future Annual Enrollment.
- If the Plan receives a court order, such as a Qualified Medical Child Support Order (QMCSO).

You can elect any lower level of Retiree life insurance coverage at any time, but you cannot increase your coverage.

Note: All requests to drop coverage become effective on the first day of the month after you notify the Service Center. You cannot drop coverage in the middle of a month, and the option cannot refund any contributions that you have already made.

If you gain a new eligible Dependent through marriage, birth, adoption or placement for adoption while you are participating in a medical option, you may enroll the Dependent under a medical option. In the case of the birth, adoption or placement for adoption of a child, your eligible spouse may also be enrolled as your covered Dependent during the Dependent special enrollment period.

The Dependent special enrollment period is a period of 30 days (60 days for birth, adoption or placement for adoption) that begins on the date of the marriage, birth, adoption or placement for adoption of a new Dependent. Coverage for Dependents who enroll during this special enrollment period will start in the case of:

- Marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received,
- A Dependent's birth, as of the date of birth, and
- A Dependent's adoption or placement for adoption, or the date of the adoption or placement for adoption.

"Placed for adoption" or "placement for adoption" means a participant assumes and retains a legal obligation for the child's total or partial support before the child reaches age 18. The child's placement with the participant ends upon the termination of that obligation.

Notify the Service Center

To make a change, you must notify the Service Center following the event that requires a change – for example, after you marry or after your spouse has an employment change that results in a gain or loss of coverage. **Any changes that you make to your benefits must be consistent with the situation requiring a change.**

> Refer to the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook.

Retiree Coverage and the Opt-Out Feature

Eligible Retirees have a one-time opportunity to opt out of their available Retiree coverages (excluding life insurance) and then re-enroll at a later date. You can use the opt-out and re-enroll feature only one time for each health care benefit (medical, dental, and vision). The opt-out feature applies separately for each of the respective benefits and is available only for those benefits for which a Retiree is currently enrolled (or was enrolled immediately before retiring).

For example, if you're currently enrolled in Retiree medical coverage only, you can opt out of medical coverage and then re-enroll for medical coverage in the future. However, a Retiree who is not currently enrolled in a coverage option (e.g., dental and/or vision coverage) cannot use the opt-out/re-enroll feature to enroll for those coverages in the future.

The opt-out feature gives you the opportunity to weigh alternatives for health care coverage and elect the best coverage for your individual circumstances. For example, you may decide that it's more beneficial to be covered by your working spouse's employer-provided health plan. Or you may gain coverage that is better, in terms of cost or benefit coverage than the Oncor Retiree coverage. If you elect and later lose this other coverage, you then have the option to re-enroll in the Oncor Retiree coverages at a later date. Evidence of Insurability is not required to re-enroll for coverage.

Retirees who are dropped from benefit coverage due to non-payment of premiums may use their one-time opt in to reinstate benefits once all premiums due have been paid in full.

Additional Provisions of the Opt-Out Feature

The following provisions also apply to the Retiree coverage opt-out feature:

- **Dependent coverage.** The provisions for adding Dependents remain the same as current provisions.
- **Upon death.** If you die before re-enrolling in one of the benefit coverages, your surviving spouse retains the one-time opportunity to re-enroll for coverage.
- **Health Reimbursement Accounts (HRA).** If a Retiree who has opted out of coverage has an HRA with a remaining balance, the account is available for 90 days only for claims incurred during the period when the participant was enrolled in the HRA medical option.
- **Health Savings Account (HSA).** If a Retiree who has opted out of coverage has an HSA and opts back in to coverage in a subsequent year, he or she will receive a new HSA contribution, if eligible. If a Retiree opts back in to coverage during the same year, then no new HSA contribution will be made.
- **Married couple (one active Oncor employee and one Oncor retired employee).** The Retiree may opt out of Retiree coverage and become covered as a Dependent under the employee's active coverage, but only at Annual Enrollment, unless there is a qualified status change that would allow mid-year enrollment. When the active employee retires, he or she has the option to opt out.
- **Married couple (both Oncor Retirees with their own Oncor Retiree coverage).** Each respective Retiree has a one-time opt-out opportunity. For example, Retiree A may opt out of coverage and become a Dependent under his or her Retiree spouse's (Retiree B) coverage. This means Retiree A has used his or her opt-out opportunity. Retiree A can re-enroll at any time in the future. **If Retiree A terminates coverage a second time, Retiree A is ineligible for future Retiree coverage under any circumstances, but may be eligible for coverage as the Dependent of Retiree B.** Retiree B retains his or her one-time opportunity to opt out of coverage, with a one-time re-enrollment option at any time in the future.
- **Life Insurance.** The ability to opt out and re-enroll does not apply to the Retiree Life Insurance Option. Retirees who currently have Retiree life insurance coverage and terminate their coverage will be ineligible to re-enroll for Oncor Retiree life insurance coverage in the future.

How to Opt Out or Re-enroll for Coverage

To opt out of Retiree coverage or to re-enroll, Retirees must contact the Service Center. The election will become effective the first day of the month following the month the Retiree calls the Service Center.

Opting out or re-enrolling for coverage also may be done during the Annual Enrollment period.

Retirees who re-enroll for coverage at a later date, after opting out, will be eligible to elect Retiree coverage only from the Plan options available at the time of their decision to re-enroll for coverage. The only exception is Retirees who are currently enrolled in the Indemnity with Legacy Rx Option. Since this is a closed option (meaning it is not accepting new participants), anyone opting out will not be able to re-enroll in this option at a later date. Any of the other options then available could be elected.

Retirees age 65 or older who use their one-time opt out election to choose prescription drug coverage under Medicare Part D, but later decide they prefer coverage under an Oncor medical option, will have a one-time opportunity to re-enroll for prescription drug benefits under an Oncor medical option.

WHEN COVERAGE ENDS

Retiree Coverage

Your coverage under a medical option, dental option, or vision option will end at the times noted below:

- The date you die,
- The last day of the month in which you stop paying any required premiums,
- The last day of the calendar year if you stop coverage when you make your annual benefit elections,
- The last day of the month if you notify the Service Center in writing that you want to stop coverage during the calendar year,
- On the date Oncor terminates the Plan or the particular option, or
- The date as determined by the Plan Administrator that any fraudulent claim has been filed by, or on behalf of, the Retiree (or other fraudulent event has occurred), or the Retiree makes an intentional misrepresentation of a material fact.

In addition, coverage under the HRA and the HSA options are available only to Retirees and their Dependents who are under age 65 and not eligible for Medicare. When you or a Dependent reaches age 65 or becomes eligible for Medicare, you must elect a different medical option for that person. For more information, see ***Your Medical Options*** in the **Medical** section of this handbook.

Your Retiree life insurance coverage will end on the last day of the calendar month or the earliest of:

- When the Plan or the Retiree life insurance option ends,
- The date insurance ends for the Retirees' class,
- Expiration of any applicable grace period following non-payment of premium,
- The date you die, or
- The date you cease to be in the eligible class.

COBRA Continuation Coverage

If coverage ends under certain situations, you or your Dependents can continue coverage under COBRA. You or your Dependent must elect this coverage within certain specified time frames and pay the full cost of this coverage. For more information, see ***Health Care Continuation Coverage (COBRA)*** in this section of the handbook.

Dependent Coverage

Your Dependent's coverage under a medical option, dental option, or vision option will end at the times noted below. A Dependent is never again eligible to participate in the Plan once coverage ends for these reasons:

- Coverage for your Dependents usually ends at the same time as your own coverage ends. Coverage for your spouse ends if you are 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*** in this section of the handbook.
- The first day of the month you choose to stop coverage for that Dependent for any reason. The last day of the month you choose to stop coverage for that Dependent for any reason and stop paying any required premiums (subject to any allowable grace period).
- The last day of the month in which you stop paying any required premium for the Dependent.
- The date your coverage ends for any reason. However, if you die, your survivors can elect surviving Dependent coverage for those benefits in which they were enrolled on the day before your death.
- The date as determined by the Plan Administrator that any fraudulent claim has been filed by, or on behalf of, the Dependent (or other fraudulent event has occurred), or you or the Dependent makes an intentional misrepresentation of a material fact.

For Retiree Dependent spouse life coverage, insurance will end on the last day of the calendar month or the earliest of:

- When the Group Policy ends,
- The date insurance ends for the Retirees' class,
- Expiration of any applicable grace period following non-payment of premium,
- The date the Retiree ceases to be in an eligible class,
- The date the Retiree dies, or
- The date the Dependent ceases to be in an eligible class.

In order for the Dependent to retain coverage, the Retiree must remain insured for Retiree coverage.

