2024

Employee Benefits Guide

cps ENERGY

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We are proud to provide you and your dependents with valuable and significant benefits. The Benefit Guide is an overview of the benefits available to you and their impact on your hard-earned compensation. Please read it carefully in order to make the best choices for you and your family. Please call Employee Benefits, 210-353-2900, if you have any questions.

See **page 30** for important information concerning Medicare Part D coverage.

In this Guide, we use the term Company to refer to CPS Energy. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

3 Eligibility and Enrollment

You and your family have unique needs, which is why CPS Energy offers a variety of benefit plans from which you may choose.

Eligibility

All full-time employees and their eligible dependents are eligible to participate in the benefit plans offered by CPS Energy.

When Does Coverage Begin?

Coverage for most plans begins on your date of hire. Due to IRS regulations, once you have made your choices, you won't be able to change your benefits until the next enrollment period unless you experience a qualifying life event.

Eligible Dependents

Eligible dependents include:

- Your legal spouse
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your spouse)
- Dependent children, regardless of age, provided they are incapable of self-support due to a mental or physical disability, and if diagnosed prior to age 26.
- Verification of dependent eligibility will be required upon enrollment.
- If you leave ineligible dependents on your coverage, you will be required to repay the plan for claims paid on their behalf and premiums will not be refunded. Ex-spouses are not eligible for coverage under any circumstances.

Note

You CANNOT change your benefit selections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child or divorce.

Your change in coverage must be consistent with your change in status. Please direct questions to Employee Benefits regarding specific life events and your ability to request changes.

Qualifying Life Events

When one of the following events occurs, you have 31 days from the date of the event to notify Employee Benefits and request changes to your coverage.

A change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)

Beginning or returning from a leave of absence, including military leave

Death in the family (leading to change in dependents or loss of coverage)

Gain or loss of other health coverage (including Medicare) by your spouse or eligible dependent

A change in your legal marital status (marriage, divorce, or legal separation)

5 Medical Benefits

BlueCross BlueShield of Texas

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Our medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as prescription medications. Medical benefits are offered through BCBSTX.

	PLAN A PPO[1]		PLAN B PPO[1]		PLAN C HDHP	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$1,500	$3,000	$750	$1,500	$1,600	$3,000
FAMILY	$4,500	$9,000	$2,250	$4,500	$3,200[2]	$6,000
COINSURANCE	20%[3]	40%[3]	20%[3]	40%[3]	20%[3]	40%[3]
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$5,000	$10,000	$5,500	$11,000	$3,200	$6,000
FAMILY	$10,000	$20,000	$11,000	$22,000	$6,400	$12,000
COPAYS/COINSURANCE						
PREVENTIVE CARE	$0	40%[3]	$0	40%[3]	$0	40%[3]
PRIMARY CARE VISIT	20%[3]	40%[3]	$20 Copay	40%[3]	20%[3]	40%[3]
SPECIALIST VISIT	20%[3]	40%[3]	$40 Copay	40%[3]	20%[3]	40%[3]
VIRTUAL VISITS	20%[3]	Not Covered	$20 Copay	Not Covered	20%[3]	Not Covered
DIAGNOSTIC SERVICES	20%[3]	40%[3]	20%[3]	40%[3]	20%[3]	40%[3]
URGENT CARE	20%[3]	40%[3]	$35 Copay	40%[3]	20%[3]	40%[3]
EMERGENCY ROOM	$200 Copay + 20%[3] (copay waived if admitted)	$200 Copay + 20%[3] (copay waived if admitted)	$200 Copay + 20%[3] (copay waived if admitted)	$200 Copay + 20%[3] (copay waived if admitted)	20%[3]	20%[3]

[1]All covered family members' eligible expenses count toward the family deductible; however, no one family member will have to meet more than the individual deductible and out-of-pocket maximum.
[2]All covered family members' eligible expenses count toward the family deductible. $3,200 family deductible must be met before coinsurance applies to anyone in the family, to include RX costs.
[3]After Deductible

BI-WEEKLY CONTRIBUTIONS (INCLUDES MEDICAL, DENTAL & VISION)

	PLAN A PPO	PLAN B PPO	PLAN C HDHP
EMPLOYEE ONLY	$44.91	$67.14	$63.48
EMPLOYEE + SPOUSE	$144.94	$191.02	$187.92
EMPLOYEE + CHILD(REN)	$114.91	$154.44	$148.10
EMPLOYEE + FAMILY	$191.82	$254.70	$244.09

Note

To get the most value out of your medical plan, be sure to visit in-network providers whenever possible.

6 Preventive Care

Did you know that most health plans must cover a set of preventive services — such as shots and screening tests — at no cost to you? Work with your Primary Care Physician to stay up-to-date on preventive services — identifying and treating illnesses early will save you time and money, and promote a healthy lifestyle in the long run!

In accordance with the U.S. Patient Protection and Affordable Care Act (ACA), many services, screenings and supplies are paid at 100% including, but not limited to, the following:

Wellness visits, physicals, and standard immunizations.

Some preventive prescriptions are covered at 100%. Go to CONNECT for a list of these medications.

Age appropriate screenings.

Anemia screenings, breastfeeding support and pumps for pregnant and nursing women.

Iron supplements (for children ages 6 to 12 months at risk for anemia)

Key Things to Remember:

- Diagnostic care to identify potential health risks is covered according to plan benefits, even if recommended or done during a preventive care visit.
- If your physician finds a specific health risk or new medical condition during your appointment, your doctor may bill those services as diagnostic medicine. These types of diagnostic services may result in out-of-pocket costs for you (i.e., deductibles, coinsurance, or copayments) because they are not considered preventive care.

