Volume 4654

WHO IS ELIGIBLE FOR COVERAGE

Employees

You are eligible if you are a regular full-time Employee of Atmos Energy Corporation.

Dependents

Your eligible Dependents are:

- Your wife or husband.
- Your unmarried children under 19.
- Your unmarried children 19 or older, but under 25 who are registered students in regular full-time attendance (12 semester hours) at a licensed or accredited school.

Dependents who are students must be mainly dependent on you for care and support. For coverage to continue during vacation periods, the child must be scheduled to enter school on the next enrollment date. Your Dependents must reside in the United States.

Children includes any of the following:

- Your stepchild.
- Your legally adopted child. (A child is considered legally adopted upon your assumption and retention of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. A child's placement for adoption terminates upon the termination of the legal obligation for total or partial support. A child who is immediately adopted by you without a preceding placement for adoption is considered to be placed for adoption on the date of the adoption.)
- Any other child who is related by blood or marriage and mainly dependent on you for care and support, and living with you in a parent-child relationship.

In the case of a newborn child, other than your natural child, you would be required to obtain legal guardianship of the child prior to the child becoming a covered Dependent. No person can be covered both as an Employee and as a Dependent under this Plan. No person can be covered as a Dependent of more than one Employee under this Plan.

WHEN COVERAGE STARTS

Your Coverage

You must enroll to get coverage (see **How to Enroll**).

Coverage starts on the latest of:

- The date you complete the 30-day waiting period.
- The date you enroll.

Your Dependent Coverage

You must enroll for the coverage for your Dependents (see **How to Enroll**).

Coverage starts on the latest of:

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

Special Provision for Newborn Children

You must enroll each of your Dependents for Dependent Coverage if they are to be covered under this Plan. If you currently have Dependent Coverage, you must still notify Dallas Human Resources at Atmos Energy Corporation of the addition of a new Dependent. However, even if you are not enrolled for Dependent Coverage, the dental benefits of the group plan are payable for your newborn child from birth for 31 days. You must file a written request with your Employer to deduct the required contributions from your pay for Dependent Coverage during the first 31 days to have the child covered under the group plan after that period of time. You will not have to give proof of insurability for the child.

If you do not file a written request with your Employer to deduct the required contributions from your pay for Dependent Coverage during those first 31 days, benefits will no longer be payable for the child after the first 31 days following the date of the child's birth. In this case, no payment will be made for any services given to the child after these initial 31 days. No other benefit or provision of the Plan will apply to the child. This includes but is not limited to the following provisions:

- Extension of benefits.
- Continuation of coverage.

Who Pays for the Coverage?

The coverage under this Plan is contributory. The contribution rates to participate in a specific coverage level are subject to change each year based on two elements (1) the cost to administer the Plan and (2) the Plan's claim experience. Each Plan Year's rates will be communicated during the annual enrollment period for that Plan Year. The Company employs an outside actuary to develop the required contribution

rates using the contracted administrative and projected net claims costs for that Plan Year. The developed rates reflect the Company's cost sharing philosophy for participants-20% of these costs.

PRE-DETERMINATION OF BENEFITS

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

Many times dental work is likely to cost more than **$200**. If so, you should ask the dentist to file for Pre-Determination of Benefits with the Claims Administrator. Most dentists know about this procedure.

Here is how it works:

- Get a dental claim form from your Employer.
- Give it to your dentist. The dentist will tell the Claims Administrator what work needs to be done. This work is called the treatment plan.
- The dentist lists the services and charges on the claim form and sends it to the Claims Administrator.
- The Claims Administrator will tell you and the dentist what amount the Plan will pay. You should discuss the treatment plan with the dentist before the work is done.

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

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

CLAIMS INFORMATION

How To File A Claim

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

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

When Claims Must be Filed

To claim dental benefits you must give the Claims Administrator written proof of your loss or expenses within 15 months after the date of the loss or the date the expenses are incurred.

No benefits are payable for claims submitted after this 15 month period. You can request that benefits be paid for late claims if you can show that:

- It was not reasonably possible to give the written proof of loss or expenses during the 15 month period.
- The proof was given to the Claims Administrator as soon as was reasonably possible.

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

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

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

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

How and When Claims Are Paid

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

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

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

Benefit Determinations

Urgent Claims that Require Immediate Action

Urgent care claims or appeals are those claims or appeals that require notification or approval prior to receiving medical care, where a delay in treatment as a result of the application of the time periods for making non-urgent care determinations could seriously jeopardize your or your Dependent's life or health or ability to regain maximum function or, in the opinion of a physician with knowledge of your or your Dependent's medical condition could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the case of an urgent care claim, the Claims Administrator shall notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator shall notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, but in no case later than 48 hours after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded you to provide the specified additional information.

A denial notice will comply with the requirements set forth below.

Pre-Service Claims

Pre-service claims or appeals are those claims or appeals that require notification or approval prior to receiving medical care.

In the case of a pre-service claim, the Claims Administrator shall notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical

circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In the case of your failure to follow the Plan's procedures for filing a pre-service claim, you shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless you request written notification. This paragraph applies only in the case of a failure by you to file a claim with the Claims Administrator that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

A denial notice will comply with the requirements set forth below.

Post-Service Claims

Post-service claims or appeals are those claims or appeals that are not pre-service claims or appeals and are filed for payment of benefits after medical care has been received.

In the case of a post-service claim, the Claims Administrator shall notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the Plan's control and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A denial notice will comply with the requirements set forth below.

Concurrent Care Claims

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Claims Administrator shall notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the course of treatment is reduced or terminated. Any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify you of the benefit determination (whether adverse or not) within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Any request to extend the course of treatment beyond the period of time or number of treatments that is not or is no longer a claim involving urgent care shall be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Denial Notification Requirements

In the event claim for benefits is denied or the Claims Administrator otherwise makes an adverse benefit determination as defined in the DOL regulations regarding claims procedures, the Claims Administrator shall provide you with written or electronic notification of such adverse benefit determination. The notification shall be written in a manner calculated to be understood by you and shall include the following:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provision on which the determination is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

(5) Any specific internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request; and

(7) In the case of a claim involving urgent care, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination concerning a claim involving urgent care, the notice described in the preceding paragraph may be provided to you orally within the time frame described above, provided that a written or electronic notification is furnished to you not later than 3 days after the oral notification.

If your claim has been denied and you wish to submit your claim for review, you must follow the Claims Review Procedure described below.

Claims Review Procedure

Upon the denial of your claim for benefits, you may file a claim for review in writing with the Plan Administrator. You must file a claim for review not later than 180 days following receipt of a notification of an adverse benefit determination. You may submit written comments, documents, records and other information relating to the claim for benefits in connection with the claim for review, and the review will take into account all such comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit

determination. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.

