BEFORE THE PUBLIC SERVICE COMMISSION

COMMONWEALTH OF KENTUCKY

IN THE MATTER OF	**) CASE NO. 2006-00464**
RATE APPLICATION BY	**)**
ATMOS ENERGY CORPORATION	**)**
MID-STATES/KENTUCKY	**)**

RESPONSE OF ATMOS ENERGY CORPORATION, KENTUCKY TO

KPSC DATA REQUEST DATED FEBRUARY 23, 2007

(KPSC DATA REQUEST NO. 2)

DR 58 – DR 80

MARCH 16, 2007

Atmos Energy
Case No 2006-0046
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Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 58
Witness: Gary Smith

Data Request:

Refer to the Smith Testimony, page 24, and to the Application, Volume 1, Tab 6, FR 10(1)(b)(7), Proposed Tariff, Original Sheet 42.1 through 42.4.

a. If the CRS mechanism is authorized as proposed, what period will be the first Evaluation Period?

b. What 12-month period will be the first Rate Effective Period?

c. How did Atmos determine that a 45-day period from initial filing of the annual CRS review to the issuance of a Commission Order by April 30 was a reasonable time for staff and the AG to complete their review and for the Commission to render its decision?

d. What does Atmos anticipate its costs will be to file and process an annual CRS case? Provide all assumptions and supporting workpapers.

e. Mr. Smith states that the tariff for the CRS mechanism includes examples of the O&M expense categories subject to adjustment under this mechanism. Provide a list of any expenses that would normally be included in a rate case that are not included in this tariff.

f. Mr. Smith states that the CRS mechanism includes a true-up which would correct for any variances in the projections employed in the preceding filing. For clarification, does the CRS mechanism compare budgeted information against actual earnings in the true-up? Explain the response.

g. Did Atmos consider allowing a dead-band around the return on equity set as the benchmark in the CRS mechanism within which Atmos would require no adjustment in rates? If yes, explain why Atmos did not include it in the proposed CRS mechanism.

h. Provide an analysis of the annual change in revenues (increase or decrease) that Atmos would have implemented each year over the past 5 years under the proposed Customer Rate Stabilization mechanism. Include all workpapers.

Response:

a. The first Evaluation Period would be the 12-month period ending December 31, 2007.

b. The first Rate Effective Period would be the 12-month period beginning May 1, 2008.

c. It is important to reiterate that an annual CRS filing will not be a traditional rate case. It will purely be a review of filed schedules designed to update the basic financial information upon which rates are based. There will be no testimony, no proposed changes in rate design, depreciation or other studies which are typically filed in a rate case. The Company's proposal contemplates the Commission being provided a complete set of financial

schedules by the March 15 Evaluation Date (filing date). These schedules should provide all the necessary information that the Commission has pre-determined is necessary to make a decision regarding the Company's proposed annual rate adjustment.

While it is hoped that any questions the filing may present can be handled in meetings or by email, the Company understands that some data requests are inevitable in such a review. As such, it is expected that two rounds of data requests can be issued if the first round is issued within 5 business days of the filing and a second round, if necessary, is issued 5 business days after the first round of responses are submitted. The Company would provide its responses within 10 business days. That totals 42 days. If the Commission cannot arrive at a decision within 45 days then the rates would automatically go into effect subject to refund after a final decision is made by the Commission. The Company itself would not be issuing data requests. Nor would hearings be necessary.

d. See also the Company's response to KPSC DR 2-56(h).

In FR(10)(10)F Schedule F-6, the Company estimates rate case expenses of $370,000. In contrast the Company estimates its annual filing expense closer to $50,000 ($20,000 legal fees, $15,000 employee expense and $15,000 in miscellaneous expenses). A greater expense would clearly indicate a litigious response to its annual filing.

The Company also proposes to include in the filing those costs incurred by the AG and Commission to review its annual filing.

e. All costs included in a traditional rate case would be included in an annual CRS filing.

f. In the historical review, actual revenues are compared to actual costs. In the prospective review, a true-up of budgeted projections made in the previous filing would occur.

g. No. The calculation to determine any required rates increase or decrease is a simple one. A deadband feature would perhaps complicate what is intended to be simple. That position notwithstanding, the Company is certainly open to such a feature if it is determined to be beneficial to the process.