7 Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Nurse Line

When to Use
You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*
Answers to questions regarding:

- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

Costs and Time Considerations**
- Usually available 24 hours a day, 7 days a week
- Typically free as part of your medical insurance

Telemedicine

When to Use
You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems
- Behavioral/Mental Health

Costs and Time Considerations**
- Visits have a consultation fee based on your plan
- Typically immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center

When to Use
You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*
- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Costs and Time Considerations**
- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Urgent Care Center

When to Use
You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*
- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Costs and Time Considerations**
- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Emergency Room

When to Use
You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*
- Heavy bleeding
- Chest pain
- Major burns
- Severe head injury

Costs and Time Considerations**
- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word “emergency” appears in the company name.

9 Helpful Resources

BlueCross BlueShield of Texas

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Virtual Visits

If you are enrolled in one of CPS Energy's medical plans, you can see and talk to a doctor from your mobile device or computer. Most visits take about 10-15 minutes and doctors can write a prescription (in participating states), if needed, that you can pick up at your local pharmacy.

Conditions Commonly Treated Through a Virtual Visit

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection/urinary tract infection
- Cold/flu
- Fever
- Rash
- Sinus problems
- Stomach ache
- Behavioral health

Virtual visits with a licensed behavioral therapist are available by appointment for conditions such as:

- Anxiety
- Depression
- Stress management
- Parenting support
- And more

Access Virtual Visits

Go to MDLive.com/bcbstx.com or call 888-680-8646 to request a virtual visit. After registering and requesting a visit, you will pay your portion of the service costs according to your medical plan, and then you will enter a virtual waiting room. During your visit you will be able to talk to a doctor about your health concerns, symptoms and treatment options. If you are enrolled in Plan B, the cost of a visit is a $20 copay. If you are enrolled in Plan A or Plan C, deductible and coinsurance will apply.

Use virtual visits when:

- Your doctor is not available
- You become ill while traveling
- You need medical care that is not an emergency health condition

Not good for:

- Anything requiring an exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/broken bones

How to Find a Provider

To see a current list of BCBSTX network providers, visit Blue Access under bcbstx.com or call Customer Care at 800-521-2227 for assistance.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms (ERs) may look a lot like urgent care centers, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are in the network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns rather than an ER could save you hundreds of dollars.

Get the Most Out of Your Benefits

Blue Cross Blue Shield of Texas offers many programs to help you and your family with health concerns.

- **24/7 Nurseline** can help you identify some options when you or a family member have a health problem or concern. Nurses are available at 800-581-0368, 24 hours a day, seven days a week, to answer your health questions.
- **Cost Estimator** is an online tool found on Blue Access for members under bcbstx.com, click Find Care, that makes it simple to research a procedure prior to receiving care, get a cost estimate and quality comparison between facilities and providers.
- **Women's Family Health** is a BCBSTX program that provides special services during every stage of your pregnancy to help you deliver a healthy baby. For more information, call 888-421-7781 or log on to Blue Access for members at bcbstx.com, click on My Health.

BCBSTX Benefits Value Advisors

Need a little help understanding your medical benefits? BCBSTX offers Benefits Value Advisors — one phone call can help you get benefits information and find in-network providers. To reach a Benefits Value Advisor, call 800-521-2227.

Benefits Value Advisors can also:

- Give you a cost estimate for healthcare services or procedures
- Schedule a doctor or procedure appointment
- Provide general health information about your condition
- Help you with pre-certification
- Tell you about online educational tools

Note

Stay connected with BCBSTX and access important health benefit information wherever you are. Text BCBSTXApp to 33633 on your phone to get the Blue Cross App.

11 Pharmacy Benefits

Prescription Drug Coverage

Our Prescription Drug Program is administered through CVS/Caremark. You will only have one ID card for both medical care and prescriptions. You may find information on your prescriptions and search for network pharmacies (e.g. CVS, Walgreens, HEB, Walmart) by logging on to caremark.com or by calling 800-966-5772.

The Prescription Drug Program provides benefits for retail and mail order services. When a generic drug is available, the plan does not cover the additional cost of purchasing a brand-name drug.

If you enroll in Plan C, the medical deductible applies to all non-preventive prescriptions. The deductible will be waived for select preventive drugs, which are listed on CONNECT.

If your doctor prescribes a specialty drug for rheumatoid arthritis, multiple sclerosis, osteoarthritis, hepatitis C, growth hormone or pulmonary arterial hypertension, the CVS/Caremark Specialty Pharmacy will work directly with your doctor to ensure that the prescribed drug dispensed to you is eligible for coverage under the plan. Some drugs in each class are excluded, but all have available alternatives that are covered.

Caremark.com helps you find convenient and affordable prescription options within a secure personal online account. With caremark.com you get 24/7 secure access to your important prescription benefit information so you can:

- **Order Prescriptions.** Set up and manage your new prescriptions from anywhere, anytime.
- **Understand Your Plan and Benefits.** The first step to getting more out of your prescription benefit is knowing how it works. This section will help you stay informed about medication costs.
- **Find Savings and Opportunities.** Learn different ways to save money based on your plan and prescriptions. Learn everything from using generic medicines to setting up mail service for maintenance prescriptions.
- **Learn About Medications.** Find list of medicines, drug interactions, generic alternatives and more.
- **Ask a Pharmacist.** Get confidential and reliable answers to your prescription and over-the-counter drug questions.