Survivor Health Care Coverage

If you die while you are actively participating in a medical option, dental option, or vision option, your surviving covered spouse and covered children can continue the medical, dental, and vision coverage that is in force on the date of your death. There is no cost to your Dependents for this coverage for the remainder of the month in which you die plus one additional calendar month.

Beyond this initial period, your Dependents must enroll for continued coverage within 30 days and pay the required contributions within 30 days after the initial period ends. For more information about survivor coverage and how to enroll, contact the Service Center.

This coverage ends on these dates:

- Medical and dental coverage for your spouse and children ends on the last day of the month in which your spouse remarries.
- Coverage for your spouse and children ends on the date your spouse fails to certify that he or she has not remarried, as required.
- Coverage for your children ends if they marry, reach the maximum age, or no longer meet the eligibility requirements. For more information, see ***Dependent Eligibility*** in this section of the handbook.
- The last day of the month in which your Dependents stop paying any required premiums (subject to any applicable grace period).
- The date the surviving Dependent(s) becomes covered under another group health plan.
- The date as determined by the Plan Administrator that any fraudulent claim has been filed by or on behalf of the Retiree, or a Dependent, or the Retiree or Dependent makes an intentional misrepresentation of a material fact.
- The date that an option is terminated.

If a Plan Changes or Ends: Amendment or Termination of the Plan

Oncor reserves the right to amend, modify, or terminate all of its employee or Retiree benefit plans, in whole or in part, at any time and for any reason, including, but not limited to, by increasing, reducing, or terminating benefits for all employees or Retirees, or for any group of employees or Retirees; changing carriers, Network administrators, or benefits; increasing premiums, Deductibles, 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.

If the Plan should end in whole, in part, or for any Retiree group, benefits will be paid up to the date of Plan termination. No benefits will be paid after the date of Plan termination, and no charges incurred after the date of Plan termination will be covered.

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 Plan – medical, prescription drug, dental, and vision coverage – contact the Service Center. Refer to the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook.

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).

COBRA Continuation Rights for Retirees

You have been receiving Retiree medical, dental, or vision benefits under the Plan because you retired. As a result, you will never again experience a termination of employment or reduction of hours from Oncor, and you will not be eligible for COBRA continuation coverage under the plan as a result of your retirement or the elimination of the Plan's Retiree medical, dental, or vision benefits. You and your covered Dependents may be entitled to COBRA continuation coverage under the Plans for other reasons as explained on the next page.

COBRA Qualifying Events and Qualified Beneficiaries

Spouse of the Retiree

Your spouse becomes a COBRA-qualified beneficiary if he or she loses coverage under the health care benefits because of either of the following qualifying life events:

- You die, or
- You become divorced or legally separated from your spouse.

Dependent Children of the Retiree

Your Dependent children become COBRA-qualified beneficiaries if they lose coverage under the health care benefits because of either of the following qualifying life events:

- You die,
- 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 to qualified beneficiaries only after the Service Center has been notified that a qualifying life event has occurred.

You, your qualified beneficiary, or a representative must notify the Service Center in these cases:

- Your death, 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 to Notify the Service Center If You Have a Qualified Life Event

You, your qualified beneficiary, or a representative must provide timely notification to the Service Center of your divorce or legal separation or your child's loss of eligibility or the affected Dependent will lose any right he or she may have to elect COBRA continuation coverage. Refer to the information found in the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook.

How COBRA Coverage Is Offered

When the Service Center is timely 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 Service Center. If your qualified beneficiary lives at another address, a separate information packet will be sent if that address is provided.

To notify the Service Center of your new address, refer to the information found in the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook. You will also find the contact information for Oncor's COBRA administrator.

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 Service Center

It is critical that you (or anyone who may become a qualified beneficiary) maintain your 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 Service Center.

Electing COBRA Continuation Coverage

If you are eligible for COBRA continuation coverage, you will receive a COBRA enrollment notice in the mail. To elect COBRA coverage, you must call the Service Center by the date listed in the notice. If COBRA continuation coverage is not elected on a timely basis, you will lose any right you may have to elect COBRA.

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 timely 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 a Retiree 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 Retiree. 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 the Service Center 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 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 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 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 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 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 Retirees.
- 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).

If You Have Questions

Questions concerning your Plan and your COBRA continuation coverage rights should be addressed with the 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 **www.dol.gov/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 **www.healthcare.gov**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the 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 Service Center.

AMENDMENT OR TERMINATION OF THE PLAN

Oncor reserves the right to amend, modify, or terminate all of its employee or Retiree 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.

> For Service Center contact information, refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook.

Medical

Medical *(continued)*

Medical *(continued)*

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare *(continued)*

MEDICAL BENEFITS

While most of us want – and try – to stay healthy and safe, over the course of our life, each of us may have an injury or illness serious enough to require a hospital stay. Medical care is expensive. The Oncor medical options are designed to help protect your finances from the high cost of a serious medical condition. The medical options also cover treatment for minor illnesses and injuries, as well as preventive care that can help you stay healthy. All in all, comprehensive medical coverage is an important part of your overall wellbeing – physical and financial!

This section of the handbook describes how the medical options work in various stages of retirement – before Medicare eligibility, when newly eligible for Medicare, when receiving Medicare, and if you become eligible for long-term disability (LTD) benefits.

Medical Coverage Decisions

When you enroll for coverage each year, you choose a coverage category and a medical option that best fit your situation. The medical options that are available depend on these factors:

- **Medicare eligibility.** The medical options that you can choose for yourself and your covered Dependents are determined by Medicare eligibility. If you are Medicare-eligible and your covered Dependents are not (or vice versa), you must make separate medical elections. This is called "Med Separate coverage." For more information, see the chart later in this section.
- **LTD eligibility.** After completing the elimination period and becoming eligible for LTD benefits, you can continue all of your medical, dental, vision, and life insurance benefits provided you were enrolled in them prior to your disability. You will continue to pay for these benefits at employee rates until you are eligible for Medicare.
- **When Medicare becomes your primary coverage as a participant receiving LTD benefits,** you are automatically moved to the Indemnity Medical Plan with Rx Option. You fall into Rate Band B. These rates are published each year during the Annual Enrollment period for the following year's coverage. Your Dependents' medical coverage remains under the same employee medical option they had prior to your Medicare eligibility, and this coverage also falls into Rate Band B. As mentioned above, these rates are published each year during the Annual Enrollment period for the following year's coverage.
- **When you become eligible for retirement,** you remain in the Indemnity Option and an Age + Years of Service calculation is used to determine your Retiree medical contribution rate. Rates are published each year during the Annual Enrollment period for the following year's coverage. At that time, if your spouse is under age 65, coverage for him or her remains unchanged but the contribution level changes to the same as the Retiree. However, if your spouse is 65 or older, then he or she must move to the Indemnity Option at the same contribution level as the Retiree.

The Scott & White Health Plan Option is only available to those living in certain geographic locations. This option is a legacy option and is closed to new participants effective January 1, 2015. If you are currently a participant in this option, you may elect to continue during Annual Enrollment. If you dis-enroll, you will not be able to re-enroll at a later date.

Note: The applicable Retiree contribution rates are subject to change from time to time at the discretion of Oncor. You will be notified if your required Retiree contribution changes.

Your Medical Options

You can choose one of the following medical options, depending on the Medicare eligibility of you and your Dependents.

If you are Medicare-eligible and your covered Dependents are not (or vice versa), you must make two separate medical elections.

When you choose a medical option, you receive the prescription drug coverage that goes with that option. You can also choose the Blue Cross and Blue Shield of Texas (BCBSTX) Indemnity Medical Only Option that has no prescription drug coverage.

If you or your Dependent is not eligible for Medicare, you may choose:	If you or your Dependent is eligible for Medicare, you may choose:
Retiree HRA Option BCBSTX PPO Plan Network	**Indemnity with Rx Option** Supplements benefits from Medicare Parts A and B
Retiree HSA Option Provides basic, high-deductible medical coverage. This option also utilizes the BlueChoice BCBSTX PPO Plan Network.	**Indemnity with Legacy Rx Option** *(This is a closed option – No new participants.)* Supplements benefits from Medicare Parts A and B
Scott & White Health Option *(available only in certain ZIP codes)* *(This is a closed option – No new participants.)* You must use a Network provider to receive benefits (except for urgent or Emergency Care for medical services).	**Indemnity Medical Only Option** > Supplements benefits from Medicare Parts A and B, but does not provide prescription drug coverage > If you or a Dependent enrolls in a Medicare prescription drug plan (Medicare Part D), your Oncor medical option will change to this option.
	Individual Health Option through Via Benefits

Special Eligibility Rules for a Retiree HSA Medical Option

Under IRS rules, you are not eligible to participate in an HSA option if you have other coverage, including Medicare, Tricare, tribal plans, or another employer's plan. Your Dependents' coverage under another health care plan will not prevent you from enrolling them in the Retiree HSA Medical Option. See the **Plan Participation** section of this handbook for details.