In conducting its review, the Plan Administrator will not afford deference to the initial adverse benefit determination, and the review will be conducted by an appropriate individual who is neither the individual who made the adverse benefit determination nor the subordinate of such individual. In deciding a claim for review that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. Any such health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of review, nor the subordinate of any such individual. The Plan Administrator will provide you with the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Further, in the case of a claim involving urgent care (whether an appeal on a claim involves urgent care requiring the expedited handling procedures is determined by the nature of the claim at the time of the appeal), the Plan Administrator will provide for an expedited review process pursuant to which your request for an expedited review may be submitted orally or in writing, and all necessary information, including the Plan's benefit determination, shall be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

In the case of an urgent care appeal, the Plan Administrator shall notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review.

In the case of a pre-service appeal, the Plan Administrator shall notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt by the Plan of your request for review.

In the case of a post-service appeal, the Plan Administrator shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt by the Plan of the claimant's request for review.

The Plan Administrator shall provide you with written or electronic notification of the Plan's benefit determination on review. In the event of an adverse benefit determination on review, the notification shall be written in a manner calculated to be understood by you and shall include the following:

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific Plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

(4) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under ERISA Section 502(a);

(5) Any specific internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request; and

(7) A statement that reads as follows: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

A claimant is not required to file more than two appeals of an adverse benefit determination prior to bringing a civil action under ERISA Section 502(a).

Legal Actions

If you want to bring a legal action against the Plan Administrator or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted, or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator, you must do so within three years of the date you are notified of the final decision on the appeal, or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator

NOTICE OF COORDINATION OF BENEFITS

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

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

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

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

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

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

How Does Coordination Work?

This provision applies when benefits for the same charges are payable under this Plan and another plan other than Medicare or Medicaid. If this Plan is Primary, it will pay benefits first. Benefits under this Plan will not be reduced due to benefits payable under other plans. If this Plan is Secondary, benefits under this Plan may be reduced to the extent of benefits payable under other plans Primary to this Plan.

If this Plan is secondary, the amount of benefits this Plan would have paid without this provision will be determined first. Then the amount of benefits paid by other plans Primary to this Plan for the same charges will be subtracted from this amount. This Plan will pay you the difference.

Which Plan is Primary?

In order to pay claims, the Claims Administrator must find out which plan is Primary and which plans are Secondary,

There are rules to find out which plan is Primary and which plans are Secondary. The rules are used until one is found that applies to the situation. They are always used in the following order:

- A plan which has no coordination of benefits provision will be Primary to a plan which does have a coordination of benefits provision.
- A plan which covers the person as an Employee will be Primary to a plan which covers the same person as a Dependent.
- A person may be covered as a Dependent under two or more plans.
- The plan that covers that person as a Dependent of the person whose birthday is earlier in the Calendar Year will be Primary to a plan that covers that person as a Dependent of a person whose birthday is later in the Calendar Year.
- If both parents have the same birthday, the plan that covered one of the parents longer will be Primary to the plan that covered the other parent for a shorter period of time.

The other plan may not have a rule based on birthdays similar to this rule. The rule in the other plan will determine which plan is Primary.

Children of Divorced or Separated Parents

The person may be covered as a Dependent under two or more plans of divorced or separated parents. The rules that are used to find out which plan is Primary and which plans are Secondary are as follows.

- The plan of the parent with custody will be Primary to a plan of the parent without custody.

Further, the parent with custody may have remarried. In that case, the order of payment will be as follows:

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

There may be a court decree that has specific terms giving one parent financial responsibility for the dental expenses of the Dependent child. If the plan which covers the parent with financial responsibility

knows the specific terms of the court decree, it is Primary to any other plan that covers that Dependent child.

A plan may cover a person as an Employee or Dependent of that Employee. This plan will be Primary to any plan that covers the person as a terminated or retired Employee, or as a Dependent of that Employee. The other plan may not have a rule for terminated or retired employees similar to this rule. In this case, this rule will not apply. If none of the above rules apply, the plan which has covered the person for the longest time will be Primary to all other plans.

Examples

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

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

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

Example A

$200	Claim
- 50	Deductible
$150	Balance
x 80%	Coinsurance (General Services)
$120	Benefit Payable under the Atmos Plan

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

Example B

$200	Claim
- 50	Deductible
$150	Balance
x 80%	Coinsurance (General Services)
$120	Benefit Payable based on the Atmos Plan Design
$105	Paid by Primary Coverage (Jan's Plan)
$ 15	Additional Benefit Payable under the Atmos Plan

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

Refund to the Plan of Overpayment of Benefits

If the Plan pays dental benefits for expenses incurred on account of you or your Dependent, you or any other person or organization that was paid must make a refund to the Plan if:

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

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

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

Subrogation

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

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

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

WHEN COVERAGE STOPS

Your Coverage

Coverage will stop on the earliest of the following:

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

When you stop being an active Employee, see your Employer about what rights you may have to continue coverage.

Your Dependent Coverage

- Coverage for all of your Dependents stops when your coverage stops or when you stop making contributions for the Dependent Coverage, whichever happens first.
- Coverage for an individual Dependent stops sooner if one of the following happens:
    - * The Dependent becomes covered as an Employee under this Plan.
    - * The Dependent stops being an eligible Dependent.

Handicapped Children

A mentally or physically handicapped child's dental coverage will not stop due to age. It will continue as long as your Dependent coverage continues and the child continues to meet the following conditions:

- The child is handicapped.
- The child is not capable of self-support.
- The child depends mainly on you for support.

You must give the Claims Administrator proof that the child meets these conditions when requested. The Claims Administrator will not ask for proof more than once a year.

Uniformed Services Employment and Reemployment Rights Act ("USERRA")

A USERRA Leave is a leave of absence taken by an employee for a call to military duty that is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. Unless otherwise provided by Atmos Energy Corporation's Military Leave of Absence Policy, the following rules apply under USERRA:

If you return from a USERRA Leave, you may reenter the Plan immediately upon return and shall receive the same benefits as existed before your USERRA Leave, subject to any changes that effected the work force as a whole, immediately upon return. If the duration of your USERRA Leave is less than thirty-one days, then you and your Dependents covered under the Plan may continue to be covered under this Plan during your USERRA Leave by paying the portion of the premium for the coverage that you would have paid if you had continued in the same position and had not taken the USERRA Leave. If you are called to a USERRA Leave and the duration of the USERRA Leave is greater than or equal to thirty-one days, then you and your Dependents covered under the Plan may continue to be covered under this Plan during your USERRA Leave, up to the maximum period of coverage described below by paying the applicable COBRA premium. The maximum duration of continued coverage available for a USERRA Leave that equals or exceeds thirty-one days shall be the lesser of:

- the 18 month period beginning on the date on which your absence for the USERRA Leave commenced; or

- the day after the date on which you fail to apply for or return to a position of employment with the Employer, as determined under USERRA.

