2025

Retiree Benefits Guide

Open Enrollment

October 21 - November 8

CPS ENERGY®

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CPS Energy is proud to provide you and your dependents with valuable and significant benefits. This Guide is an overview of the benefits available to you. Please read it carefully in order to make the best choices for you and your family for the 2025 plan year and consult Employee Benefits with any questions.

See **page 22** 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 Welcome to 2025 Open Enrollment

It's Time To Elect Your 2025 Benefits!

Open Enrollment is your annual opportunity to learn about your benefit options and choose the plans that are best for you. Information about your 2025 benefit options and the enrollment process are provided in this Guide.

The election period starts **October 21 and ends November 8.** All changes will become effective January 1, 2025.

Who Is Eligible?

Retirees may continue coverage for dependents who were enrolled in the plan as of the date of retirement.

Eligible dependents include:

- Spouse
- Children up to age 26
- Children of any age who were physically or mentally disabled before their 26th birthday

Remember – 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. Dependents removed from the plan after retirement cannot be added back to the plan. Ex-spouses are not eligible for coverage under any circumstances.

Waiving Coverage

If you waive health coverage for the 2025 plan year, you will not be allowed to re-enroll at a later date.

What's New

- Increase to monthly premiums
- Increase to Medical Plan deductibles and out-of-pocket maximums

4 Medical Coverage

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

Plan A and Plan B are offered to all retirees; however, only those retirees who are over age 65 will be eligible to receive the CPS Energy contribution into the Health Care Account (HCA) associated with Plan A. Company contributions remain at the same levels as last year for eligible retirees.

All retirees are eligible to enroll in Plan C; however, only those who are under age 65 may enroll in the Health Savings Account (HSA) associated with the Plan. More details are provided throughout this Guide.

Medicare and You: What Is Medicare?

Medicare is health insurance for retirees who fall within the categories listed below:

- Age 65 or older
- Under age 65 with certain disabilities
- Any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare Parts A, B and D

There are different parts of Medicare that will assist with coverage for hospital care, medical coverage and prescription coverage.

Medicare Part A (Hospital Insurance) helps cover:

- Inpatient care in hospitals
- Inpatient care in a skilled nursing facility (not custodial or long-term care)
- Hospice care services
- Home healthcare services

Medicare Part B (Medical Insurance) helps cover:

- Doctors' services and tests
- Hospital outpatient care
- Home healthcare
- Durable medical equipment
- Some preventive services to help maintain your health and to keep certain illnesses from getting worse

Medicare Part D (Medicare Prescription Drug Coverage) Helps Cover the Cost of Prescription Drugs

You may have received information from Medicare and various insurance companies about your ability to enroll in Medicare Part D, a voluntary prescription drug program.

Your Responsibilities When Medicare Eligible

When you become eligible for Medicare, it is important that you elect Medicare Part B immediately. It is also important that the doctors you select accept Medicare reimbursements. As a retiree, when you are eligible for Medicare it immediately becomes primary (i.e., pays first) and your benefits under Plan A, Plan B or Plan C become secondary (i.e., pays after Medicare) whether or not you elect Medicare Part B.

If you do not elect Medicare Part B — or if your doctor does not accept Medicare — you will be responsible for the full amount that Medicare Part B would have paid in addition to any out-of-pocket expenses required under your CPS Energy medical coverage.

COORDINATION WITH MEDICARE FOR THOSE WHO RETIRED ON OR AFTER FEB. 1, 1993*

BCBSTX CALCULATES	BCBSTX CALCULATES	CPS ENERGY GROUP HEALTH PLAN PAYS	RETIREE PAYS
What CPS Energy Plan A, Plan B, or Plan C would pay if no Medicare	Medicare payment under Part A & B	The difference between CPS Energy payment and Medicare's payment	What you pay if your only coverage is Plan A, Plan B, or Plan C
$X	$Y	$X - $Y = payment from CPS Energy Group Health Plan	

*If you retired prior to February 1, 1993, your Coordination of Benefits process works differently (and has not changed for 2025).