About the Networks

All of Oncor's medical options – except the Scott & White Health Option, which offers the Scott & White Network, and the Individual Health Option through Via Benefits – 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 are comfortable using in the Network you choose. You cannot switch medical options within a Plan Year if 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 costs and you pay a smaller amount. When you choose providers outside the Network, the Plan usually pays a lower portion of 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, and the claim will have to be resubmitted for review and adjusted, if appropriate.

Medical Care Away from Home – For Retirees and Dependents Who Are Not Eligible for Medicare

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 visit the doctor and hospital finder at **www.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 BCBSTX determines that the care was an emergency, benefits are paid at the In-Network rates.

> If you are not eligible for Medicare and are participating in one of the other options, you may call Health Advocacy Solutions (BCBSTX) at **1.877.213.6898** or log onto **www.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 Claims Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

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

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

The Scott & White Health Plan Option

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

About the Retiree HRA and Retiree HSA

If you enroll in the Retiree HRA Medical Option or Retiree HSA Medical Option, you may be eligible to receive payment from Oncor for incentives you earn by completing certain wellness activities. These are explained each year in your Annual Enrollment materials and *Your Guide to Benefits*. If your incentive activities are completed by the announced deadlines, you will receive the amount of your incentives, less applicable income taxes, in the form of a paper check from Oncor.

> If you reach age 65 before the incentive is distributed, you will not receive an incentive check.

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

MEDICARE MEDICAL PLAN OPTIONS

When you or your covered Dependent becomes eligible for Medicare (age 65), you have the following medical options:

- The Indemnity with Rx Option
- The Indemnity with Legacy Rx Option (if you retired and turned 65 prior to January 1, 2006)
- The Indemnity Medical Only Option
- The Individual Health Option through Via Benefits

The following sections give you information about Medicare and how our medical options work for persons who are Medicare eligible.

Because the medical options work with Medicare, it is important that you and your Dependents enroll for Medicare as soon as possible after becoming eligible.

How Medicare Works

Here is a quick "refresher" on Medicare – what it is and what it covers.

Generally, you are eligible for Medicare if you are age 65 or over, if you are disabled and qualify for Social Security disability benefits, or if you have end-stage renal disease.

For details, please see the Medicare booklet titled *Medicare & You* available at www.medicare.gov.

Medicare provides four basic types of coverage:

Medicare Part A	> Covers some of the expenses for inpatient hospital services, skilled nursing facility services, and certain types of home health and hospice care > Is available to you at no cost
Medicare Part B	> Covers doctor and outpatient hospital services, medical equipment and supplies, and other health services > Requires a monthly contribution
Medicare Part C	> Allows Medicare Advantage Plans, which are an alternative to Medicare Parts A and B coverage. These health plans contract with Medicare to offer enhanced benefits for hospitalization, doctor's visits, and prescription drugs. > Requires a monthly contribution
Medicare Part D	> Covers prescription drugs > Requires a monthly contribution

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

Coordination with Medicare

If you are eligible for primary coverage from Medicare, you receive coverage under the Indemnity with Rx, Indemnity with Legacy Rx, Indemnity Medical Only, or you may choose the Individual Health Option, Via Benefits.

If you are a Retiree 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. You can contact the Service Center for more information about Medicare, your eligibility, and how your benefits will be affected by Medicare.

How the Medical Options Work with Medicare

Indemnity with Rx and Indemnity with Legacy Rx Options

If you are a Retiree and are eligible for Medicare, the options are secondary to Medicare. This means that the Plan provides benefits for eligible expenses that are not covered or fully paid for by Medicare.

This coordination of benefits happens whether or not you actually apply for or receive Medicare benefits. It's important that you enroll for Medicare Part A and Part B when you are first eligible.

For a general discussion of how coordination of benefits works, refer to ***Coordination of Benefits*** in the **Plan Administration** section. Different rules apply if you or your Dependents have coverage from another employer.

Indemnity Medical Only Option

This option is for persons who decide to elect Medicare Part D Prescription Drug coverage. The option coordinates benefits with Medicare in the same way as the Indemnity with Rx and Indemnity with Legacy Rx Options, but does not provide any prescription drug benefits.

Via Benefits Options

Via Benefits gives Retirees that are Medicare eligible and age 65 or over access to the country's largest private Medicare exchange. Via Benefits can help you find medical, pharmacy, dental, and vision insurance plans that fit your health care needs and budget often for less than you would pay to participate in a traditional health plan.

Via Benefits is individual health insurance. If you enroll in coverage found through Via Benefits, you will not be enrolled in an Oncor-provided medical or prescription drug option. You may choose to re-enroll in an Oncor medical option during any future Annual Enrollment. You may only re-enroll in an Oncor-sponsored option one time. Refer to the **Plan Participation** section of this handbook for more information on re-enrollment.

When you enroll for coverage with Via Benefits, a Health Reimbursement Account (HRA) will be set up for you. Oncor will fund the account each year, based on the amount that Oncor would have normally spent on premiums if you had continued coverage under the Plan. This amount will vary by individual.

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

INDEMNITY WITH Rx AND INDEMNITY WITH LEGACY Rx OPTIONS

These options are available to Retirees and their Dependents who are Medicare eligible.

The Legacy Rx Option became a closed plan as of January 1, 2006.

Eligibility for Indemnity with Rx vs. Indemnity with Legacy Rx

These two options are both available to Medicare-eligible participants. However, your eligibility is pre-determined based on your age on January 1, 2006:

- If you turned age 65 after January 1, 2006, you have coverage under the Indemnity with Rx Option.
- If you retired and turned age 65 before January 1, 2006, you may elect coverage under the Indemnity with Legacy Rx Option or the Indemnity with Rx Option.

The only difference between these two options is the prescription drug coverage as detailed on the ***Fact Sheet: Prescription Drug Coverage***.

How the Indemnity with Rx Option Works

- You can receive care from any provider you choose. You receive discounts on your medical charges if you use Network providers.
- Each year, you must meet an individual or family Deductible before the option starts to pay benefits.
- Once you meet a Deductible, the option pays 80% of the Allowable Amount for most expenses. You pay the remaining charges.
- The option pays eligible preventive care expenses for you and your spouse at 100%. There is no Deductible for eligible preventive care.
- If your expenses reach the Out-of-Pocket Maximum during a calendar year, the option pays 100% of most remaining expenses for the rest of the Plan Year.
- These options provide prescription drug coverage through SilverScript.

About the Deductible

The Deductible is the amount of covered medical expenses you pay each year before the option starts to pay most eligible medical expenses.

Each covered person must meet the individual medical Deductible each year before the option starts to pay most benefits.

These options also have a family Deductible. The family Deductible provides protection against high Deductible expenses for larger families. If combined expenses from all covered family members reach the family Deductible, no further Deductibles will be required from your family for the rest of the year.

All eligible medical charges 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 option or that exceed the Allowable Amount or other option limits,
- Deductibles, Coinsurance amounts, and Copayments for prescription drugs, or
- The $250 penalty for failure to precertify an out-of-network hospital admission.

About Coinsurance

You share in the cost of medical services through Coinsurance. Coinsurance is the portion of charges that you and the option each pay for covered services. The option's Coinsurance is the percentage of charges shown on the ***Fact Sheet: Indemnity with Rx and Indemnity with Legacy Rx Options***. Your Coinsurance is the remaining portion of charges.

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

About the Annual Out-of-Pocket Maximums

The options place a maximum on the amount of money you have to pay out-of-pocket each year for your share of covered medical expenses (your Deductible and Coinsurance). This is called the Out-of-Pocket Maximum. The Out-of-Pocket Maximum provides protection against high Coinsurance expenses during a year. Once you or a covered Dependent reaches the Out-of-Pocket 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 options shows the Out-of-Pocket Maximums.

The Out-of-Pocket Maximum applies to each covered person each calendar year. However, 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.

The following charges do not count toward the annual Out-of-Pocket Maximum:

- Any charges that are not covered by the option or that exceed the Allowable Amount or other option limits,
- The $250 penalty for not precertifying a hospital admission,
- Expenses paid by the Prescription Drug Program,
- The annual medical Deductible, and
- Prescription Copayments.

About Covered Charges

The options pay benefits for services and supplies that are specifically covered by the option. The types of covered charges are shown on the ***Fact Sheet: Indemnity with Rx and Indemnity with Legacy Rx Options***. The covered charge must also be a medical service that is Medically Necessary and the recoverable expense will be limited to the reasonable and customary amount for the medical service provided.