h. The Company is unable to conduct a meaningful analysis of the change in revenues over the past five years if the Customer Rate Stabilization (CRS) had been in effect due in large part to the fact that Company's current rates were set in 1999 and therefore, there is no baseline information available for the past five years. Further, the settlement of the 1999 rate case did not include a specified return on equity. Therefore, any analysis for the past five years would necessarily include so many assumptions that it would be rendered meaningless. Company is willing to participate in a meeting to fully explain the mechanism and how it would operate. The proposed CRS mechanism is a prospective rate adjustment mechanism which is trued-up each year. The mechanism would review per books results and apply adjustments to certain expenses and rate base items in accordance with terms of the Order in this Case, and track to the authorized return which will be established in the Case. Partly in recognition that the CRS mechanism is new, the Company proposes that the mechanism be approved as a limit-term pilot program.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 59
Witness: Gary Smith

Data Request:

Refer to the Smith Direct Testimony, page 25, line 6 through page 28, line 13, regarding the rebalancing of the residential customer charge.

a. Does Atmos consider the CRS mechanism to be a form of revenue decoupling? Explain the response.

b. Will Atmos still need to increase its customer charge as proposed if Atmos is authorized to implement the CRS mechanism? Explain the response.

Response:

a. Although Atmos Energy does not consider the proposed CRS mechanism a "decoupling" mechanism, the Company recognizes that the CRS does achieve certain benefits similar to those achieved through decoupling mechanisms. Decoupling mechanisms, to the Company, refer to a family of rate designs which break the traditional link between volumes delivered and the achievement of authorized distribution revenue requirements. One example of a rate design meeting this "decoupling" definition would be full recovery through fixed monthly customer charges with no volumetric distribution rates. In this sense, "decoupling" refers strictly to the revenue side of the equation, not to the cost side or to the overall return.

   The CRS mechanism proposed by the Company, however, is intended to monitor the overall return and correct for any over-/under-achievement of the authorized rate of return. Since the CRS would, necessarily, consider both the revenue and cost elements in order to monitor the overall return, the mechanism would in effect decouple earnings from volumetric links.

b. As stated in testimony, we believe the proposed rate structure (with higher customer charges) is more reflective of the underlying fixed cost nature of natural gas distribution and operations. Therefore, we believe that rebalancing our rates to collect more of our distribution revenues through non-volumetric charges is the appropriate course, even in combination with the experimental CRS.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 60
Witness: Gary Smith

Data Request:

Refer to the Smith Testimony, pages 22 through 25. Concerning the proposed CRS mechanism:

a. Has a CRS mechanism exactly like the one proposed in this proceeding been approved in any of the other regulatory jurisdictions in which Atmos operates? If yes, identify the jurisdiction, indicate when the CRS mechanism was approved, and state how many annual reviews have been undertaken using the mechanism.

b. Has a CRS mechanism similar to the one proposed in this proceeding been approved in any of the other regulatory jurisdictions in which Atmos operates? If yes, identify the jurisdiction, identify all the differences between the approved mechanism and the CRS mechanism proposed in this proceeding, indicate when the CRS mechanism was approved, and state how many annual reviews have been undertaken using the mechanism.

c. Concerning the accounting and pro-forma adjustments to the historical period and the "typical" forward-looking known and measurable adjustments, who determines the adjustments that would be included? Explain the response.

d. Under the procedure envisioned in the CRS mechanism, would any party to the annual proceeding or the Commission be able to propose or investigate accounting, pro forma, or forward-looking known and measurable adjustments that had not been identified by Atmos? Explain the response.

e. Explain in detail why testimony should not be filed in support of any proposed accounting, pro forma, or forward-looking known and measurable adjustment.

f. Explain in detail what incentives or controls are included in the proposed CRS mechanism to encourage Atmos to control or contain the growth of its operating expenses.

Response:

a. No, the Company is not aware of a mechanism exactly like our proposed CRS.

b. Yes. The Company has attached, as Attachment KPSC DR 2-60(b), a summary of Revenue Stabilization Mechanisms published recently by the American Gas Association (AGA). The December 2006 AGA report provides an overview of the various mechanisms in place similar to the one proposed in this case.

c. With respect to the prospective review of the Rate Effective Period, the Company will propose only those specific or typical adjustments, or other adjustments which are consistent in some manner with previously granted

adjustments, approved by the Commission in the most recent rate case. Sufficient documentation for each of these adjustments will be filed by the Company upon its initial annual filing.

As our response to KPSC DR 2-57(c) indicates, there will be very limited adjustments to the historical review of the Evaluation Period.