Leave of Absence Under The Family and Medical Leave Act

If you take a leave of absence under the Family and Medical Leave Act, you may continue your coverage during the period of your leave of absence, but not to exceed a period of 12 weeks, provided that you pay any required contributions under the Plan. You may elect to either pre-pay your required contributions, pay your required contributions on the same schedule as they would have been due had the leave not been taken, or agree with your employer in writing to reimburse the employer for your contributions upon your return to work following your leave. If you notify the employer during your leave that you will not be returning to work, you coverage under the Plan will be terminated on the date following the date you gave such notice to your employer. If you choose not to retain medical coverage during FMLA leave, your coverage under this Plan, subject to any changes that affect the work force as a whole, will be restored upon your return to service with the employer. You will be treated as though no service or coverage interruption had occurred.

CONTINUATION OF COVERAGE

Disability

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

Continuation of Health Coverage (COBRA) and Your Notice Obligations

When certain "qualifying events" occur that would cause you or your "Qualifying Beneficiaries" to lose the health benefits provided by your Plan, you or your Qualified Beneficiary will be offered the option to purchase continuing health care coverage benefits from your Plan for a limited time period, provided you exercise your rights in a timely manner and comply with the notice provisions described in this Section.

EVENTS QUALIFYING YOU OR YOUR BENEFICIARIES TO BE OFFERED CONTINUATION COVERAGE UNDER THE PLAN

(1) You must notify the Plan Administrator within 60 days of either of the following occurrences:

(a) your divorce or legal separation from your spouse; or

(b) the date any of your dependent children no longer qualifies as a dependent under this Plan (i.e., age 19, age 25 if enrolled as a full time student and not married, or over age 19 and either no longer enrolled as a full time student, or married).

(2) Your employer will notify the Plan Administrator within 30 days in the event one of the following other qualifying events occurs:

(a) the termination of your employment for reasons other than gross misconduct or your notification to your employer that you do not intend to return to work following a Family and Medical Leave Act leave of absence;

(b) the reduction of your hours of employment;

(c) your death;

(d) you become entitled to benefits under Title XVIII of the Social Security Act; or

(e) your employer or former employer providing the health benefits begins or is subject to a bankruptcy under Title XI of the United States Code beginning on or after July 1, 1986.

(3) The Qualified Beneficiary entitled to elect the continuation coverage under the Plan is you or your beneficiary under the Plan if you or your beneficiary would lose coverage under the Plan as the result of one of the qualifying events in paragraphs 1 or 2 above. The Qualified Beneficiary entitled to elect continuation coverage under the Plan includes any child born to you or your spouse or adopted by you or placed for adoption with you effective on or after January 1, 1997.

(4) Your Plan Administrator will send you (or your beneficiary in the event the occurrence was described in (1)(a) or (b) or (2)(c)) an option to elect to continue to be covered by your Plan for a limited time period upon completion of the election and payment of the premium. You and your beneficiary should receive a notice from the Plan Administrator permitting you to elect to continue coverage within 14 days of the date the Plan Administrator received notice of the occurrence of one of the qualifying events. You or your beneficiary will then have 60 days in which to elect to purchase the continuation coverage. The premium for the continuation coverage elected will not be due sooner than 45 days after the election is made and may be paid in monthly installments. However, you will be required to pay for all months of coverage following your qualifying event, with your first payment applied to the first month following coverage termination at the qualifying event.

(5) Your right to continue to be covered by the benefits in your Plan will be the right to continue in the same benefit(s) or in the benefit(s) offered individuals who are similarly situated beneficiaries under the Plan, subject to the same modifications and changes.

(6) The Continuation Coverage benefits may be continued for up to 18 months if the right to elect continuation coverage arose because your work hours were reduced or your employment was terminated. The continuation coverage benefits may be continued up to 36 months if the right to elect continuation coverage arose because of either:

(a) your divorce or legal separation from your spouse;

(b) your dependent child ceasing to be a dependent under your Plan;

(c) your eligibility for Medicare benefits;

(d) your employer's proceeding in bankruptcy under Title 11 of the United Stated Codes; or

(e) your death.

(7) Your right to Continuation Coverage benefits may be extended from 18 months to 29 months if you or one of the qualified beneficiaries becomes disabled for Social Security purposes within 60 days of the date your employment terminates or you lose coverage due to a reduction in hours.

(8) If after an event described in (2)(a) above and while you are covered under COBRA continuation coverage one of the other Qualifying Events in (1) or (2) occurs, you or your beneficiaries must notify the Plan Administrator because you or your beneficiaries may be entitled to an extension of up to 18 months of coverage to up to 36 months of coverage.

(9) Your rights to purchase continuation coverage may terminate if your employer terminates all its health benefit plans.

TERMINATION OF YOUR CONTINUATION COVERAGE

Your continuation coverage may terminate before the end of the maximum period of coverage outlined above if any of the following events occur:

(1) your employer terminates all of its health benefit plans;

(2) you fail to pay the premium due for the continuation coverage and do not pay it within the 30-day grace period;

(3) you, your spouse or your dependent becomes entitled to coverage under Medicare; or

(4) you or your beneficiary becomes covered after making the COBRA continuation coverage election under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition that you or your beneficiary has, or for all years on and after January 1, 1997, you or your beneficiary becomes covered under another group health plan and that group health plan's preexisting condition exclusion or limitation terminates or otherwise does not apply to you or your beneficiary.

COBRA CLAIMS

File a claim by completing a claim form and attaching your bills to the form. COBRA should be written on each of the bills.

BENEFITS AVAILABLE AFTER COVERAGE STOPS

Some benefits are paid after coverage stops.

Dental Care Benefit

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

- When a tooth or teeth are first prepared for fixed bridgework, crowns, inlays, onlays or gold restorations while the person is covered and the service or supply is given within 60 days after coverage stops.

- When a tooth is opened for root canal work while the person is covered and the work is completed within 60 days after coverage stops.

- When the impression for full or partial removable dentures is taken while the person is covered and the dentures are installed within 60 days after coverage stops.

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

GLOSSARY

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

Calendar Year
A period of one year beginning with a January 1.

Claims Administrator
Metropolitan Life Insurance Company is the Claims Administrator. The Claims Administrator does not insure the benefits described in this booklet.

Covered Dental Expense

In-Network Benefits:
The charges based on the Preferred Dentist Program Schedule of Maximum Payments for covered dental expenses. These services must be performed or prescribed by a dentist who is a Participating Provider and necessary in terms of generally accepted dental standards.

Out-of-Network Benefits:
The reasonable and customary charges for covered dental expenses. These services must be performed or prescribed by a dentist who is not a Participating Provider and are necessary in terms of generally accepted dental standards.