Maintenance Choice Pharmacy Benefit

The Maintenance Choice program allows members to fill a 90-day prescription at CVS retail pharmacies or through the CVS/Caremark mail order pharmacy and only pay a 60-day copay. That's one month of savings! **You may continue to use a non-CVS pharmacy for maintenance prescriptions, but you must call CVS/Caremark at 800-966-5772 to opt out of the Maintenance Choice program.** If you opt out and choose not to utilize the CVS/Caremark mail order or retail pharmacy, you'll pay three non-discounted copays. Your opting out does not prevent you from choosing to use the CVS pharmacy benefit at a later date.

For more information regarding your prescription coverage, contact CVS/Caremark's Customer Care at 800-966-5772 — 24 hours a day, seven days a week — or visit caremark.com for specific plan information.

PrudentRx Program

Plan A and Plan B includes the PrudentRX program for specialty medications which is designed to lower your out-of-pocket costs. When enrolled in PrudentRx, your out-of-pocket cost will be $0 for medications included on the PrudentRx exclusive specialty drug list. If you opt out, you will be responsible for the 30% coinsurance (only the amount you pay out of pocket will apply toward your deductible/out of pocket for essential health benefit medications — non-essential health benefit medications do not apply toward deductible/out of pocket). To speak with someone or opt out of the program, contact PrudentRx at 800-578-4403.

Mail Order Prescriptions

Filling a mail order prescription can save you time and money. Follow these steps to make the transition to mail order:

- Ask your doctor to write your prescription for a 90-day supply of your medication.
- Submit your prescription to CVS/Caremark online at caremark.com, by phone at 800-966-5772 or by mail along with the mail order claim form.

	PLAN A PPO	PLAN B PPO	PLAN C HDHP	
	IN-NETWORK	IN-NETWORK	IN-NETWORK	
RETAIL RX (30-DAY SUPPLY)				
RX DEDUCTIBLE	$0	$0	Included with Medical	
OUT-OF-POCKET MAXIMUM	Included with Medical	Included with Medical	Included with Medical	
GENERIC BEFORE BRAND IS REQUIRED				
USE OF A GENERIC DRUG IN THESE DRUG CLASSIFICATIONS IS REQUIRED PRIOR TO FILL OF BRAND-NAME DRUG	Acid Reflux (PPI)	Acid Reflux (PPI)	Acid Reflux (PPI)	
	Cholesterol (HMG)	Cholesterol (HMG)	Cholesterol (HMG)	
	High Blood Pressure (ACE)	High Blood Pressure (ACE)	High Blood Pressure (ACE)	
	RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)		HDHP PREVENTIVE DRUGS	ALL OTHER DRUGS (AFTER DEDUCTIBLE)
GENERIC	$10 Copay	$15 Copay	$15 Copay	$15 Copay
FORMULARY BRAND	30%, no deductible	30%, no deductible $30 min	30%, $30 min	30%, $30 min
NON-FORMULARY BRAND	50%, no deductible	50%, no deductible $50 min	50%, $50 min	50%, $50 min
MAIL PHARMACY / MAINTENANCE CHOICE (90-DAY SUPPLY)				
GENERIC	$20 Copay	$30 Copay	$30 Copay	$30 Copay
FORMULARY BRAND	30%, $120 max	30%, $120 max	30%, $120 max	30%, $120 max
NON-FORMULARY BRAND	50%, $150 max	50%, $175 max	50%, $175 max	50%, $175 max
SPECIALTY PHARMACY				
ELIGIBLE SPECIALTY DRUGS	10%, $100 max	20%, $150 max	20%, $150 max	20%, $150 max
SPECIALTY RX BENEFIT	ENROLLED IN PRUDENTRX[1]		DOES NOT APPLY	DOES NOT APPLY
CVS SPECIALTY PHARMACY DRUGS	$0	$0		
	NOT ENROLLED IN PRUDENTRX[1]			
CVS SPECIALTY PHARMACY DRUGS	30%	30%		

Note: Out-of-Network coverage is not available and Compound drugs are not covered
[1]See page 11 for program details

13 Q&A: Generic Drugs

What is a generic drug?

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, route of administration, risks, safety and strength as the original drug. In other words, generics provide the same clinical benefit as those or other brand-name versions.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. FDA requires that generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA-approved generic drugs have met the same rigid standards as the brand-name drug. To gain FDA approval, a generic drug must:

- Contain the same active ingredients as the brand-name drug (inactive ingredients may vary)
- Be identical in strength, dosage form, and route of administration
- Have the same use indications
- Be bioequivalent
- Meet the same batch requirements for identity, strength, purity, and quality
- Be manufactured under the same strict standards of FDA's Good Manufacturing Practice Regulations required for brand-name drugs

Are generic drugs cheaper than brand-name medications?

Typically, yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit caremark.com.

14 Dental Benefits

Regular dental checkups do more for your well-being than just preserve a healthy smile. CPS Energy's dental coverage will provide you and your family with affordable options for overall health. Coverage is available through MetLife.

Network Dentists

To find a network dentist, visit MetLife at metlife.com/mybenefits or call 800-438-6388. If you choose to use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C).

Find a Provider on the MetLife Mobile App

Finding a professional near you just got easier with the MetLife Mobile App[2].