BlueCross BlueShield of Texas

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Medical Benefits

Our medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers. Medical benefits are administered by BCBSTX. The option you elect will be in place for all of the 2025 plan year, unless you have a qualifying life event.

Medical Summary and Retiree Contributions

	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	$1,600	$3,200	$850	$1,700	$1,700	$3,200
FAMILY	$4,800	$9,600	$2,550	$5,100	$3,400[2]	$6,400
COINSURANCE	20%[3]	40%[3]	20%[3]	40%[3]	20%[3]	40%[3]
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$5,100	$10,200	$5,600	$11,200	$3,400	$6,400
FAMILY	$10,200	$20,400	$11,200	$22,400	$6,800	$12,800
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. $3,400 family deductible must be met before coinsurance applies to anyone in the family, to include RX costs.
[3]After Deductible

	PLAN A PPO	PLAN B PPO	PLAN C HDHP	DENTAL	VISION
MONTHLY RETIREE CONTRIBUTIONS*					
RETIREE	$96.87	$148.15	$139.72	$5.46	$1.29
RETIREE + SPOUSE	$312.14	$418.45	$411.32	$18.64	$3.68
RETIREE + CHILD(REN)	$247.56	$338.77	$324.14	$14.49	$3.10
FAMILY	$411.41	$556.49	$532.03	$24.84	$6.30
MONTHLY EMPLOYER CONTRIBUTIONS					
RETIREE	$603.85	$592.42	$592.47	$27.01	$5.21
RETIREE + SPOUSE	$1,159.43	$1,135.76	$1,125.93	$49.56	$9.31
RETIREE + CHILD(REN)	$943.70	$920.22	$919.34	$40.72	$8.28
FAMILY	$1,550.69	$1,517.14	$1,516.50	$66.08	$12.32

*Your monthly contributions for retiree healthcare will differ based upon your age and years of service at the time of your retirement.
The premiums shown apply if you retired at age 55 or after with 35 years of benefits service. Surviving Spouses pay the full premium equal to the Retiree Contribution plus Employer Contribution.

6 Helpful Resources

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) 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 licensed behavioral health therapists are available by appointment for conditions such as:

- Anxiety
- Depression
- Grief and loss
- Stress management
- And more

Access Virtual Visits

Go to MDLive.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.
- You need behavioral health services

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 BCBSTX 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

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 that makes it simple to research a procedure prior to receiving care, get a cost estimate and quality comparison between facilities and providers.

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.

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.

7 Preventive Care

Did you know that most health plans must cover 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.

According to 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 and standard immunizations
- Age appropriate screenings
- Some preventive prescriptions are covered at 100%

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. 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.

8 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. Or you're on vacation and are under the weather. 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
- Bronchitis
- Urinary tract infection
- Sinus problems

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
- Managing your general health

Costs and Time Considerations**
- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Short 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

Costs and Time Considerations**
- Copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but urgency determines order seen and wait time

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 might 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.

10 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

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 "HOME" 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, 1 in 5 adults are living with a mental illness.

12 Health Care Account (Plan A)
Post-65 Retirees Only

A Health Care Account (HCA) is an IRS-approved, employer-funded, tax-advantaged employer health benefit plan that reimburses retirees for out-of-pocket medical expenses.

You can use this money for doctors' office visits, diagnostic tests, and more. The HCA helps you cover costs that you would normally pay out-of-pocket prior to meeting your annual deductible.

CPS Energy hopes that by seeing what care actually costs, you'll learn the best ways to maximize your dollars. Your HCA can be used for your qualified medical expenses under your plan, as well as for any dependent(s) on the plan, such as your spouse and/or child(ren).

What Medical Expenses Can Be Paid With HCAs?