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

Fact Sheet: Indemnity with Rx and Indemnity with Legacy Rx Options

Network/Provider Choice	BCBSTX BlueChoice PPO Plan **Note:** You can go to any provider you choose, but will be responsible for filing claims for services received by Out-of-Network providers.
Deductible	Refer to *Your Guide to Benefits* that you receive each year during Annual Enrollment for specific information.
> You Only	
> Family	
Coinsurance Maximum (excludes Deductibles and Copayments)	
> You Only	
> Family	
	Plan Pays
Physician's Service	
> Doctor's office and home 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
Adult Preventive Care	
> Annual physical exam > Cardiovascular screening > 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, regardless if billed as preventive/routine or diagnostic. > Prostate cancer screening after age 50 (after age 40 if there is a family history or other risk factor), including exam and PSA > 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)

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

	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)
Inpatient Hospital Care	
> Hospital room and board up to the semiprivate room rate. You must precertify inpatient hospitalization or a penalty will apply. > 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 transfusion (when not replaced), and treatment of pulmonary tuberculosis > Private duty nursing > 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 child – 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 > Reduction mammoplasty	80% after you meet Deductible
> Renal dialysis – In-Network coverage only	80% after you meet Deductible, not covered if provider is Out-of-Network

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

	Plan Pays
Outpatient Care	
> Outpatient surgery > Services or supplies provided for outpatient treatment at a hospital, ambulatory surgical facility, or radiation therapy center > Second surgical opinion if 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 > Emergency room. If possible, contact your physician before going to the emergency room to determine if Emergency Care is needed. > 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
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, including: – 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 must be precertified. > 120-day maximum per calendar year. > Home infusion therapy. You must precertify treatment.	80% after you meet Deductible
> Hospice care when life expectancy is 6 months or less (includes bereavement counseling). You must precertify hospice care before services begin.	100% (no Deductible)

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

	Plan Pays
Family Planning/Maternity Care	
> Office visits (prenatal and postnatal) > 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. > Newborn nursery services, including initial exam > Services and supplies provided by a birthing center for 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
> Maternity coverage for Dependent children – Normal pregnancy	No coverage except for complications of pregnancy
– Complications of pregnancy	80% after you meet Deductible
Other Services and Supplies	
> Chiropractic services. Note that lab and X-ray charges related to chiropractic treatment are covered under "Outpatient Care."	80% after Deductible for up to 25 visits per calendar year
> 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 > 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	80% after you meet Deductible

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

	Plan Pays
Other Services and Supplies *(continued)*	
> Bariatric surgery (after meeting precertification requirements)	80% after you meet Deductible, not covered if provider is Out-of-Network
> Wigs, when needed for baldness resulting from chemotherapy, alopecia, radiation therapy, or surgery	80% after you meet Deductible, up to $500 per calendar year
Hearing Care	
> Routine hearing exam – 1 exam per calendar year	100% (no Deductible)
> Hearing therapy > Hearing aids – 1 pair every 36 months, $5,000 maximum	80% after you meet Deductible
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 impacted teeth when Medically Necessary > Services to treat or correct a congenital defect for a newborn child	80% after you meet Deductible
Routine Vision Care	
> Routine vision exams – 1 exam per calendar year	100% (no Deductible)
> Vision hardware – eyeglass lenses and frames, and contact lenses	Not covered
Mental Health and Chemical Dependency	
> Mental Health – Outpatient (precertification required for certain outpatient treatments) – Inpatient (precertification required) > Chemical Dependency – Outpatient (precertification required for certain outpatient treatments) – Inpatient (precertification required)	80% after you meet Deductible

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

Fact Sheet: Prescription Drug Coverage

If you enroll in:

- **The Indemnity Medical Only Option.** This option does not provide prescription drug benefits.
- **The Via Benefits Option.** Prescription drug benefits vary based on the Via Benefits Option you choose. Refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook for Via Benefits contact information.
- **The Indemnity with Rx Option or Indemnity with Legacy Rx Option.** This chart shows your prescription drug benefits.

Prescription Drug (Rx) Coverage	Indemnity with Rx			Indemnity with Legacy Rx		
Rx Deductible per Person	$300			$50		
Coinsurance/Copayment Maximum per Person	$4,000 (excludes Rx Deductible)					
	Up to 30-day supply	Up to 60-day supply	Up to 90-day supply	Up to 30-day supply	Up to 60-day supply	Up to 90-day supply
	Retail (Per Prescription Fill)					
Value	$5 Copay(1)	$10 Copay(1)	$15 Copay(1)	20%, $20 max	20%, $40 max	20%, $60 max
All Other Generic	$10 Copay(1)	$20 Copay(1)	$30 Copay(1)	20%, $20 max	20%, $40 max	20%, $60 max
Preferred Brand Name	30%, $100 max	30%, $200 max	30%, $300 max	20%. $40 max	30%, $80 max	30%, $120 max
Non-Preferred Brand Name	40%, $120 max	40%, $240 max	40%, $360 max	40%, $50 max	40%, $100 max	40%, $150 max
Specialty	$250 Copay(1)	N/A	N/A	$150 v(1)	N/A	N/A
	Mail Order (Per Prescription Fill)					
Value	$10 Copay(1)	$10 Copay(1)	$10 Copay(1)	$7.50 Copay(1)	$7.50 Copay(1)	$7.50 Copay(1)
All Other Generic	$20 Copay(1)	$20 Copay(1)	$20 Copay(1)	$7.50 Copay(1)	$7.50 Copay(1)	$7.50 Copay(1)
Preferred Brand Name	30%, $200 max	30%, $200 max	30%, $200 max	$25 Copay(1)	$25 Copay(1)	$25 Copay(1)
Non-Preferred Brand Name	40%, $240 max	40%, $240 max	40%, $240 max	$50 Copay(1)	$50 Copay(1)	$50 Copay(1)
Specialty	$250 Copay(1)	N/A	N/A	$150 Copay(1)	N/A	N/A
Lifetime Maximum Rx Benefits	Unlimited for both Retail and Mail Order prescriptions					

(1) No Deductible

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

Charges That Are Not Covered

Although the option covers most health care expenses, it does not cover all medical charges. The following charges are not covered by the BCBSTX Indemnity with Rx Option:

- Acupuncture, acupressure, and acupuncture therapy,
- Allergy and specific non-standard allergy services and supplies, including but not limited to, skin titration, cytotoxicity testing treatment of nonspecific 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,
- Any services or supplies not specifically defined as eligible expenses in this Plan,
- 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 that are not rendered or are rendered to a person not eligible for coverage under the option,
- Charges submitted for services by an unlicensed hospital, physician, or other provider or not within the scope of the provider's license,
- 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, and other home test kits; splints, neck braces, compresses, and other devices not intended for reuse by another patient,
- Drugs, medications, supplies, and services covered under the SilverScript Pharmacy Program are not covered under the medical options,
- 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,
- Elective abortions,
- 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 to 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,

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

Charges That Are Not Covered *(continued)*

- 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, hearing exams given during a stay in a hospital or other facility, or any tests, appliances, and devices for the improvement of hearing, including hearing aids and amplifiers,
- 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, personal transporters, any vehicle or other transportation device,
- 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,
- Infertility services, treatments, procedures, or supplies that are designed to enhance fertility or the likelihood of conception,
- 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, to have preferred access to physician services, 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, SilverScript, or other applicable vendor 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 provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law, or any household member,
- Services of a resident physician or intern rendered in that capacity,
- 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,
- 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 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,
- Sex change treatments, drugs, services, or supplies relating to changing sex or sexual characteristics,
- 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,
- 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,

Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible

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,
- Weight-loss treatments, drugs, or supplies intended to decrease or increase body weight, control weight, or treat obesity, including morbid obesity (except bariatric surgery when Medically Necessary), and
- Work-related illness or injury 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, an occupational illness, or similar program under local, state, or federal law.

INDEMNITY MEDICAL ONLY OPTION

This option is available to Retirees who are Medicare eligible.

This option provides identical benefits to those provided through the Indemnity with Rx Option – with one important exception: it does not provide prescription drug coverage.

If you or a Dependent enrolls in a Medicare Prescription Drug plan (also called "Medicare Part D"), your Oncor option will change to this Indemnity Medical Only Option. The change occurs when Medicare notifies Oncor of your enrollment in Medicare Part D. Your prescription drug coverage will be provided under Medicare, and you will not have prescription coverage with Oncor under any medical option.

If you want to change to a medical option that provides Oncor prescription coverage at a later date, you will have an opportunity to do so during Annual Enrollment.

VIA BENEFITS OPTION

This option is available only to Retirees who are Medicare eligible.

This is a Medicare Advantage Plan (Part C). This option replaces Medicare Parts A and B.

Via Benefits gives Retirees that are Medicare eligible and age 65 or over access to the country's largest private Medicare exchange. Via Benefits can help you find medical, pharmacy, dental, and vision insurance plans that fit your health care needs and budget often for less than you would pay to participate in a traditional health plan.