You can:

- Locate dental plan providers
- View coverage details
- Get estimates for most procedures

It's easy! Search "MetLife" at iTunes App Store or Google Play to download the App.

It's fast! Quickly search the network of thousands of providers, right from your mobile device.

It's available 24 hours a day, seven days a week.

[2]To use the MetLife mobile app, you can choose to register at metlife.com/mybenefits from a computer or directly through the app.

IN-NETWORK BENEFIT SUMMARY

ANNUAL DEDUCTIBLE	
INDIVIDUAL	$50
ANNUAL MAXIMUM	
PER PERSON	$1,500
COVERED SERVICES	
PREVENTIVE SERVICES	100%
BASIC SERVICES	80%[1]
MAJOR SERVICES	50%[1]
ORTHODONTICS	50%[1]
ORTHODONTIC LIFETIME MAXIMUM	$2,000

[1]After Deductible

Note

In addition to keeping your teeth healthy, regular dental check-ups can help dentist spot symptoms of other serious conditions such as osteoporosis, cancers, and diabetes.

15 Vision Benefits

Even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, CPS Energy offers a comprehensive vision benefit provided by MetLife. To find a participating MetLife provider, go to metlife.com/mybenefits or call 800-438-6388.

	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
COVERED MATERIALS			
LENSES			
SINGLE VISION LENSES	$25 Copay	Up to $30	Every calendar year
BIFOCAL LENSES	$25 Copay	Up to $50	
TRIFOCAL LENSES	$25 Copay	Up to $65	
FRAMES			
RETAIL FRAME EQUIVALENT	$200 Allowance	Up to $70	Every other calendar year (KidsCare: Every calendar year)
CONTACT LENSES			
NECESSARY	Covered in full with material copay	Up to $210	Every calendar year (KidsCare: Every calendar year)
ELECTIVE	$200 Allowance	Up to $105	
COPAYS			
EXAMINATION	$15 Copay	Up to $45	Every calendar year (KidsCare: 2 eye exams every calendar year)
MATERIALS	$25 Copay	N/A	N/A

Note

You can mix and match and get two pairs of glasses, contacts, prescription sunglasses or one pair of glasses and a set of contacts. For more information, contact MetLife at 800-438-6388 or your vision provider.

16 Health Savings Account

Take charge of your healthcare spending with a Health Savings Account (HSA). Contributions to an HSA are tax-free and withdrawals for qualified medical expenses are tax-free.

Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependent(s), even if they are not covered by your plan.

HSA Bank will issue you a debit card, giving you direct access to your account balance. When you have a qualified expense, you can use your debit card to pay. You must have a balance to use your debit card. There are no receipts to submit for reimbursement, but we recommend you save your receipts. IRS Publication 502 provides a complete list of eligible expenses and can be found on irs.gov.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in a qualified HDHP
- You are not covered by your spouse's non-HSA health plan
- Your spouse does not have a Healthcare FSA or Health Reimbursement Arrangement
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare, Medicaid, or TRICARE
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration)

Individually Owned Account

You own and administer your HSA. You determine how much you'll contribute to the account, when to use the money to pay for qualified expenses, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it in the calendar year. The money in this account is yours, even if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

Maximize Your Tax Savings

Contributions to an HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open an account with HSA Bank). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified expenses, they are tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

Each year, the IRS places a limit on the maximum amount that can be contributed to an HSA. For 2024, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,150
FAMILY	$8,300
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	$250
EMPLOYEE + SPOUSE OR CHILD(REN)	$500
FAMILY	$750

How to Enroll

- 1. You must elect Plan C
- 2. Designate your contribution
- 3. Acknowledge HSA agreement

CPS Energy will establish an HSA account in your name and deposit contributions on a bi-weekly schedule once bank account information has been provided and verified.

17 Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for various out-of-pocket expenses.

Flexible Spending Accounts

We offer three FSAs to help you budget for eligible expenses. These include:

- Healthcare FSA (can be used for medical, dental and vision expenses for those on Plan A or Plan B)
- Limited Purpose FSA (can be used for dental and vision expenses)
- Dependent Care FSA (dependent daycare expenses)

When you enroll in an FSA, you can set aside pre-tax money from your paycheck to pay for eligible expenses. And, you will be provided a debit card that allows you to pay for expenses at point-of-service instead of submitting a claim form and waiting for reimbursement.

Estimate Your Expenses Carefully

FSA is use it or lose it. This means you must incur eligible expenses by December 31, 2024, and submit them by March 15, 2025, otherwise your funds will be forfeited.

Make sure to carefully choose how much money you expect to spend on healthcare and dependent care expenses for the year.

How to Use the Account

You can use your FSA debit card at locations such as doctors, dentist offices, vision service providers and pharmacies.

You must always provide receipts and Explanation of Benefits (EOBs) for any debit card charges. If you don't provide proof that an expense was valid, it can result in your card being deactivated and your expense being deemed taxable. Contact HSA Bank at 844-650-8936 with questions.

Healthcare FSA

You can contribute up to $3,050 (or the IRS limit for 2024, if different) for qualified medical expenses with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. Enrollment amount is available to you on the 1st business day of each year. You can even pay for eligible expenses with an FSA debit card at the same time you incur them, so you don't have to wait for reimbursement.

Eligible expenses:

- Medical copays, deductibles and coinsurance for services covered by the medical plan
- Prescription drug copays and coinsurance for drugs covered by the medical plan
- Dental and orthodontic care
- Other eligible healthcare expenses not covered by the medical plan

See IRS Publication 502 at irs.gov for a full list of qualified expenses.