- You can use your HCA to pay for qualified medical expenses covered by the plan.
- Any combination of deductible or coinsurance.

Using Your HCA

The money in your HCA can be used to offset your deductible. You'll use HCA dollars first, and these dollars count toward the annual deductible. In some cases, there may be a gap between the end of HCA dollars and before the annual deductible has been met. In this situation, you'll pay out-of-pocket until the deductible is reached.

Preventive care services are covered by the plan at 100%, so you don't have to use HCA dollars for these visits/services.

Note

Retirees age 65 or older on Plan A are eligible for the HCA on January 1.

Submitting a Claim

When a member receives a covered service from an in-network provider, the provider should submit the claim to the plan for processing to make sure that:

- The claim is a covered service.
- The member receives the benefit of any discounts that have been negotiated with a network physician.
- The claim is counted toward the deductible(s) and the member's out-of-pocket maximum(s).
- BCBSTX will then use available HCA funds to pay providers, or members, directly for expenses applied to the deductible.

IRS Rules for HCAs

- Only the employer can contribute to an HCA.
- If the HCA dollars are not completely used in a plan year, the unused funds may (if permitted by the employer) remain in the HCA to be used for medical expenses incurred in the next year or years.
- Any contributions the employer makes to the HCA are not taxable to the member. Further, any claim payments made from the member's HCA are not taxable to the member/account holder.

RETIREE AGE 65 AND OLDER

	CPS ENERGY HCA CONTRIBUTION
RETIREE ONLY	$250
RETIREE + SPOUSE	$500
RETIREE + CHILD(REN)	$500
RETIREE + FAMILY	$750

13 Health Savings Account (Plan C)
PRE-65 RETIREES ONLY

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

Only pre-65 retirees are eligible to participate in the HSA. 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 medical 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.

Eligible expenses include doctors' office visits, eye exams, prescription expenses, laser eye surgery and more. IRS Publication 502 provides a complete list of eligible expenses and can be found on irs.gov.

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 medical 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. There are no vesting requirements or forfeiture provisions.

Eligibility

You are eligible to open and fund an HSA if:

- You are under the age of 65
- You are not covered by your spouse's non-HSA health plan
- Your spouse does not have a Healthcare FSA or HCA
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare 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)

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 monthly basis once bank account information has been provided and verified.

Maximize Your Tax Savings

Your contributions to the HSA are tax-deductible, and 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 withdrawn tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical 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 2025, contributions (which include any CPS Energy contribution) are limited to the following:

HSA FUNDING LIMITS	
RETIREE	$4,300
FAMILY	$8,550
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

CPS ENERGY HSA CONTRIBUTION	
RETIREE	$250
RETIREE & SPOUSE OR CHILD(REN)	$500
FAMILY	$750

HSA contributions in excess of the IRS annual contribution limits are generally subject to a 6% excise tax.

Once a CPS Energy HSA account has been established, you may be able to roll over funds from another HSA. For more enrollment information, contact Employee Benefits or visit hsabank.com.

Note

The HSA is only available to Retirees under the age of 65 on Plan C.

15 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 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.

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.

Pharmacy Benefit Summary

	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	
MAXIMUM OUT-OF-POCKET	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				
ALL ELIGIBLE PRESCRIPTIONS	10%, $100 max	20%, $150 max	20%, $150 max	20%, $150 max
COMPOUND DRUGS	Not Covered	Not Covered	Not Covered	Not Covered

Note: Out-of-Network coverage not available

17 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, safety and strength as the original drug. In other words, generics provide the same clinical benefit as those of 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. The Food & Drug Administration (FDA) requires 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 that much cheaper than brand-name medications?

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.

18 Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. CPS Energy offers affordable plan options from MetLife for routine care and beyond.

Network Dentists

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). To find a network dentist, visit MetLife at metlife.com/mybenefits or call 800-438-6388.