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

Covered Family Members
You, your wife or husband, and Dependent children are covered under the Plan.

Participating Provider
A dentist who has been selected by Metropolitan Life Insurance Company for inclusion in the Preferred Dentist Program. These Participating Providers agree to accept Metropolitan Life Insurance Company Preferred Dentist Program Schedule of Maximum Payments as payment in full for services rendered.

Physician
A legally qualified:

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

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

Preferred Dentist Program

This is a program to offer a covered person the opportunity to receive dental care from dentists who are designated by us as Participating Providers. When dental care is given by Participating Providers, the covered person will generally incur less out-of-pocket cost for the services rendered.

Preferred Dentist Program Directory
The list that consists of selected dentists who:

- are located in the covered person's area; and
- have been selected by Metropolitan Life Insurance Company to be Participating Providers and are part of the Preferred Dentist Program. These Participating Providers agree to accept Metropolitan Life Insurance Company Preferred Dentist Program Schedule of Maximum Payments as payment in full for services rendered.

Provider
A dentist who is not a Participating Provider

Definitions of Common Dental Terms

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

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

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

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

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

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

Gingivae
The gums or soft tissue surrounding the teeth and bone.

Gingivectomy
The cutting away of the diseased gums (gingival) when the underlying bone is not yet affected.

Periodontal Disease

A disease which weakens and destroys the gums, bone and membrane surrounding the teeth. This disease is sometimes called Vincent's Disease, Gingivitis or Pyorrhea.

Periodontist
A dentist whose practice is limited to the treatment of Periodontal Disease.

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

Root Canal Therapy (Endodontic Therapy)
Treatment of a tooth having a damaged pulp. Usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling the spaces with sealing material.

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

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

YOUR RIGHTS UNDER ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrators office and at other specified locations, such as worksites, all Plan documents including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain copies of all Plan documents including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated summary plan description, upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

- Receive a summary of this Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself , spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under this Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Covered Persons and other Plan participants and beneficiaries.

No one, including the Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If a claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse this Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person who was sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PLAN INFORMATION

Name of Plan: Atmos Energy Corporation Group Dental Plan

Name and Address of Employer who is the Plan Sponsor:
Atmos Energy Corporation
P.O. Box 650205
Dallas, Texas 75265-0205

Source of Contributions and Funding:
The Plan is funded by direct benefit payments from the general assets of your Employer. The employee's contribution toward the cost of the Plan is at a rate determined by your Employer.

Plan Details:
The Plan's provisions relating to eligibility to participate and termination of eligibility, as well as a description of the benefits provided by the Plan, are described in detail in this dental benefits booklet, which directly precedes this ERISA information.

Plan Amendment or Termination:
The Plan Sponsor reserves the right to modify, suspend, amend or terminate the Plan at any time. Your Employer does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement. Any benefits, rights or obligations of participants and beneficiaries under the Plan following termination are described in detail in this dental benefits booklet, which directly precedes this ERISA information.

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

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

Plan Number (PN) - 511

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

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

Plan Administrator
The Vice President of Human Resources at Atmos Energy Corporation.

Telephone Number of Plan Administrator
(972) 855-4021

Type of Administration
Metropolitan Life Insurance Company pursuant to the terms of this Summary Plan Description administers the Plan on behalf of the Plan Administrator.

The Dental Benefits are paid from funds provided by your Employer on behalf of the Plan in accordance with an administrative service contract with Metropolitan Life Insurance Company.

D-978186.4

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 1st Data Request Dated November 21, 2006
DR Item 24
Witness: Robert R. Cook, Jr. and Thomas Petersen

Data Request:

Provide, in the format provided as Schedule 5, an analysis of the gross additions, retirements and transfers for each major functional plant property group or account for Atmos occurring in the forecasted test period. Provide this information for both Kentucky gas operations and total company operations. For any account in which transfers regularly occur in the normal course of business, also include a general description of the nature of the transfers.

Response:

Please see attached file: Case 2006-00464 PSC DR1-24ATT.xls

The response to this request includes actual information relative to Kentucky gas operations and total company operations. Forecasted information is provided for Kentucky gas operations as well as the Shared Services and Division General Office rate divisions which support the Kentucky gas operations.

Atmos Energy Corporation
Case No. 2006-00464
Gross Additions, Retirements, and Transfers
As of _____

Data: _____ Base Period _X_ Forecasted Period
Type of Filing: _X_ Original _____ Updated _____ Revised
Workpaper Reference No(s).: _____

Schedule 5
Page 1 of 11
Witness Responsible

Line No.	Account No.	Account Title	Beginning Balance	Additions	Retirements	Transfers/Reclassifications			Ending Balance
						Amount	Explanation of Transfers	Other Accounts Involved	

1 For the consolidated KY results see page 2-4 of 11 tab B.2.2 F
2 For Kentucky (DIV 09 only) see page 5-7 of 11 tab B.2.3 F 09
3 For the shared services (DIV 02 and Div 12) results see pages 8-9 of 11 tabs B.2.3 F 02 and 12
4 For the Kentucky/Mid-States Division's general office (DIV 91) see pages 10-11 of 11 tab B.2.3 F 91

Atmos Energy Corporation, KY
Case No. 2006-00464
Jurisdictional Gross Additions, Retirements, and Transfers
From July 1, 2007 to June 30, 2008

Data:_____Base Period_X__Forecasted Period
Type of Filing:___X____Original_____Updated
Workpaper Reference No(s).