Limited Purpose FSA

Designed to complement a Health Savings Account, a Limited Purpose FSA allows for reimbursement of eligible dental and vision expenses. Enrollment amount is available to you on the 1st business day of each year. You may contribute up to a maximum of $3,050 (or the IRS limit for 2024, if different).

Note

Use of the FSA debit card requires that you submit your receipts to support it is a valid expense.

Daycare FSA

The Daycare FSA allows you to set aside pre-tax funds to help pay for qualifying relative, spouse, or child dependents. Reimbursement from your Daycare FSA is limited to the total amount that is deposited in your account at that time.

- IRS annual contribution is $5,000 per family to pay for dependent child or elder care expenses on a pre-tax basis.
- Eligible dependents include children younger than the age of 13 and/or a disabled dependent who spends at least eight hours a day in your home.
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- To be reimbursed, you must provide the tax identification number or Social Security number of the caregiver.

Eligible Daycare FSA Expenses

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time.

Eligible expenses include:

- In-home babysitting services (not by an individual you claim as a dependent)
- Care of a preschool child by a licensed nursery or daycare provider
- Before- and after-school care
- Day camp
- In-house dependent daycare

IRS Regulations

IRS regulations state that you may not be reimbursed for dependent daycare expenses if you are off work due to illness, on a leave of absence or if your spouse is not working or a full-time student. See IRS Publication 503 at irs.gov for more information.

Note

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

19 FSA vs HSA

Flexible Spending Accounts		Health Savings Accounts
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	TAXATION	HSA contributions are tax free; the account grows tax free; and funds are spent tax free on qualified expenses.
You can contribute up to $3,050 in 2024 to an FSA. This amount may be increased annually.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,150 combined in 2024 (up to $8,300 for families). Ages 55+ can make an annual $1,000 "catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed, or an allowed rollover amount.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care) and Limited Use FSA (used to pay for eligible dental and vision expenses).	OTHER TYPES	There is only one type of HSA.

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

20 Wellness

The TakeCharge Wellness Program provides resources to help educate you about your health, achieve your healthy lifestyle change goals, maintain your existing healthy lifestyle and manage health conditions you may have. Visit CONNECT for additional information.

Wellness Incentive

CPS Energy offers the TakeCharge Wellness Incentive Program. By participating in the Program, you can earn up to $900 ($500 for employees and $400 for spouses) to help offset CPS Energy health plan premiums in the following year. Additional incentives are also available.

For additional information, call Wellness at 210-353-2900 Option 4 or email Wellness@cpsenergy.com.

Airrosti Benefit Coverage

Airrosti provides a thorough clinical assessment to evaluate soft tissue injury that may be causing you pain. It is manual therapy to the soft tissue or joints through a hands-on approach to improve function and range of motion.

Airrosti is available to all employees and dependents covered under the CPS Energy Health Plan. The first eight visits are covered with the following coinsurance/copay:

- Plan A: 10% no deductible
- Plan B: $20 copay
- Plan C: 10% after deductible

Wellness Program

It is important to CPS Energy that we continue to offer resources that help you maintain or achieve your health goals. Here is a summary of some amazing programs that we offer. Be on the lookout for additional details and eligibility requirements for each of these programs in your Wellness Guide.

- Teledoc Chronic Management programs (formally Livongo) for Diabetes Management, Diabetes Prevention & Hypertension
- Discounted Weight Watchers memberships
- Onsite Registered Dietitian Program
- Onsite Coaching
- Active&Fit ExerciseRewards program, discounted fitness memberships, and more
- Healthy Discounted Food Options in onsite cafes, vending, and micro marts
- Wellness Grants
- Healthy Selfie Challenges
- Onsite Biometrics
- Track your incentive status and access your health and wellness information through Virgin Pulse. Details can be found in your Wellness Guide!

Note

According to the CDC, quitting smoking improves your health and quality of life and can even add up to 10 years to your life expectancy! Certain over the counter Nicotine Replacement therapies are covered at 100% through the CPS Energy pharmacy plan. A prescription is required. Call CVS Caremark for details.

21 Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Mental Health and Your Medical Plan

When your covered EAP services run out, the medical plan covers behavioral and mental health services. Coverage includes virtual therapy from MDLive. Via video or telephone, you can receive confidential 1-on-1 counseling from the privacy and convenience of your home. Your licensed virtual therapist may provide a diagnosis, treatment, and medication if needed. You can see the same therapist with each appointment and establish an ongoing relationship. See plan documents for specifics on coverage for inpatient and outpatient services.

An important aspect of your overall wellbeing is emotional wellness — the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.

The Big Five of Emotional Wellness

Practice mindfulness.
Practice deep breathing, take a walk, enjoy nature, and stay present in each moment.

Strengthen social connections.
Reach out to a friend or family member daily — even if it's just a call or text.

Get quality sleep.
Keep a consistent sleep schedule and limit electronic use before bed.

Improve your outlook.
Treat people with kindness, including yourself.

Deal with your stress in healthy ways.
Think positively, exercise regularly, and set priorities.

Other Mental Health Resources

No matter your problem, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

988 Suicide & Crisis Lifeline

Dial 988 to be connected with 24/7/365 emotional support.

Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line

Text "HELLO" to 741741

Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center

Veterans and their families call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.

Note

According to the Centers for Disease Control, more than 1 in 5 U.S. adults live with a mental illness.