When you enroll for coverage with Via Benefits, a Health Reimbursement Account (HRA) will be set up for you. Oncor will fund the account each year, based on the amount that Oncor would have contributed toward the cost of your medical premiums if you had continued coverage under the Oncor Retiree Welfare Plan. This amount will vary by individual.

Medical Options for Those Who Become Medicare Eligible and/or Turn Age 65 During the Plan Year

BECOMING MEDICARE-ELIGIBLE AND/OR TURNING AGE 65 DURING THE PLAN YEAR

If you or your spouse will turn age 65 during the Plan Year, your Oncor options will change because you become eligible for Medicare.

Here are the steps you need to transition to Medicare.

Step 1: Contact Social Security to Apply for Medicare

If you are already receiving Social Security retirement or disability benefits, the Social Security Administration (SSA) should contact you a few months before you become eligible for Medicare and give you the information you need. If you live in one of the 50 states or Washington, D.C., you will be enrolled in Medicare Parts A and B automatically. You must pay a premium for Part B coverage.

If you opt out of Part B coverage, you will have a gap in coverage, as the Oncor plans will pay as though you have Part B, regardless of whether or not you are actually enrolled in Part B.

If you are not already receiving Social Security benefits, contact the SSA to sign up for Medicare about three months before your 65th birthday. Medicare is effective the first of the month in which you turn 65. If your birthday is on the first of the month, Medicare is effective the first of the preceding month. As soon as you get your Medicare card, call the Service Center to give them your Medicare Beneficiary Identifier (MBI).

Step 2: Review the Medical Options for Participants and Dependents Who Are Eligible for Medicare

Once you become eligible for Medicare, you will need to enroll in a new medical option under the Plan for the rest of the year. If you or your spouse is not eligible for Medicare, you will be enrolled in what is known as Med Separate coverage. The participant who is Medicare eligible will be enrolled in one of the options available for Medicare-eligible participants and the participant who is not Medicare eligible will still be eligible to participate in the medical options available to participants who are not eligible for Medicare until he/she is eligible for Medicare.

Step 3: Contact the Service Center

After you review your medical options, contact the Service Center within 30 days of becoming Medicare eligible (turning 65). You should be aware that it takes approximately 45 days for your enrollment in SilverScript to become effective, so the sooner you enroll, the better.

During the call, the Service Center representative will answer your questions and enroll you in an option. **If you do not call the Service Center, you will be enrolled in the Indemnity with Rx Option for Medicare-eligible participants.**

> Once you start Medicare, you will have to meet a new Deductible when you move into the Medicare-eligible Retiree medical option. See ***Medical and Prescription Drug (Rx) Options for Those Who Are Medicare Eligible*** in this section of the handbook for details.

Medical Options for Those Who Become Medicare Eligible and/or Turn Age 65 During the Plan Year

SilverScript Prescription Drug

When you become eligible for the benefits for Participants Age 65 or Over (Medicare Eligible), you will receive a SilverScript "Welcome Kit" sent to your home. If you want Oncor's Prescription Drug Program, call SilverScript when you receive the Welcome Kit to enroll right away by instructing them that you are waiving the "opt-out" waiting period.

SilverScript follows the guidelines of the Centers for Medicare and Medicaid Services (CMS) in processing Medicare Part D Prescription Drug Plan enrollments. This process can take up to 60 days. Per Medicare rules, you cannot be enrolled automatically in the Medicare Part D Plan for 21 days after your application is accepted by Medicare unless you call to accept the plan. Otherwise, SilverScript will default you into the Oncor option at the end of the 21-day period.

You should apply for Medicare three months before you reach age 65. As soon as you get your Medicare card with your Medicare Beneficiary Identifier (MBI), call the Service Center and give them your MBI so you can be set up in the Oncor Prescription Drug Program. If the Service Center does not have your MBI at least 45 days before the month you turn age 65, your enrollment may be delayed.

> Your enrollment confirmation and prescription coverage may not be in place on the first day of your Medicare eligibility due to this requirement. However, if you call SilverScript to confirm that you do want to enroll, you may reduce this delay in implementing your coverage.

Medicare Premiums May Be Adjusted Based on Income

Medicare requires some people, based on their income, to pay higher premiums for Medicare Part B (medical insurance) and prescription drug coverage (Part D). If this applies to you, Social Security will send you information about your adjustment and how it was determined. These amounts and requirements are a federal law and cannot be waived or changed by Oncor.

Your Medicare Part B (medical insurance) Premium includes:

- The Standard Part B Premium amount,
- Any surcharge that may apply for late enrollment or re-enrollment, and
- An income-related monthly adjustment amount (IRMAA). The IRMAA is based on your modified adjusted gross income (MAGI) from your income tax return two years ago. (If you apply in 2019, your MAGI is based on your 2017 income tax return.)

If you have prescription drug coverage, you also may be charged prescription drug coverage IRMAA in addition to your monthly premium. The IRMAA is generally deducted from your monthly Social Security benefits, regardless of how you pay your premiums.

About Rules of the Centers for Medicare and Medicaid Services (CMS)

CMS rules do not allow enrollment in more than one Medicare Part D program at a time. While you are enrolled in the Oncor Prescription Drug Program, if you enroll in another Medicare Part D program, or if you have other coverage that transitions its prescription drug coverage to a Medicare Part D program, you will be automatically dis-enrolled from the Oncor Prescription Drug Program. If this happens, you will be moved into the Indemnity Medical Only option.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

If you are under age 65 and not eligible for Medicare, you have these medical options available to you:

- The Retiree HRA Medical Option,
- The Retiree HSA Medical Option, and
- The Scott & White Health Plan Option (if available in your area and you are currently enrolled in this closed legacy option).

RETIREE HRA MEDICAL OPTION

The Retiree HRA Medical Option uses the Blue Cross and Blue Shield of Texas (BCBSTX) PPO Network, and includes individual and family In-Network Deductibles, Coinsurance, and Out-of-Pocket Maximums. Refer to *Your Guide to Benefits* that you receive each year during Annual Enrollment for specific information. You may also access this guide by logging onto **oncorbenefits.com/ret**.

If you enroll in the Retiree HRA Medical Option, you may be eligible to receive payment from Oncor for incentives you earn by completing certain wellness activities. These are explained each year in *Your Guide to Benefits*. If you (and/or your spouse) complete incentive activities by the announced deadlines, you will receive the amount of your incentives, less applicable income taxes, in the form of a paper check from Oncor.

How the Retiree HRA Medical Option Works

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

- 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 Retiree 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.
- 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 Retiree 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 benefits. In addition, 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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

The Retiree HRA Medical Option also has family medical and prescription drug Deductibles. The family Deductible provides protection against high Deductible expenses for larger families. If combined expenses from all covered family members reach the family Deductible amounts, no further Deductibles will be required from your family for the rest of the year.

Only prescription drug expenses (excluding prescription drug Copayments) count toward the individual and family prescription drug Deductible.

All eligible medical expenses 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,
- Prescription drug copays,
- 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 Retiree 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 Retiree 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 each pay for covered services. The option's Coinsurance is the percentage of charges shown on the ***Fact Sheet: Overview of the Retiree HRA and Retiree HSA Medical Options*** ("Fact Sheet") in this section – usually 80% for In-Network Services and 60% for Out-of-Network Services. Your Coinsurance is the remaining portion of charges, which you may be responsible to pay.

About the Annual Out-of-Pocket 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 Out-of-Pocket Maximum. Once you or a covered Dependent reaches the Out-of-Pocket 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 Out-of-Pocket Maximum.

The Out-of-Pocket 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 Out-of-Pocket Maximum for prescription drugs.

The following charges do not count toward the annual Out-of-Pocket Maximum:

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

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

About the Retiree HRA

Oncor offers incentives when you and your covered spouse complete various preventive and wellness activities by set deadlines.

Any incentives earned will be paid to you in the form of a check from Oncor. The money can be used for any expenses, and is not limited to health care expenses. Incentives paid are subject to ordinary income tax.

Refer to *Your Guide to Benefits* that you receive each year during Annual Enrollment for specific information. You can also access this guide by logging onto **oncorbenefits.com/ret**.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

RETIREE HSA MEDICAL OPTION

The Retiree HSA Medical Option uses the Blue Cross and Blue Shield of Texas (BCBSTX) PPO Network, and provides qualified, high-deductible medical coverage. This option includes individual and family In-Network Deductibles, Coinsurance, and Out-of-Pocket Maximums.

If you enroll in the Retiree HSA Medical Option, you may be eligible to receive payment from Oncor for incentive activities you (and/or your spouse) complete by the announced deadlines. You will receive the amount of your incentives, less applicable income taxes, in the form of a paper check from Oncor. For specific information, refer to *Your Guide to Benefits* that you receive during Annual Enrollment each year. You may also access this guide by logging onto **oncorbenefits.com/ret**.