FR 10(10)(b)2.2
Schedule B-2.2
Sheet 2 of 11

Line No.	Acct. No.	Account Title	Beginning Balance	Additions	Retirements	Transfers/Reclassifications Amount	Explanation Of Transfers *	Other Accounts Involved	Ending Balance
			$	$	$	$			$
1	Account 101-1000 Gas Plant in Service - General								
2		Intangible Plant							
3	301.00	Organization	76,480	0	0	0			76,480
4	302.00	Franchises & Consents	119,853	0	0	0			119,853
5	303.00	Misc. Intangible Plant	408,053	0	0	0			408,053
6									
7		Total Intangible Plant	604,386	0	0	0			604,386
8									
9		Natural Gas Production Plant							
10	325.20	Producing Leaseholds	2,353	0	0	0			2,353
11	325.40	Rights of Ways	83,422	0	0	0			83,422
12	331.00	Production Gas Wells Equipment	3,492	0	0	0			3,492
13	332.01	Field Lines	47,163	0	0	0			47,163
14	332.02	Tributary Lines	528,218	0	0	0			528,218
15	334.00	Field Meas. & Reg. Sta. Equip	198,469	0	0	0			198,469
16	336.00	Purification Equipment	44,369	0	0	0			44,369
17									
18		Total Natural Gas Production Plant	907,486	0	0	0			907,486
19									
20		Storage Plant							
21	350.10	Land	261,127	0	0	0			261,127
22	350.20	Rights of Way	4,682	0	0	0			4,682
23	351.00	Structures and Improvements	4,700	0	0	0			4,700
24	351.02	Compression Station Equipment	159,811	0	0	0			159,811
25	351.03	Meas. & Reg. Sta. Structues	23,138	0	0	0			23,138
26	351.04	Other Structures	144,554	0	0	0			144,554
27	352.00	Wells	62,814	0	0	0			62,814
28	352.01	Well Construction	2,113,527	0	0	0			2,113,527
29	352.02	Well Equipment	531,954	0	0	0			531,954
30	352.03	Cushion Gas	1,694,833	0	0	0			1,694,833
31	352.10	Leaseholds	178,530	0	0	0			178,530
32	352.11	Storage Rights	54,614	0	0	0			54,614
33	353.01	Field Lines	178,501	0	0	0			178,501
34	353.02	Tributary Lines	209,458	0	0	0			209,458
35	354.00	Compressor Station Equipment	546,780	0	0	0			546,780
36	355.00	Meas & Reg. Equipment	288,851	0	0	0			288,851
37	356.00	Purification Equipment	243,119	0	0	0			243,119
38									
39		Total Storage Plant	6,700,993	0	0	0			6,700,993

Atmos Energy Corporation, KY
Case No. 2006-00464
Jurisdictional Gross Additions, Retirements, and Transfers
From July 1, 2007 to June 30, 2008

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Sheet 3 of 11

Data:_____Base Period__X___Forecasted Period
Type of Filing:___X____Original_____Updated
Workpaper Reference No(s).

Line No.	Acct. No.	Account Title	Beginning Balance	Additions	Retirements	Transfers/Reclassifications Amount	Explanation Of Transfers *	Other Accounts Involved	Ending Balance
1		Transmission Plant							
2	365.10	Land	26,970	0	0	0			26,970
3	365.20	Rights of Way	838,245	0	0	0			838,245
4	366.02	Structures & Improvements	214,065	0	0	0			214,065
5	366.03	Other Structues	69,172	0	0	0			69,172
6	367.00	Mains	406,111	0	0	0			406,111
7	367.01	Mains - Steel	22,433,694	1,455,214	269	0			23,888,640
8	369.00	Meas. & Reg. Equipment	185,854	0	0	0			185,854
9	369.01	Meas. & Reg. Equipment	2,868,111	186,045	0	0			3,054,156
10									
11		Total Production Plant - LPG	27,042,224	1,641,259	269	0			28,683,215
12									
13		Distribution Plant							
14	374.00	Land & Land Rights	98,315	0	0	0			98,315
15	374.01	Land	51,571	0	0	0			51,571
16	374.02	Land Rights	244,565	0	0	0			244,565
17	374.03	Land Other	2,784	0	0	0			2,784
18	375.00	Structures & Improvements	312,033	0	0	0			312,033
19	375.01	Structures & Improvements T.B.	105,699	0	0	0			105,699
20	375.02	Land Rights	46,591	0	0	0			46,591
21	375.03	Improvements	4,005	0	0	0			4,005
22	376.00	Mains Cathodic Protection	10,507,053	681,577	382	0			11,188,248
23	376.01	Mains - Steel	66,092,134	4,291,514	89,009	0			70,294,638
24	376.02	Mains - Plastic	26,875,554	1,744,369	21,356	0			28,598,568
25	378.00	Meas. & Reg. Sta. Equipment General	3,038,630	197,965	25,253	0			3,211,342
26	379.00	Meas & Reg. Sta. Equipment - City Gate	1,277,515	0	0	0			1,277,515
27	379.05	Meas & Reg. Sta. Equipment T.B.	1,636,212	0	0	0			1,636,212
28	380.00	Services	76,867,604	6,745,999	1,508,326	0			82,105,277
29	381.00	Meters	14,302,490	927,756	0	0			15,230,246
30	382.00	Meter Installations	35,767,624	2,344,374	498,327	0			37,613,672
31	383.00	House Regulators	5,217,924	338,470	0	0			5,556,394
32	384.00	House Reg Installations	154,276	0	0	0			154,276
33	385.00	Ind. Meas. & Reg. Sta. Equipment	4,760,011	308,767	0	0			5,068,778
34	386.00	Other Property on Cust Prem	0	0	0	0			0
35									
36		Total Distribution Plant	247,362,591	17,580,791	2,142,653	0			262,800,729

Atmos Energy Corporation, KY
Case No. 2006-00464
Jurisdictional Gross Additions, Retirements, and Transfers
From July 1, 2007 to June 30, 2008

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Schedule B-2.2
Sheet 4 of 11

Data:_____Base Period__X___Forecasted Period
Type of Filing:___X____Original_____Updated
Workpaper Reference No(s).

Line No.	Acct. No.	Account Title	Beginning Balance ** $	Additions ** $	Retirements ** $	Transfers/Reclassifications Amount ** $	Transfers/Reclassifications Explanation Of Transfers *	Transfers/Reclassifications Other Accounts Involved	Ending Balance ** $
1		General Plant (see note * *)	71,393	0	0	0			71,393
2	389.00	Land & Land Rights	65,954	0	0	0			65,954
3	390.01	Structures Frame	193,598	0	0	0			193,598
4	390.02	Structures & Improvements	774,269	0	0	0			774,269
5	390.03	Improvements	14,251	0	0	0			14,251
6	390.04	Air Conditioning Equipment	1,935,733	10,275	2,324	0			1,943,684
7	390.09	Improvement to Leased Premises	2,555,492	8,067	125,895	0			2,437,664
8	391.00	Office Furniture & Equipment	1,101	0	291	0			810
9	391.02	Remittance Processing Equip	124,717	0	7,698	0			117,019
10	391.03	Office Machines	520,049	0	16,476	0			503,573
11	392.00	Transportation Equipment	18,735	0	4,274	0			14,460
12	392.01	Trucks	114,455	0	5,568	0			108,887
13	392.02	Trailers	3,887	0	63	0			3,824
14	393.00	Stores Equipment	1,507,750	0	117,174	0			1,390,576
15	394.00	Tools, Shop & Garage Equip	3,125	0	0	0			3,125
16	396.00	Power Operated Equipment	230,004	0	12,496	0			217,508
17	396.03	Ditchers	270,437	0	5,670	0			264,767
18	396.04	Backhoes	36,506	0	5,093	0			31,413
19	396.95	Welders	2,656,814	7,041	10,303	0			2,653,551
20	397.00	Communication Equipment	3,338	0	0	0			3,338
21	397.01	Communication Equip. - Mobile Radios	41,432	0	0	0			41,432
22	397.02	Communication Equip. - Fixed Radios	312,236	0	0	0			312,236
23	397.05	Communication Equip. - Telemetering	2,850,542	0	0	0			2,850,542
24	398.00	Miscellaneous Equipment	40,867	0	0	0			40,867
25	399.00	Other Tangible Property	1,172,637	182,248	0	0			1,354,885
26	399.01	Other Tangible Property - Servers - H/W	600,134	6,896	0	0			607,031
27	399.02	Other Tangible Property - Servers - S/W	724,910	0	0	0			724,910
28	399.03	Other Tangible Property - Network - H/W	56,964	0	0	0			56,964
29	399.04	Other Tangible Property - CPU	60,318	0	0	0			60,318
30	399.05	Other Tangible Property - MF Hardware	923,486	583,878	34,570	0			1,472,794
31	399.06	Other Tangible Property - PC Hardware	3,653,056	14,705	214	0			3,667,546
32	399.07	Other Tang. Property - PC Software	7,099,478	521,826	9,573	0			7,611,731
33	399.08	Other Tang. Property - Application Software	656,173	0	167	0			656,006
34	399.09	Other Tang. Property - Mainframe S/W	1,297,650	0	0	0			1,297,650
35	399.24	Other Tang. Property - Gen. Startup Costs							
36									31,568,576
37		Total General Plant	30,591,492	1,334,935	357,851	0			331,265,384
38									
39		Total Plant	313,209,171	20,556,986	2,500,773	0			1,543,040
40									
41		CWIP without AFUDC	1,543,040						
42									