23 Survivor Benefits

It's not always easy to talk with your family about how they'll be provided for if you aren't around, but it's an important conversation to have. Survivor benefits provide financial assistance in an absence and can help you plan for the unexpected.

Life Insurance

CPS Energy provides a portion of your life insurance coverage, and you have the opportunity to elect additional coverage for yourself and your dependents.

The company offers two types of life insurance:

- Term Life Insurance with optional dependent life coverage.
- Supplemental life insurance for employees and their dependents.

Term Life Insurance Plan

Employees are automatically enrolled in the Term Life Insurance Plan. The Plan pays two times your annual salary and is effective on your date of hire.

The Company pays for the first $20,000 of your coverage, and you pay for the balance of the premiums at $.13 per $1,000 of coverage.

Dependent Life Insurance

This Plan provides coverage for your spouse and child(ren). The total cost is $3.20 per month, regardless of the number of dependents. Coverage is $12,000 for a spouse and $6,000 per child, and children are covered until age 26.

It is important to contact Employee Benefits after milestone events to update policy information and confirm whether Evidence of Insurability is required.

Supplemental Life Insurance

This is an optional plan offered through UNUM. Coverage is in addition to the Term Life Insurance Plan. New employees may elect $50,000 automatic coverage up to 30 days past their date of hire; additional coverage will require evidence of insurability. All employees may elect supplemental insurance at any time, with evidence of insurability.

You may elect coverage in $10,000 increments up to 4 times your annual salary, with a maximum of $500,000. Evidence of insurability is required:

- For any election over $50,000 at initial enrollment
- Any increased coverage amounts at annual enrollment

After you elect supplemental life insurance for yourself, you may also elect life insurance for your spouse in $5,000 increments, not to exceed the lesser of 50% of your supplemental life coverage volume or $250,000 (benefits are subject to age reduction schedule). Evidence of insurability is required:

- For any election over $25,000 at initial enrollment
- Any increased coverage amounts at annual enrollment

You may choose $5,000 or $10,000 in coverage for your dependent children at a cost of $0.85 or $1.70 respectively.

Employee Supplemental Life insurance will be reduced when you reach certain ages, as outlined below:

- 65% of the original amount when you reach age 70
- 45% of the original amount when you reach age 75
- 30% of the original amount when you reach age 80
- 20% of the original amount when you reach age 85

Note

Your beneficiary doesn't have to be a person. A trust, or a legal agreement that lets you place property under the control of a trust manager, can be named the beneficiary. The beneficiary can also be a charity or simply your estate.

24 Income Protection

CPS Energy offers disability coverage to provide financial support during a debilitating illness or injury.

Short-Term Disability

If you suffer from an illness or injury that prevents you from working, we provide financial protection through short-term disability at no cost to you. Employees are eligible for benefits 6 months after their date of hire. For an approved continuous leave of absence, benefits are paid for up to 25 weeks, after the first week of disability.

Currently, employees can supplement Short-Term Disability benefits up to 100% of their base pay through sick and then vacation time. Please refer to the table below.

Effective February 1, 2024, employees with 6 months to 5 years of service can increase the benefit to 100% of their base pay by supplementing this benefit using Paid Time Off (PTO) instead of sick/vacation time using the table as a guide.

PERIOD OF SHORT -TERM DISABILITY	% OF REGULAR SALARY PAID THRU SHORT-TERM DISABILITY BENEFIT	OPTIONAL SICK HOURS[1] SUPPLEMENTED WEEKLY	TOTAL % OF REGULAR SALARY PAID
FIRST WEEK OF DISABILITY ("ELIMINATION PERIOD")	0% Use Sick Leave (then Vacation, if Sick Leave is exhausted)	40 hours	100%
NEXT 5 WEEKS OF DISABILITY (WEEKS 2 - 6)	100%	0 hours	100%
NEXT 4 WEEKS OF DISABILITY (WEEKS 7 - 10)	80%	8 hours	100%
NEXT 16 WEEKS OF DISABILITY (WEEKS 11 - 26)	70%	12 hours	100%

[1]May use Sick Leave, then Vacation, or PTO, if Sick Leave is exhausted, to supplement up to 100% of pay

Effective, February 1, 2024, employees with 5 years or more of service, Short-Term Disability benefits will be covered at 100% up to 26 weeks of the approved leave.

For more information, access CONNECT or email **leave@cpsenergy.com**.

Long-Term Disability

Full-time employees are eligible for the Income Plan six months after date of hire. If approved, benefits begin after being disabled from your own occupation for six continuous months. After 24 months, you will remain eligible for benefits if you are disabled from any occupation and are approved for Social Security Disability Income benefits. Your long-term disability benefits will continue until you are able to return to work or until you reach the Social Security normal retirement age — unless you become disabled on or after your 62nd birthday, in which case your coverage is extended based on the program schedule. Benefits will end at the end of 24 months if you are disabled for a mental or nervous condition.