How the Retiree HSA Medical Option Works

- 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.
- 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.
- 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.

About the Deductible

The Deductible is the amount of covered medical expenses you and your family pay each year before the Retiree 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, mental health, and chemical dependency expenses 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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

About Coinsurance

You share in the cost of medical services through Coinsurance.

Coinsurance is the portion of charges that you and the option each pay for covered services. The option's Coinsurance is the percentage of charges shown on the ***Fact Sheet*** for your Network – usually 100% or 80% for In-Network Services and 60% for Out-of-Network Services. Your Coinsurance is the remaining portion of charges.

About the Annual Coinsurance Maximums

The Retiree 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 Retiree 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 Retiree HSA

Oncor offers incentives when you and your covered spouse complete various preventive and wellness activities by set deadlines.

Any incentives earned will be paid to you in the following year in the form of a check from Oncor. The money can be used for any expenses, and is not limited to health care expenses. Incentives paid are subject to ordinary income tax.

Refer to *Your Guide to Benefits* that you receive each year during Annual Enrollment for specific information. You can also access this guide by logging onto **oncorbenefits.com/ret**.

Covered Expenses

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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

GENERAL INFORMATION ABOUT RETIREE HRA AND RETIREE HSA 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 and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

Medical Options: Incentive and Reward Opportunities

In both the Retiree HRA and Retiree HSA Medical Options, you can earn incentives based on certain wellness and preventive actions you and, in some cases, your spouse complete within certain timelines.

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.

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 **oncorbenefits.com/ret**.
>
> To confirm that your completed *Physician Results Form* has been received and/or check your health risk factors, you can call the Incentive Information provider. For contact information, refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

Fact Sheet: Overview of the Retiree HRA and Retiree HSA Medical Options

	Retiree HRA Medical Option		Retiree HSA 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. These options utilize 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)

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

	Retiree HRA Medical Option		Retiree HSA 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) Regardless if billed as preventive/routine or diagnostic		100% (No Deductible) when billed as routine/preventive. These services, when billed as diagnostic, will be subject to Deductible and Coinsurance.	
	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			

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

	Retiree HRA Medical Option		Retiree HSA 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			

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

	Retiree HRA Medical Option		Retiree HSA 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, including: – 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% (No Deductible)	60% after you meet Deductible	100% after you meet 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

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

	Retiree HRA Medical Option		Retiree HSA 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

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

	Retiree HRA Medical Option		Retiree HSA 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			

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

	Retiree HRA Medical Option		Retiree HSA 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

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

Charges That Are Not Covered

Although the option covers most health care expenses, it does not cover all medical charges. The following charges are not covered under the Retiree HRA Medical Option or Retiree HSA Medical Option:

- 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,

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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,
- 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,
- Sex change treatments, drugs, services, or supplies relating to changing sex or sexual characteristics,
- 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,

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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, and
- 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 onto **www.swhp.org**, or
- Contact the Service Center. Refer to the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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 Retiree HRA and Retiree HSA 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 Retirees' 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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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 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 **www.CVSCaremarkSpecialtyRx.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 **www.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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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 **www.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, Copayment, or Coinsurance amount. 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 **www.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 amounts, or Copayments 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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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

The Copays and maximums for specific types of medication are subject to change. Refer to *Your Guide to Benefits* that you receive each year during Annual Enrollment for specific information. You may also access this guide by logging on to **oncorbenefits.com/ret**.

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

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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 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,
- 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,
- Immunizations (covered under the Oncor medical option),
- Infertility medications,
- 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),

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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,
- Sex change drugs or supplies related to changing sex or sexual characteristics, including hormones and hormone therapy,
- 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 if you need to find a participating retail pharmacy, if you lose your ID card, if you want to check whether a drug is a preferred brand drug, or if you have any other questions about the program. For CVS Caremark contact information, refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook.

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

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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 amounts, and Copayments are the same as those for other medical and surgical benefits under your medical option.

BCBSTX Health and Wellness Programs for Those Not Eligible for Medicare

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:

- 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,
- 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, 7 days a week, and
- Special Beginnings Program®.

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

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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 Retirees 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 Retiree HRA and Retiree HSA 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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

Hospice Care

Participants in Retiree HRA and Retiree HSA 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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

Organ Transplants

Participants in Retiree HRA and Retiree HSA 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	> Bone marrow/stem cell
> Heart	> Heart/lung
> Kidney	> Kidney/pancreas
> Liver	> Lung
> Pancreas	

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 in connection with a bone marrow transplant, 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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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 on the next page.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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.

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 and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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:

- 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 Retiree HRA and Retiree HSA 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:

- 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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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.

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.

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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.

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

Medical and Prescription Drug (Rx) Options for Those Not Eligible for Medicare

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.

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 will be secondary to Medicare and 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. You can contact the Service Center for more information about Medicare, your eligibility, and how Medicare will affect your benefits.

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 and Retirees 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 each year during Annual Enrollment. You can also access the guide at **oncorbenefits.com/ret**.

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 option's Coinsurance is the percentage of covered charges shown on the Fact Sheet for your dental option. 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 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 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 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 option.

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.

In Case of a Dental Emergency

If you have a dental emergency, the dental options pay a benefit at the Network level of coverage even if the services and supplies were not provided by a Network provider up to the dental emergency maximum. The care provided must be a covered service or supply. You must submit a claim to Aetna describing the care given. Additional dental care to treat your dental emergency will be covered at the appropriate Coinsurance level.

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, pre-medication, 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.

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.

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. 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 on the Service Center Website, on the insurance carrier's website at **www.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 that are less than the $150 frame allowance.
- 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 frame.
- 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 Copays apply. Retirees 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 .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		
Vision exam	You pay $10	Option reimburses up to $40
Eyeglasses		
Single vision lenses	You pay $0(1)	Option reimburses up to $40
Lined bifocal lenses	You pay $0(1)	Option reimburses up to $60
Lined trifocal lenses	You pay $0(1)	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(2)	You pay $0	Option reimburses up to $210
Elective(3)	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) Popular lens upgrades (such as no-line bifocals and anti-reflective coating) are available at a discount to you.

(2) 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.

(3) 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 Laser Vision Network of America (LVNA). LVNA is a nationwide Network of more than 300 laser vision providers who service UnitedHealthcare Vision members. The Network was established in 1999 and offers the most extensive geographic coverage in the United States. It currently serves over 75 million members through some of the largest health and vision insurers in the industry.

- To ensure the quality of its patient care, LVNA chooses to credential its surgeons through a credentials verification organization that is accredited by a nationally recognized agency.
- By combining LasikPlus Vision Centers with independent surgeons, you have an extensive choice of laser technology alternatives.
- The Vision Option's call center is staffed exclusively with LASIK-trained representatives available to assist you seven days a week.

You and your covered Dependents are entitled to one of the following discounts (not available to the general public):

- 15% off standard or Reasonable and Customary prices, and
- 5% off any promotional price.

Call **1.888.563.4497** or access **www.uhclasik.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 the vision insurance carrier. 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.

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.

Life Insurance

LIFE INSURANCE OPTIONS

Life insurance pays a benefit to your beneficiary in the event of your death or to you in the event of the death of your spouse covered by the Plan.

This section provides a summary of the Life Insurance coverage available to eligible Retirees and their Dependents. If you have any questions about the information in this section, refer to the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook.

> If you are married to another Oncor employee or Retiree, you must each be insured as an employee or Retiree under the Optional Life Insurance Plan, and not as a spouse.

Group Term Life Insurance

All Retiree Life Insurance currently offered is group term insurance. There is no cash value for term life insurance.

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 (called Life Insurance Program A) or change coverage to that offered under the new flexible benefits program. If you chose to keep your Program A coverage, your coverage is different from that currently offered under the Plan. This is a closed legacy Life Insurance Option.

Life Insurance Program B

If you were receiving LTD benefits before retirement for a disability that began before 2002, you could have continued your coverage under Life Insurance Program B.

YOUR RETIREE LIFE INSURANCE OPTIONS FACT SHEET

These Life Insurance Options are available to you when you retire. After retirement, you can elect a lower coverage option, but you cannot increase your coverage.

Type of Coverage	Coverage Amount
Retiree Life Insurance Options	
Company-Paid Coverage	$10,000
Retiree-Paid Coverage	Up to the amount of your Employee Life Option on date of retirement in multiples of 1 times to 7 times, up to a maximum of $2 million
Spouse Life Insurance Option	.25, .50, 1, 2, 3, 4, 5, or 6 times pay, up to a maximum of $250,000

- If you are a Retiree who chose to continue life insurance under Life Insurance Program A, see ***Life Insurance Program A*** in this section of the handbook for a description of coverage.
- If you are an LTD employee and eligible for coverage under Program B, see ***Life Insurance Program B*** in this section of the handbook for a description of coverage.