* Transfers are a normal course of events in all accounts and represent changes in function of equipmpent or a choice in previous year closings.

** All Intangible and General Plant amounts include Kentucky, Div. 09 general plant 100%, plus allocations of General Office general plant from Div. 02 at 5.20%, Div. 12 at 5.60% and Div 91 at 36.78%.

Atmos Energy Corporation, KY
Case No. 2006-00464
Gross Additions, Retirements, and Transfers -- Division 09 Western Only
From July 1, 2007 to June 30, 2008

Data:_____Base Period__X___Forecasted Period
Type of Filing:___X____Original_____Updated
Workpaper Reference No(s).

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Schedule B-2.3
Sheet 5 of 11

Line No.	Acct. No.	Account Title	Beginning Balance	Test Yr Additions	Retirements	Transfers/Reclassifications Amount	Explanation Of Transfers *	Other Accounts Involved	Ending Balance
			$	$	$	$			$
1		Account 101-1000 Gas Plant in Service - General							
2		Intangible Plant							
3	301.00	Organization	8,330	0	0				8,330
4	302.00	Franchises & Consents	119,853	0	0				119,853
5	303.00	Misc. Intangible Plant	0	0	0				0
6									
7		Total Intangible Plant	128,182	0	0	0			128,182
8									
9		Natural Gas Production Plant							
10	325.20	Producing Leaseholds	2,353	0	0				2,353
11	325.40	Rights of Ways	83,422	0	0				83,422
12	331.00	Production Gas Wells Equipment	3,492	0	0				3,492
13	332.01	Field Lines	47,163	0	0				47,163
14	332.02	Tributary Lines	528,218	0	0				528,218
15	334.00	Field Meas. & Reg. Sta. Equip	198,469	0	0				198,469
16	336.00	Purification Equipment	44,369	0	0				44,369
17									
18		Total Natural Gas Production Plant	907,486	0	0	0			907,486
19									
20		Storage Plant							
21	350.10	Land	261,127	0	0				261,127
22	350.20	Rights of Way	4,682	0	0				4,682
23	351.00	Structures and Improvements	4,700	0	0				4,700
24	351.02	Compression Station Equipment	159,811	0	0				159,811
25	351.03	Meas. & Reg. Sta. Structues	23,138	0	0				23,138
26	351.04	Other Structures	144,554	0	0				144,554
27	352.00	Wells	62,814	0	0				62,814
28	352.01	Well Construction	2,113,527	0	0				2,113,527
29	352.02	Well Equipment	531,954	0	0				531,954
30	352.03	Cushion Gas	1,694,833	0	0				1,694,833
31	352.10	Leaseholds	178,530	0	0				178,530
32	352.11	Storage Rights	54,614	0	0				54,614
33	353.01	Field Lines	178,501	0	0				178,501
34	353.02	Tributary Lines	209,458	0	0				209,458
35	354.00	Compressor Station Equipment	546,780	0	0				546,780
36	355.00	Meas & Reg. Equipment	288,851	0	0				288,851
37	356.00	Purification Equipment	243,119	0	0				243,119
38									
39		Total Storage Plant	6,700,993	0	0	0			6,700,993

Western Kentucky Gas Company
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Line No.	Acct. No.	Account Title	Beginning Balance	Additions	Retirements	Transfers/Reclassifications Amount	Explanation Of Transfers *	Other Accounts Involved	Ending Balance
			$	$	$	$			$
1		Transmission Plant							
2	365.10	Land	26,970	0	0				26,970
3	365.20	Rights of Way	838,245	0	0				838,245
4	366.02	Structures & Improvements	214,065	0	0				214,065
5	366.03	Other Structues	69,172	0	0				69,172
6	367.00	Mains - Cathodic Protection	406,111	0	0				406,111
7	367.01	Mains - Steel	22,433,694	1,455,214	269				23,888,640
8	369.00	Meas. & Reg. Equipment	185,854	0	0				185,854
9	369.01	Meas. & Reg. Equipment	2,868,111	186,045	0				3,054,156
10									
11		Total Production Plant - LPG	27,042,224	1,641,259	269	0			28,683,215
12									
13		Distribution Plant							
14	374.00	Land & Land Rights	98,315	0	0				98,315
15	374.01	Land	51,571	0	0				51,571
16	374.02	Land Rights	244,565	0	0				244,565
17	374.03	Land Other	2,784	0	0				2,784
18	375.00	Structures & Improvements	312,033	0	0				312,033
19	375.01	Structures & Improvements T. B.	105,699	0	0				105,699
20	375.02	Land Rights	46,591	0	0				46,591
21	375.03	Improvements	4,005	0	0				4,005
22	376.00	Mains Cathodic Protection	10,507,053	681,577	382				11,188,248
23	376.01	Mains - Steel	66,092,134	4,291,514	89,009				70,294,638
24	376.02	Mains - Plastic	26,875,554	1,744,369	21,356				28,598,568
25	378.00	Meas & Reg Sta Equip - General	3,038,630	197,965	25,253				3,211,342
26	379.00	Meas & Reg. Sta. Equipment - City Gate	1,277,515	0	0				1,277,515
27	379.05	Meas & Reg. Sta. Equipment T.B.	1,636,212	0	0				1,636,212
28	380.00	Services	76,867,604	6,745,999	1,508,326				82,105,277
29	381.00	Meters	14,302,490	927,756	0				15,230,246
30	382.00	Meter Installations	35,767,624	2,344,374	498,327				37,613,672
31	383.00	House Regulators	5,217,924	338,470	0				5,556,394
32	384.00	House Reg. Installations	154,276	0	0				154,276
33	385.00	Ind. Meas. & Reg. Sta. Equipment	4,760,011	308,767	0				5,068,778
34	386.00	Other Property on Cust Prem	0	0	0				0
35									
36		Total Distribution Plant	247,362,591	17,580,791	2,142,653	0			262,800,729