	IN-NETWORK BENEFIT SUMMARY
ANNUAL DEDUCTIBLE	
INDIVIDUAL	$50
ANNUAL MAXIMUM	
PER PERSON	$1,500
COVERED SERVICES	
PREVENTIVE SERVICES	100%
BASIC SERVICES	80%*
MAJOR SERVICES	50%*
ORTHODONTICS	50%*
ORTHODONTIC LIFETIME MAXIMUM	$2,000

*After deductible

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.

Note

Virtual Dentistry (Problem-focused exams) are covered twice a year in addition to your regular preventive benefits. This allows you to get a virtual dental visit and not have the exam count towards your regular exam limitation. For more information, contact MetLife at 800-438-6388.

19 Vision Benefits

MetLife

We provide quality vision care for you and your family through MetLife. To find a participating MetLife provider, go to metlife.com/mybenefits or call 800-438-6388.

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

Note

Blue light filtering is a covered lens enhancement benefit to help reduce eye strain caused by prolonged exposure to blue-light emitted devices such as computers and mobile devices. For more information, contact MetLife at 800-438-6388.

20 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. These statements are also posted on the carrier's website for your review.

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 Care Account (HCA) – A personal healthcare account that you could use to pay for qualified expenses when not enrolled in an HSA. Only retirees age 65 and older are eligible for an HCA contribution from CPS Energy.

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 Plan C HDHP to open an HSA. Funds contributed to an HSA roll over from year to year.

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 plan – 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.

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.

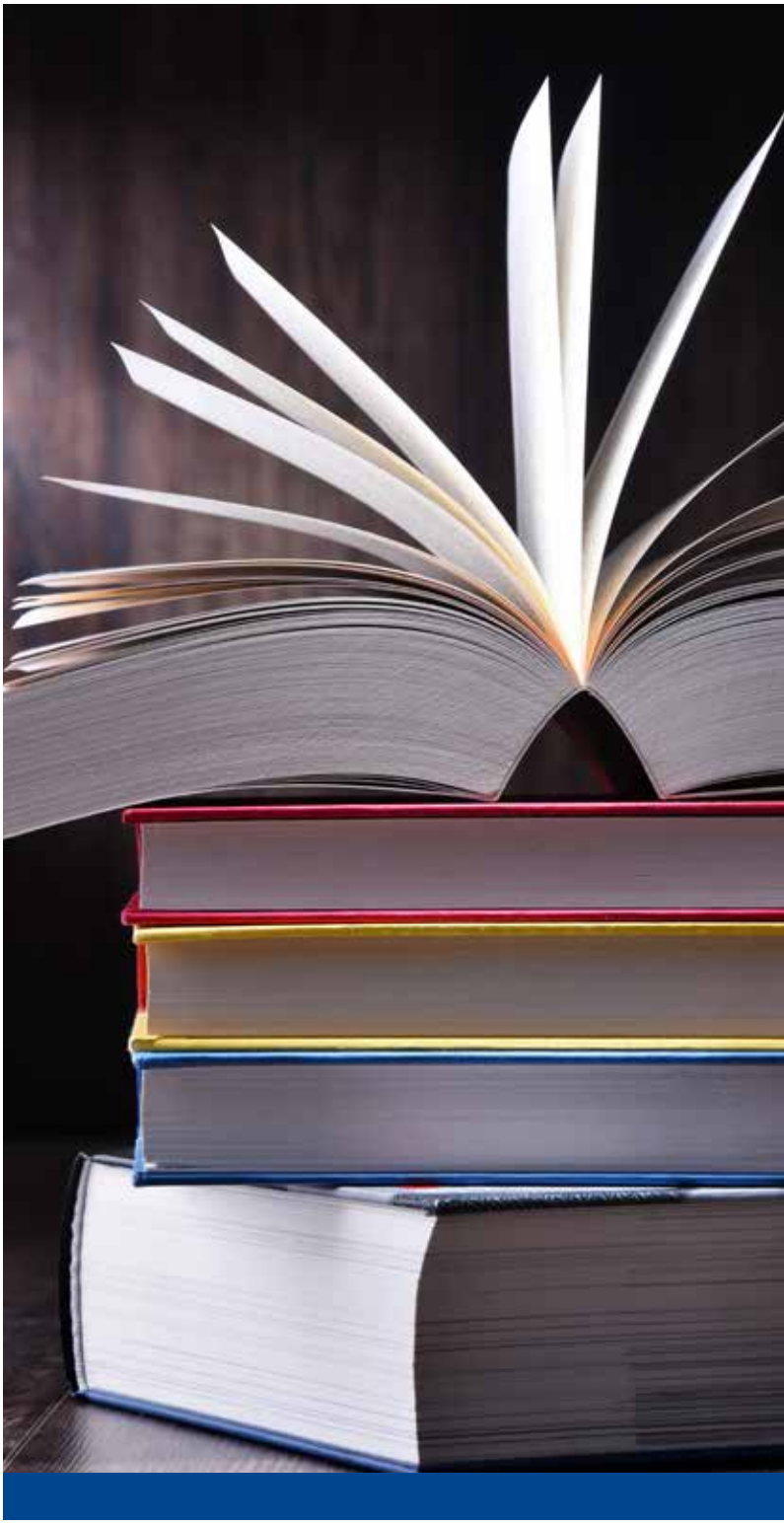
Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **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 retirees 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 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 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, 2025
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 healthcare 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 30 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 30 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.