> **Note:** Spouse coverage cannot exceed the amount of coverage the Retiree has elected.

RETIREE LIFE INSURANCE OPTION

Retiree Life Insurance Option Coverage

Your Retiree coverage cannot be greater than the amount of coverage you had as an active employee at the time you retired. Once you have enrolled for Retiree Life Insurance, you can reduce the amount of coverage (from your current amount down to one times your annual base pay at the time of retirement) but you cannot increase your coverage amount.

Oncor pays for $10,000 of coverage for you.

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 also add the percentage of Life Insurance you want each beneficiary to receive.

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 Service Center. Refer to the ***Tools and Resources Contact Information*** for the Service Center number in the **Overview** section of this handbook.

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

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.

Premiums Based on Tobacco-User Status

Unless you are enrolled in Life Insurance Program A, your premiums for the Retiree Life Insurance Option and the Spouse Life Insurance Option, if applicable, are based on tobacco usage. You are considered to "use tobacco products" if, in the past two years, you smoked cigarettes, pipes, or cigars; used snuff; or chewed tobacco. It is your responsibility to notify the Service Center if you or your spouse has a change in your tobacco-user status.

SPOUSE LIFE INSURANCE OPTION

Eligibility

You can enroll in the Spouse Life Insurance Option if you were enrolled for Spouse Life Insurance coverage immediately prior to your retirement.

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 Insurance Option Coverage

You can choose any of the Spouse Life Insurance coverage choices available up to the coverage you had immediately prior to your retirement.

The coverage choices are based on your annual base pay at retirement. 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 Insurance coverage that is greater than your Retiree Life Insurance coverage, and there is a maximum coverage limit of $250,000 for the Spouse Life Insurance Option.

Spouse Life Insurance Option Coverage Choices

- 25% times annual base pay
- 50% times annual base pay
- 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 Insurance Option and any benefits are paid to you.

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 Insurance Option benefit before your spouse's death.

You can receive up to 80% of the face value of your spouse's coverage. The minimum payout is $20,000 and the maximum payout is $200,000. For details, call the Service Center. Refer to the ***Tools and Resources Contact Information*** for the Service Center number in the **Overview** section of this handbook.

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

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.

CHILD LIFE INSURANCE OPTION

(Available to Children of LTD Participants Only)

Eligibility

You can enroll your children for the Child Life Insurance Option if you are receiving LTD benefits under an Oncor LTD plan.

Child Life Insurance Option Coverage

You can choose any of the Child Life Insurance Option coverage choices available through the Plan.

When you elect the Child Life Insurance 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 Insurance Option Coverage Choices

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

Beneficiary

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

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

LIFE INSURANCE PROGRAM A

Eligibility

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

You can change to the Retiree Life Insurance 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

Options*	Coverage Amount
Option 1	Any amount up to $20,000 (company-paid basic life)
Option 2	1 times your annual base pay up to a maximum of $20,000 (rounded to the nearest $1,000). Oncor pays the first $20,000.
Option 3	2 times your annual base pay rounded to the next higher $1,000. Beginning at age 66, this amount will be reduced each year in 5 equal amounts until age 70, at which time the benefit will equal 1 times your annual base pay.

*Under all coverage options, Oncor will pay the premium cost for the first $20,000 of coverage for which you are eligible, regardless of age. For coverage in excess of $20,000, you pay the full cost of coverage in excess of $20,000.

Coverage Reduction After Age 65 for Retirees Who Choose Option 3

When you reach age 66, Retiree Life Insurance coverage is reduced each year in five equal annual increments until Retiree-paid coverage is one times your annual base pay at age 70. This coverage amount remains in effect for the rest of your life.

The annual reductions start on the first month after you reach age 66 (or on your 66th birthday, if your birthday is on the first of the month), and continue for five years.

Your premiums are adjusted as the reductions are applied.

Option 3 Example

If you were earning $50,000 and choose Option 3 of Program A, your coverage under Program A would be $100,000 (or two times your annual base pay). Beginning at age 66, your maximum allowable coverage is reduced in equal increments of 10% (or $100,000 x 10% = $10,000 per year) until your maximum allowable coverage is $50,000 (or 100% of your annual pay).

In this example:

- On your 66th birthday (which is January 1), your maximum allowable coverage would be reduced to $90,000 ($100,000 minus $10,000 or 10%).
- On your 67th birthday, your maximum allowable coverage would be reduced to $80,000 ($90,000 minus $10,000 or 10%).
- On your 68th birthday, your maximum allowable coverage would be reduced to $70,000 ($80,000 minus $10,000 or 10%).
- On your 69th birthday, your maximum allowable coverage would be reduced to $60,000 ($70,000 minus $10,000 or 10%).
- On your 70th birthday, your maximum allowable coverage would be reduced to $50,000 ($60,000 minus $10,000 or 10%).
- After your 70th birthday, your maximum allowable coverage will continue to be $50,000 (or 10% of your annual pay).

Dependent Life Insurance

If you are an LTD participant, you can elect Dependent Life Insurance of $15,000 for your spouse and $5,000 coverage 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 received.

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

LIFE INSURANCE PROGRAM B

Eligibility

You participate in Program B if you retired before January 1, 2002, or were an LTD participant on January 1, 2002, and did not continue coverage under Program A.

Program B Coverage

Type of Coverage	Coverage Amount
Retiree Life Insurance Options	
Company-Paid Coverage	$10,000
Retiree-Paid Coverage	1 times your annual base pay, up to a maximum of $2 million

Retiree Life Insurance

If you were covered under Program B as an LTD employee, you can elect one of the following Retiree options:

- Oncor-provided coverage of $10,000, or
- Coverage equal to your annual base pay at retirement, rounded up to the next $1,000. (Oncor provides the first $10,000 and you pay for additional coverage at the rates then in effect; the current rates are communicated during the Annual Enrollment period.)

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 received.

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 Service Center as soon as possible.

A death certificate will be required when your claim is filed. The claim should be filed as soon as possible after the death.

To obtain contact information for the Service Center, refer to the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook.

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.

SITUATIONS AFFECTING LIFE INSURANCE BENEFITS

Life Insurance coverage is designed to provide a range of protection. But, some situations could affect your benefits. Those situations are summarized below.

- If you do not furnish proof of loss or if you do not furnish it within the prescribed time period, payment of your benefits will be delayed or denied.
- If you fail to make any required contributions for coverage when they are due, your coverage will end.

If the Plan Ends

The company 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 should end, benefits may be paid for any valid claims incurred prior to such termination.

SPOUSE LIFE INSURANCE CONVERSION

In the following situations, your spouse can continue Spouse Life Insurance Option coverage through the option's conversion provisions:

- If you die.
- If you and your spouse divorce.

The option's conversion provision gives you an advantage. Your spouse can continue Spouse Life Insurance Option coverage without providing the Statement of Health (SOH) that would be required if he or she were applying for an individual policy.

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

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. You must then complete the application process and pay the first premium during MetLife's request period.

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 **1.800.638.6420** for any additional questions regarding conversion. You cannot continue a higher amount of coverage for your Dependents than you continue for yourself.

You pay the coverage premiums directly to MetLife.

Disability

For Long-Term Disability (LTD) Participants

As an LTD Participant, your coverage changes as you move through different stages. This section provides more details.

OVERVIEW

Here is a summary of the stages:

- **After completing the required Elimination Period, typically 180 days of disability and becoming eligible for LTD benefits,** you can continue all of your medical, dental, vision, and life insurance benefits – provided you were enrolled in them prior to your disability and for as long as you continue to receive LTD benefits. You will continue to pay for these benefits at employee rates until you become eligible for Medicare.
- **When you become eligible for Medicare as a participant receiving LTD benefits, you must notify the Plan Administrator.** At that point, you will be moved to the Indemnity with Rx Option, and you and your covered Dependents will pay Rate Band B Retiree contributions for this coverage until you become eligible for retirement.
- **When you become eligible for retirement,** you remain in the Indemnity with Rx Option and an Age + Years of Service calculation is used to determine your Retiree medical Rate Band contribution rate. At that time, if your spouse is under age 65, coverage for him or her remains unchanged, but the contribution level changes to the same as the Retiree. However, if your spouse is 65 or older, then he or she must move to the same option and contribution level as you, the Retiree.

WHAT HAPPENS WHEN YOU FIRST BECOME AN LTD PARTICIPANT

From the time you become eligible for LTD benefits through Oncor, you will:

- Pay the active employee rates for medical, dental, vision, and life insurance,
- Pay no premiums for LTD, and
- Not be eligible for accidental death and dismemberment (AD&D) benefits.