Western Kentucky Gas Company
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Line No.	Acct. No.	Account Title	Beginning Balance $	Additions $	Retirements $	Transfers/Reclassifications Amount $	Explanation Of Transfers *	Other Accounts Involved	Ending Balance $
1		General Plant							
2	389.00	Land & Land Rights	71,393	0	0				71,393
3	390.01	Structures Frame	0	0	0				0
4	390.02	Structures & Improvements	193,598	0	0				193,598
5	390.03	Improvements	774,269	0	0				774,269
6	390.04	Air Conditioning Equipment	12,129	0	0				12,129
7	390.09	Improvement to leased Premises	1,382,343	0	109,621				1,382,343
8	391.00	Office Furniture & Equipment	1,615,532	0	0				1,505,911
9	391.02	Remittance Processing Equip.	0	0	161				0
10	391.03	Office Machines	94,992	0	16,476				94,831
11	392.00	Transportation Equipment	523,081	0	4,274				506,605
12	392.01	Trucks	18,735	0	5,568				14,460
13	392.02	Trailers	114,455	0	0				108,887
14	393.00	Stores Equipment	0	0	115,789				0
15	394.00	Tools, Shop & Garage Equip	1,462,268	0	0				1,346,479
16	396.00	Power Operated Equipment	0	0	12,496				0
17	396.03	Ditchers	230,004	0	5,670				217,508
18	396.04	Backhoes	270,437	0	5,093				264,767
19	396.05	Welders	36,506	0	0				31,413
20	397.00	Communication Equipment	1,141,094	0	0				1,141,094
21	397.01	Communication Equipment - Mobile Radios	3,338	0	0				3,338
22	397.02	Communication Equipment - Fixed Radios	41,432	0	0				41,432
23	397.05	Communication Equip. - Telemetering	312,236	0	0				312,236
24	398.00	Miscellaneous Equipment	2,511,890	0	0				2,511,890
25	399.00	Other Tangible Property	0	0	0				0
26	399.01	Oth Tang Prop - Servers - H/W	175,990	0	0				175,990
27	399.02	Oth Tang Prop - Servers - S/W	113,473	0	0				113,473
28	399.03	Other Tangible Property-Network HW	511,781	0	0				511,781
29	399.04	Other Tangible Property - CPU	0	0	0				0
30	399.05	Other Tangible Property - MF Hardware	0	559,519	0				0
31	399.06	Other Tangible Property - PC Hardware	3,387,403	0	0				559,519
32	399.07	Other Tang. Property - PC Software	242,979	0	0				3,387,403
33	399.08	Other Tang. Property - Application Software	522,254	0	0				242,979
34	399.09	Other Tang. Property - Mainframe S/W	0	0	0				522,254
35	399.24	Other Tangible Property - General Start Up Costs							0
36			15,763,610	559,519	275,149	0			16,047,980
37		Total General Plant	297,905,086	19,781,570	2,418,071	0			315,268,585
38									
39		Total Plant	461,362						461,362
		CWIP without AFUDC							

* Transfers are a normal course of events in all accounts and represent changes in function of equipment or a choice in previous year closings.

Atmos Energy Corporation, KY
Case No. 2006-00464
Gross Additions, Retirements, and Transfers -- Division 02 General Office
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Line No.	Acct. No.	Account Title	Beginning Balance $	Test Yr. Additions $	Retirements $	Transfers/Reclassifications Amount $	Explanation Of Transfers *	Other Accounts Involved	Ending Balance $
1		Account 101-1000 Gas Plant in Service - General							0
2		General Plant	0	0	0				0
3	389.00	Land & Land Rights	0	0	0				0
4	390.01	Structures Frame	0	0	0				0
5	390.02	Structures & Improvements	0	0	0				0
6	390.03	Improvements	0	0	0				7,270,042
7	390.04	Air Conditioning Equipment	7,117,145	197,587	44,689				8,822,235
8	390.09	Improvement to Leased Premises	8,951,294	155,134	284,193				15,586
9	391.00	Office Furniture & Equipment	21,183	0	5,597				182,666
10	391.02	Remittance Processing Equip	327,603	0	144,936				18,885
11	391.03	Office Machines	18,885	0	0				0
12	392.00	Transportation Equipment	0						0
13	392.01	Trucks	0						(2,122)
14	392.02	Trailers	(910)	0	1,213				(1,193)
15	393.00	Stores Equipment	3,879	0	5,072				0
16	394.00	Tools, Shop & Garage Equipment	0						0
17	396.00	Power Operated Equipment	0						0
18	396.03	Ditchers	0						0
19	396.04	Backhoes	0						914,389
20	396.05	Welders	1,112,531	0	198,142				0
21	397.00	Communication Equipment	0						0
22	397.01	Communication Equipment - Mobile Radios	0						0
23	397.02	Communication Equip. - Fixed Radios	0						631,550
24	397.05	Communication Equip. - Telemetering	631,550	0	0				10,196
25	398.00	Miscellaneous Equipment	10,196	0	0				11,290,447
26	399.00	Other Tangible Property	7,866,226	3,424,220	0				2,043,413
27	399.01	Other Tangible Property - Servers - H/W	1,910,789	132,624	0				1,917,244
28	399.02	Other Tangible Property - Servers - S/W	1,917,244	0	0				1,095,465
29	399.03	Other Tangible Property - Network H/W	1,095,465	0	0				1,159,964
30	399.04	Other Tangible Property - CPU	1,159,964	0	0				2,904,230
31	399.05	Other Tangible Property - MF Hardware	3,566,594	(89,595)	572,769				1,619,191
32	399.06	Other Tangible Property - PC Hardware	1,340,534	282,781	4,124				55,566,368
33	399.07	Other Tang. Property - PC Software	46,113,543	9,618,520	165,696				2,572,152
34	399.08	Other Tang. Property - Application Software	2,575,367	0	3,215				0
35	399.09	Other Tang. Property - Mainframe Software	0	0	0				
36	399.24	Other Tang. Property - General Start Up Costs							98,030,707
37									
38		Total Plant - Div 02	85,739,081	13,721,272	1,429,645	0			19,570,952
39									
40		CWIP without AFUDC	19,570,952						

* Transfers are a normal course of events in all accounts and represent changes in function of equipment or a choice in previous year closings.