24 Important Contacts

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

Nurse Line
800-581-0368

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

Deferred Compensation Plan
Empower
800-701-8255
empowermyretirement.com

Glenn Walker
346-568-6740
glenn.walker@empower.com

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

Health Savings Account
HSA Bank
844-650-8936
hsabank.com

JPMorgan
888-719-8932

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

Employee Benefits
PO BOX 1771 - RT0201
San Antonio, TX 78296
Phone: 210-353-2900
Fax: 210-353-3351
empben@cpsenergy.com

2025 Retiree Open Enrollment Form

Submit only if making changes

Retiree Information

Last Name, First Name, MI	Last four of SSN
Address, City, State, Zip Code	Phone Number

Changing Health Plan Option

☐ PPO Plan A ☐ PPO Plan B ☐ PPO Plan C

☐ Waive Medical ☐ Waive Health Savings Account

Status

☐ Retiree

☐ Surviving Spouse

(R)emove[1]	Last Name, First Name, MI	Gender M	Gender F	Date of Birth	Social Security Number
	Retiree				
	Spouse				
	Child				
	Child				

[1]**Dependents removed from coverage are not eligible to enroll at a later date**

THIS SECTION FOR PRE-65 RETIREES ONLY

Health Savings Account

Coverage	Annual Funding Limit[2]	-	CPS Energy Contribution	=	Retiree Contribution
Retiree	$4,300		$250		
Retiree + Spouse	$8,550		$500		
Retiree + Children	$8,550		$500		
Retiree + Family	$8,550		$750		

[2]**Individuals who are age 55 or older by the end of the tax year can make an additional catch-up contribution of $1,000**

☐ **I acknowledge that I have read and understand the Health Savings Account Authorized Agent Agreement** (located on the back of this form) (Plan C Only)

My signature below indicates my understanding that these elections remain in effect until I am eligible to make another election during an annual enrollment period or because of a qualified status change. I understand that I must report and submit in writing any requests for plan changes due to a status change within 31 days of the event. I authorize CPS Energy to deduct from my pension annuity the required deductions on a post-tax basis.

Retiree Signature:_____ **Date:** _____

If making changes, return to: CPS Energy, P.O. Box 1771 RT0201, San Antonio, TX 78296 or email: empben@cpsenergy.com or Fax: 210-353-3351

CPS ENERGY®