You have the one-time opt-out privilege, as described more fully under ***Retiree Coverage and the Opt-Out Feature*** in the **Plan Participation** section. This callout provides a brief overview of this privilege.

About the Opt-Out Feature

Eligible Retirees and those receiving LTD benefits have a one-time opportunity to opt out of their available coverages (excluding life insurance) and then re-enroll at a later date. You can use the opt-out and re-enroll feature only one time for each health care benefit (medical, dental, and vision).

The opt-out feature:

- Applies separately for each of the respective benefits and is available only for those benefits for which a participant is currently enrolled (or was enrolled immediately before retiring or LTD benefits began). For example, if you're currently enrolled in medical coverage only, you can opt out of medical coverage and then re-enroll for medical coverage in the future. However, a Retiree or LTD participant who is not currently enrolled in a coverage option (e.g., dental and/or vision coverage) cannot use the opt-out/re-enroll feature to enroll for those coverages in the future.
- Gives you the opportunity to weigh alternatives for health care coverage and elect the best coverage for your individual circumstances. For example, you may decide that it's more beneficial to be covered by your working spouse's employer-provided health plan. Or you may gain coverage that is better, in terms of cost or benefit coverage than the Oncor coverage. If you elect and later lose this other coverage, you then have the option to re-enroll in the Oncor coverages at a later date. A Statement of Health (SOH) is not required to re-enroll for coverage.

Participants who are dropped from benefit coverage due to non-payment of premiums may use their one-time opt in to reinstate benefits.

ONCE YOU ARE ELIGIBLE FOR MEDICARE

When Social Security disability income is approved, Medicare eligibility is triggered. At that time, your medical option defaults to the Medicare secondary plan, Indemnity with Rx Option. You may choose to:

- Keep the default plan, the Indemnity with Rx Option,
- Choose Indemnity Medical Only Option, or
- Choose a plan from the Via Benefits Exchange.

Rate Band B applies until actual retirement when the points are calculated to determine the amount of company subsidy that applies to the cost of medical coverage.

You will begin paying Retiree rates for dental and vision, if applicable. Retiree rates are equal to 100% of the cost. You will pay active life insurance rates until retirement.

IF YOU HAVE DEPENDENTS YOUNGER THAN AGE 65

If you are on Medicare and you have covered Dependents younger than age 65, your Dependents will move to the Retiree Under-65 Plan and pay Rate Band B rates until you retire. Upon retirement, the contribution converts to the appropriate rate band based on actual points.

SOURCES OF PLAN BENEFITS

Claims Administrator

MetLife (or Aetna) administers claims for Oncor LTD benefits. You should send all claims, doctor's statements, address changes, and other information to the appropriate administrator (MetLife or Aetna, based on your date of disability), as well as to the Service Center. For Service Center contact information, refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook.

For disabilities that began between and including May 1, 2001, and June 30, 2008, or on or after January 1, 2011, benefits are paid through a group insurance policy issued through:

MetLife
200 Park Avenue
New York, New York 10166

For disabilities that began between and including July 1, 2008 and through December 31, 2010, benefits are paid through a group insurance policy issued through:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

For disabilities that began before May 1, 2001, benefits are self-insured and funded out of the company's general assets and paid through:

MetLife
200 Park Avenue
New York, New York 10166

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

Plan Sponsor and Plan Administrator:
Oncor Electric Delivery Company LLC
1616 Woodall Rodgers Freeway
Dallas, TX 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, TX 75202-1234

Types of Plans/Plan Identification

The Plan provides a variety of health and welfare benefits including medical, prescription drug, dental, vision, life insurance, and disability (for Long-Term Disability participants only). The formal Plan name and Plan number are:

Plan Name: Oncor Retiree Welfare Plan

Plan Number: 502

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 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 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.

> For Service Center contact information, refer to the ***Tools and Resources Contact Information*** in the **Overview** section of this handbook.

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	
Retiree HRA Option Retiree HSA Option Indemnity with Rx Option Indemnity with Legacy Rx Option Indemnity Medical Only	Blue Cross and Blue Shield of Texas P. O. Box 660044 Dallas, TX 75266–0044 **1.877.213.6898** www.bcbstx.com
Scott & White Health Plan Option	Scott & White Health Plan 1206 West Campus Drive Temple, TX 76502 **1.800.321.7947** www.swhp.org
Via Benefits	Via Benefits 1350 N. Glenville Drive Richardson, TX 75081 **1.866.322.2824** my.viabenefits.com
MDLIVE Telemedicine: Phone-in Service for 24/7 Physician Access	**1.888.680.8646** www.MDLIVE.com/bcbstx

Options, Programs, and Networks	Claims Administrators, Third-Party Administrators, and Insurers
Prescription Drugs	
CVS Caremark (All medical benefits options except the Via Benefits Option) The Indemnity Medical Only Option does not have prescription drug coverage.	Paper Claims: CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 **1.866.339.0593** www.caremark.com Mail Order: CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467 www.caremark.com
SilverScript (If you are eligible for Medicare and are covered under the Indemnity with Rx Option or the Indemnity with Legacy Rx Option)	**1.800.706.9346** www.caremark.com
Tobacco Cessation and Weight Management Program	**1.877.213.6898** (Once enrolled, call **1.866.412.8795**) www.bcbstx.com
COBRA Administrators and Retiree Premium Payments	Chard Snyder 6867 Cintas Boulevard Mason, OH 45040 **1.513.459.9997** **1.800.982.7715** **Fax: 1.513.459.9947** www.chard-snyder.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** www.aetna.com
Vision Benefit Option	UnitedHealthcare Vision Attn: Claims Department P.O. Box 30978 Salt Lake City, UT 84130 **1.800.638.3120** www.myuhcvision.com
Life Insurance Options (Includes Retiree Life Option, Spouse Life Option, Program A, and Program B. Child Life Option is available only to LTD participants.) **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) Retirees and their spouses who are age 65 or older, (ii) Retirees 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 Service Center. Refer to the ***Tools and Resources Contact Information*** for the Service Center in the **Overview** section of this handbook.

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 (except Via Benefits)	CVS Caremark* SilverScript* (For those who are eligible for Medicare and are covered under the Indemnity with Rx Option or the Indemnity with Legacy Rx Option)
Dental	Aetna*
Vision	UnitedHealthcare Vision*
Health Reimbursement Account	ConnectYourCare
Health Savings Account	Fidelity
Life Insurance	MetLife*
Long-Term Disability (LTD participants only)	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, TX 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 Claim (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 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 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.
Life Insurance Benefit Claims 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 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 **Plan Participation** 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 Service Center during regular office hours.

Glossary

Allowable Amount

The maximum amount determined by the Claims Administrator, Blue Cross and Blue Shield of Texas (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 covered providers.

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,
- Legally adopted children (or children who have been placed with you for adoption),
- Stepchildren as long as you (the Oncor Retiree) 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 Retiree) 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 Retiree) and you claim the children as dependents on your federal income taxes.

For the Medical, Dental, and Vision 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.

Life Insurance for Children
- If you are a Retiree, your children are not eligible for Life Insurance.
- If you are an LTD participant in the Retiree Life Insurance Program, your covered children may continue life insurance coverage until age 26. However, for purposes of Life Insurance, your children are not eligible (regardless of their age) if they are married or are serving in the armed forces.

  Once you move from LTD-participant status to Retiree status, your Child Life Insurance coverage ends. Your child can continue Life Insurance coverage through portability or by converting to an individual policy.

Eligible Charge

An Eligible Charge is 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.

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).

Indemnity Medical Option

The medical option offered to you if Medicare is your primary medical insurer. These medical options provide traditional indemnity medical benefits when you or your Dependents receive covered health care services.

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.

Life Insurance Program B

A life insurance option that is available to Retirees who were employed by Oncor before the flexible benefits program became available. Retirees eligible for the flexible benefits program are not eligible to enroll in Program B.

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.

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. Once you reach the individual or family Out-of-Pocket Maximum, the option pays 100% of most covered expenses for the rest of the year.

Participating Employer

Oncor Electric Delivery Company LLC

Plan Year

The calendar year.

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.

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.

Service Center Website

You use this website 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.

Retiree Life Insurance Option

The Retiree Life Insurance Option is an extension of the Employee Life Option you had on the day before your retirement.

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.

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.

Via Benefits

An option available so you can choose coverage from the universe of fully insured Medicare-supplement and Medicare Advantage plans. It is not part of the Oncor Retiree Plan. Via Benefits can help you find medical, pharmacy, dental, and vision insurance plans that fit your health care needs and budget. Oncor may fund the account each year, based on the amount of your Oncor subsidy. If you enroll in coverage through Via Benefits, your coverage will be provided by the individual carrier of your Via Benefits policy, and will be subject to the terms of that policy.