CPS Energy will provide a benefit of 50% of your monthly base wage to a maximum of $7,500 per month. This amount is taxable income to you, as you are not contributing to the cost of this coverage. You also have the option to purchase an additional 20% benefit for a total benefit of 70% of the monthly base wage to a maximum of $15,000 per month. The additional 20% benefit will not be taxable to you, as you will pay for this coverage with after-tax payroll contributions. The premium for the additional 20% coverage is $0.12 per $100 of your monthly base wage. See table below to determine your premiums:

LONG-TERM DISABILITY MONTHLY PREMIUM FOR THE ADDITIONAL 20% BENEFIT

ANNUAL BASE WAGE (EXAMPLES)	MONTHLY BASE WAGE: ANNUAL SALARY / 12 OR HOURLY RATE X 2080 / 12	MONTHLY PREMIUM: MONTHLY BASE WAGE / 100 X $0.12	BI-WEEKLY PAYROLL DEDUCTION: MONTHLY PREMIUM X 12 / 26
$30,000	$30,000 / 12 = $2,500	$2,500 / 100 x $0.12 = $3.00	$3.00 x 12 / 26 = $1.38
$60,000	$60,000 / 12 = $5,000	$5,000 / 100 x $0.12 = $6.00	$6.00 x 12 / 26 = $2.77
$90,000	$90,000 / 12 = $7,500	$7,500 / 100 x $0.12 = $9.00	$9.00 x 12 / 26 = $4.15
$120,000	$120,000 / 12 = $10,000	$10,000 / 100 x $0.12 = $12.00	$12.00 x 12 / 26 = $5.54
$150,000	$150,000 / 12 = $12,500	$12,500 / 100 x $0.12 = $15.00	$15.00 x 12 / 26 = $6.92

26 Retirement Planning

It's never too early — or too late — to start planning for your retirement. The CPS Energy plans provide you with the tools and flexibility you need to retire comfortably and securely.

Retirement Plans

Defined Benefit Plan

The Plan offers a defined benefit plan that provides monthly retirement income. A defined benefit plan works very differently from a 401(k) plan. The benefit is determined by a formula calculation that considers age, years of service, average monthly compensation and a Social Security offset. CPS Energy assumes the risk for investment assets with the assistance of an investment management company and an internal Administrative Committee.

CPS Energy contributes funds to meet future payouts. Employees qualify for retirement benefits when they have 25 years of benefit service, are age 55 with 10 years of benefit service or are age 65, which is considered normal retirement age.

An employee who leaves CPS Energy before becoming eligible for retirement is entitled to 100% of his/her contributions plus accumulated interest on those contributions. The employee may also be eligible for matching employer contributions, depending on the vesting schedule shown in the chart following.

VESTING SCHEDULE

YEARS OF SERVICE	PERCENTAGE VESTED
Less than 3	0%
3	20%
4	40%
5	60%
6	80%
7 or greater	100%
Or, upon reaching age 40, automatically 100% vested	

Deferred Compensation Plan

This is a voluntary plan through Empower that helps supplement your savings for retirement. The account allows you to defer current income and invest dollars that grow tax-deferred. Employees can enroll at any time with as little as $10 per pay period. You select the funds that you will invest in and the percentage allocated to each. You may increase, decrease, stop and restart contributions each month without fees or penalties. There are also catch-up provisions if you are age 50 or over and want to maximize your contributions for retirement.

Employees select their investment portfolio from the funds offered. Employees have access to view their investments online and can make changes at any time. Since the plan is qualified, you can transfer dollars from other qualified plans such as 401(k), 403(b) or IRA plans into your Empower account.

Withdrawals can be made without penalty upon separation of employment or for allowable hardships during employment (i.e., foreclosure, medical expenses, etc.). Beginning January 1, 2024, the plan will allow for loans.

Your deferred compensation is portable. If you change jobs, you can consolidate your savings in another 457(b) plan, or a qualified 401(k), 403(b), or IRA, if desired.

Note

Social Security replaces about 40% of an average person's income, according to the Social Security Administration. It's important to know approximately how much you'll be receiving in retirement to plan accordingly. Use the retirement estimator on the SSA's website for a free estimate.

27 Additional Benefits

CPS Energy knows the value of well-rounded, balanced employees, which is why we offer a variety of additional benefits to help manage life's daily stresses.

Employee Assistance Program

CPS Energy cares about you and your family's total health management — mental, emotional and physical. For that reason, we provide an Employee Assistance Program (EAP) through PeopleGuidanceResources at no cost to you.

Whether you are interested in work/life resources, mental health assistance, or legal and financial advice, the EAP service can connect you and members of your household with a variety of professionals. With just one phone call, at any hour of the day or night, you can have access to helpful resources. The EAP benefit includes six free visits per issue per year with a licensed professional. All services provided are confidential and will not be shared with CPS Energy. For more information, access CONNECT.

The Program provides referrals to help with:

- Emotional health and well-being
- Alcohol or drug dependency
- Marriage or family relationship problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Tuition Assistance

Employees who have completed six months of service are eligible for tuition reimbursement for approved courses related to their work at CPS Energy. The benefit pays up to $5,250 annually. For more information, access CONNECT.

Texas College Savings 529 Plan

The Texas College Savings Plan allows employees to save for college expenses. Employees can enroll save money for their children, spouse, or self for post-high school educational expenses.

Assets and earnings grow federal tax-free for the life of the account and they can be used at colleges and universities across the nation. As long as the account is used for qualified educational expenses, money can be withdrawn federal tax-free. Qualified expenses include tuition, required fees, books, supplies and certain room and board expenses. The benefit can be transferred to anyone, provided it is used for educational expenses. 529 plans are excluded from estates, so an account can be gifted without penalty.

Accounts can be started with only $25 through automatic payroll deduction. Subsequent investments can start with a minimum of $15. If no one enrolls in higher education, the money can be withdrawn at a 10% penalty, plus tax on earnings.