Atmos Energy Corporation, KY
Case No. 2006-00464
Gross Additions, Retirements, and Transfers -- Division 12 Customer Service
From July 1, 2007 to June 30, 2008

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Line No.	Acct. No.	Account Title	Beginning Balance	Test Yr. Additions	Retirements	Transfers/Reclassifications Amount	Explanation Of Transfers *	Other Accounts Involved	Ending Balance
			$	$	$	$			$
1	Account 101-1000 Gas Plant in Service - General								
2		General Plant							
3	389.00	Land & Land Rights	0	0	0				0
4	390.01	Structures Frame	0	0	0				0
5	390.02	Structures & Improvements	0	0	0				0
6	390.03	Improvements	0	0	0				0
7	390.04	Air Conditioning Equipment	0	0	0				0
8	390.09	Improvement to leased Premises	3,018,160	0	0				3,018,160
9	391.00	Office Furniture & Equipment	56,077	0	0				56,077
10	391.02	Remittance Processing Equip	0	0	0				0
11	391.03	Office Machines	0	0	0				0
12	392.00	Transportation Equipment	0	0	0				0
13	392.01	Trucks	0						0
14	392.02	Trailers	0						0
15	393.00	Stores Equipment	0	0	0				0
16	394.00	Tools, Shop & Garage Equipment	0	0	0				0
17	396.00	Power Operated Equipment	0						0
18	396.03	Ditchers	0						0
19	396.04	Backhoes	0						0
20	396.05	Welders	0						0
21	397.00	Communication Equipment	24,199,330	0	0				24,199,330
22	397.01	Communication Equipment - Mobile Radios	0						0
23	397.02	Communication Equip. - Fixed Radios	0						0
24	397.05	Communication Equip. - Telemetering	0						0
25	398.00	Miscellaneous Equipment	1,916	0	0				1,916
26	399.00	Other Tangible Property	214,670	0	0				214,670
27	399.01	Other Tangible Property - Servers - H/W	10,022,296	74,788	0				10,097,083
28	399.02	Other Tangible Property - Servers - S/W	6,861,747	0	0				6,861,747
29	399.03	Other Tangible Property - Network H/W	459,784	0	0				459,784
30	399.04	Other Tangible Property - CPU	0	0	0				0
31	399.05	Other Tangible Property - MF Hardware	0	0	0				0
32	399.06	Other Tangible Property - PC Hardware	3,628,122	62,306	85,470				3,604,958
33	399.07	Other Tang. Property - PC Software	2,854,096	0	0				2,854,096
34	399.08	Other Tang. Property - Application Software	74,584,982	246,360	17,088				74,814,253
35	399.09	Other Tang. Property - MF Software	0	0	0				0
36	399.24	Other Tang. Property - General Start Up Costs	23,172,326	0	0				23,172,326
37									
38		Total Plant - Div 12	149,073,507	383,453	102,558	0			149,354,402
39									
40		CWIP without AFUDC	(62,147)						(62,147)

* Transfers are a normal course of events in all accounts and represent changes in function of equipment or a choice in previous year closings.

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Line No.	Acct. No.	Account Title	Beginning Balance	Test Yr. Additions	Retirements	Transfers/Reclassifications Amount	Explanation Of Transfers *	Other Accounts Involved	Ending Balance
1		Intangible Plant	$	$	$	$			$
2	301.00	Organization	185,309	0	0				185,309
3	302.00	Franchises & Consents	0	0	0				0
4	303.00	Misc Intangible Plant	1,109,552	0	0				1,109,552
5									
6		Total Intangible Plant	1,294,861	0	0				1,294,861
7									
8									
9		Distribution Plant							
10	376.01	Mains - Steel	0	0	0				0
11									
12		Total Distribution Plant	0	0	0				0
13									
14									
15	Account 101-1000 Gas Plant in Service - General								
16		General Plant							
17	389.00	Land & Land Rights	0	0	0				0
18	390.01	Structures Frame	179,339	0	0				179,339
19	390.02	Structures & Improvements	0	0	0				0
20	390.03	Improvements	0	0	0				0
21	390.04	Air Conditioning Equipment	5,771	0	0				5,771
22	390.09	Improvement to Leased Premises	38,834	0	0				38,834
23	391.00	Office Furniture & Equipment	1,281,671	0	4,068				1,277,604
24	391.02	Remittance Processing Equip	0	0	0				0
25	391.03	Office Machines	34,505	0	4,805				29,700
26	392.00	Transportation Equipment	(10,915)	0	14,553				(25,467)
27	392.01	Trucks	0	0	0				0
28	392.02	Trailers	0	0	0				0
29	393.00	Stores Equipment	10,698	0	0				10,698
30	394.00	Tools, Shop & Garage Equipment	123,124	0	3,049				120,075
31	396.00	Power Operated Equipment	8,497	0	0				8,497
32	396.03	Ditchers	0	0	0				0
33	396.04	Backhoes	0	0	0				0

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Line No.	Acct. No.	Account Title	Beginning Balance	Test Yr. Additions	Retirements	Transfers/Reclassifications Amount	Explanation Of Transfers *	Other Accounts Involved	Ending Balance
			$	$	$	$			$
1		General Plant contd.							
2	396.05	Welders	0	0	0				0
3	397.00	Communication Equipment	279,270	19,145	0				298,416
4	397.01	Communication Equipment - Mobile Radios	0	0	0				0
5	397.02	Communication Equip. - Fixed Radios	0	0	0				0
6	397.05	Communication Equip. - Telemetering	0	0	0				0
7	398.00	Miscellaneous Equipment	831,253	0	0				831,253
8	399.00	Other Tangible Property	76,993	0	0				76,993
9	399.01	Other Tangible Property - Servers - H/W	71,663	0	0				71,663
10	399.02	Other Tangible Property - Servers - S/W	8,273	0	0				8,273
11	399.03	Other Tangible Property - Network H/W	238,424	0	0				238,424
12	399.04	Other Tangible Property - CPU	0	0	0				0
13	399.05	Other Tangible Property - MF Hardware	0	0	0				0
14	399.06	Other Tangible Property - PC Hardware	1,454,326	69,416	0				1,523,742
15	399.07	Other Tang. Property - PC Software	98,204	0	0				98,204
16	399.08	Other Tang. Property - Application Software	766,349	21,392	0				787,741
17	399.09	Other Tang. Property - Mainframe Software	0	0	0				0
18	399.24	Other Tang. Property - General Start Up Costs	0	0	0				0
19									
20		Total General Plant	5,496,280	109,953	26,474				5,579,759
21									
22		Total Plant - Div 091	6,791,141	109,953	26,474				6,874,620
23									
24		CWIP without AFUDC	183,457						183,457

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