28 Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- **Limited Use FSA –** Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Minimum Essential Coverage – Covers 100% of the cost of certain preventive services, when delivered by a network provider. Helps cover the costs of certain medical expenses incurred due to an accident or sickness at a specified benefit amount for a limited number of days per year.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network** – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network** – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating** – Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs** – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs** – Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs** – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs** – Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered. These medications are usually required to be filled at a specific pharmacy.
- **Prior Authorization** – A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy** – The goal of a Step Therapy Program is to guide employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from CPS Energy About Your Prescription Drug Coverage and Medicare under the BCBSTX Plan A PPO, Plan B PPO and Plan C HDHP Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CPS Energy and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. CPS Energy has determined that the prescription drug coverage offered by the BCBSTX Plan A PPO, Plan B PPO and Plan C HDHP plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CPS Energy coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CPS Energy and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CPS Energy changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2024
Name of Entity/Sender:	CPS Energy
Contact—Position/Office:	Employee Benefits
Address:	500 McCullough Ave San Antonio, TX 78215
Phone Number:	210-353-2900

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Employee Benefits at 210-353-2900.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Employee Benefits at 210-353-2900.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(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 the 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 towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Employee Benefits at 210-353-2900.

32 Important Contacts

Medical
Blue Cross Blue Shield
800-521-2227
bcbstx.com
Policy #242667

Nurse Line
800-581-0368

MDLive
888-680-8646
MDLive.com/bcbstx.com

Flexible Spending Accounts & Health Savings Account
HSA Bank
844-650-8936
hsabank.com

Pharmacy Benefits
CVS/Caremark Group
800-966-5772
caremark.com
Policy #6201

Wellness Program
Employee Benefits
210-353-2900, Option 4
wellness@cpsenergy.com

Dental & Vision
MetLife
800-438-6388
metlife.com/mybenefits
Policy #0215189

Employee Assistance Program
PeopleGuidanceResources
855-257-4313
guidanceresources.com
App: GuidanceNow℠
Web ID: CPSE

Life Insurance
Employee Benefits
210-353-2900, Option 2
empben@cpsenergy.com

Disability Absence Management
210-353-2900, Option 3
leave@cpsenergy.com

Matrix
877-202-0055

Retirement Benefits
Pension Plan
Employee Benefits
210-353-2900, Option 2
empben@cpsenergy.com

Deferred Compensation Plan
Empower
Glenn Walker
346-568-6740
glenn.walker@empower.com

Employee Benefits
Phone: 210-353-2900, Option 1
Fax: 210-353-3351
email: empben@cpsenergy.com

33 Notes

34 Notes

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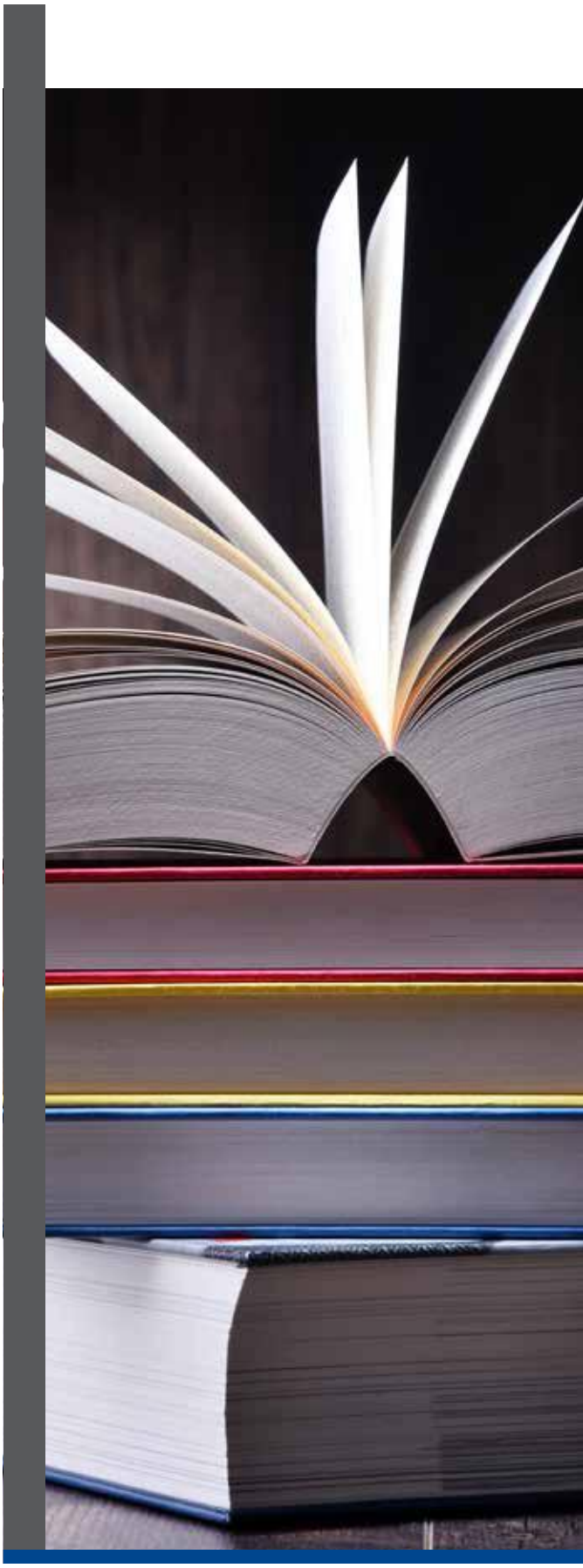

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