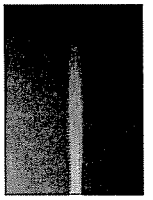
Ultimately, the Commission will determine the adjustments to be included in any rate changes through this mechanism.

d. Yes. Any such adjustment that the Commission Staff or AG would propose should be submitted to the Company for the Company's consideration coincident with the submission of any data requests. Should the Company disagree with any such adjustment, and want to further pursue such an adjustment, the Commission Staff or AG is free to reiterate its position in its recommendation to the Commission.

e. Please refer to the Company's response to KPSC DR 2-60(c) above. It is not necessary to file testimony to justify any adjustment. If in the Company's initial filing, meetings, emails or in response to data requests the Company has not sufficiently justified any adjustment, the Commission Staff or AG may state their position in their respective recommendation to the Commission.

f. Atmos Energy's record in providing rates which have historically been among the lowest in the state and the nation speaks strongly for the Company's efficient business model and its motivation to maintain its industry leadership in that regard. Certainly from a business perspective, cost containment is essential to ensure our rates remain competitive. An annual review would not alter the controls currently in place to contain costs. The goal would still be the same: incur only those costs which are prudent and necessary to provide safe, reliable and high quality customer service. Certainly any proposed change in rates would still be subject to Commission review and approval. If anything, the increased frequency of Commission review may provide more incentive to control costs.

AGA
American Gas Association



NATURAL GAS
RATE ROUND-UP
A Periodic Update on Innovative Rate Designs
December 2006

Revenue Stabilization Mechanisms

This issue of the *AGA Rate Round-Up* describes a rate design method that stabilizes customers' bills as well as stabilizes the utility's earnings. The mechanism also reduces the costs of regulatory proceedings to adjust natural gas rates and thereby reduces costs for consumers and the public.

DESCRIPTIONS AND COMPARISONS

Revenue Stabilization Programs

Revenue stabilization, also known as rate stabilization, is a rate design mechanism that decouples a utility's profits from its gas throughput. The mechanism works by adjusting the utility's rates up or down to meet pre-established return and revenue targets. The adjustment amount calculated is added to or subtracted from the commodity charge of the utility in the next period, and the utility files a revised rate schedule with the regulator. Revenue stabilization is not incentive regulation because no reward is granted to the company for hitting performance targets. Instead, revenue stabilization is one of several innovative rate designs that break the link between recovery of a utility's fixed costs and the energy consumption of the utility's customers. Natural gas utilities in five states have received approval for revenue stabilization and the mechanism is pending in a sixth state.

The mechanics and results of revenue stabilization programs are similar to both revenue decoupling mechanisms and weather normalization adjustment (WNA) clauses. As with decoupling, an expedited revenue study is performed in lieu of a general rate case and there are more periodic, yet generally smaller, rate adjustments. The mechanism takes into account normalized customer consumption patterns. Revenue stabilization ensures that the utility does not over-recover or under-recover its authorized distribution charge. However, there are some important differences. The expedited rate study of a revenue stabilization mechanism includes cost elements as well as revenue components. Utility infrastructure investment between rate cases is an important cost item on which many revenue stabilization programs focus. Some revenue stabilization programs benchmark expenses and disallow new expenses greater than the benchmark. Annual adjustment to the utility's rates ensures that the actual return on equity (ROE) falls within a numerical band around the allowed ROE. Revenue stabilization

adjustments may be symmetrical around the ROE band, in that the rate adjustment amount is the same for over-earning the allowed return as it is for under-recovering the allowed return. In some programs, the adjustment is graduated, with some sharing by customers and shareholders of returns above the authorized amount.

Revenue Stabilization and Other Innovative Rate Design Comparisons

More than one rate design method exists that will break the link between volumes of gas consumed and cost recovery for the utility. **Weather normalization adjustment clauses** are rate adjustment mechanisms that neutralize the impact of unusually cold or warm weather on a gas company's revenues and income. Adjustment clauses of all types are actuated without the need for a formal rate hearing.

Another innovative rate technique is **fixed variable rate design**, which places all of the utility's fixed costs, including a regulated profit on the value of the utility's investment in plant and equipment used to provide service to the customer, into a fixed monthly charge called a service charge or a demand charge. This charge is similar to the monthly fee charged by cable TV companies and is unrelated to the amount of gas (or number of TV programs) used by the customer. The basic differences among the various programs include the following:

- With **revenue stabilization**, rates remain volumetric, but if **returns** vary from the level in the rate case, rates are adjusted in the next period.
- With **revenue decoupling mechanisms**, rates remain volumetric, but if **marginal revenues** vary from the level in the rate case, rates are adjusted in the next period.
- Rates remain volumetric with **weather normalization adjustment clauses**, but if **weather-related revenues** vary from the level in the rate case, rates are adjusted either simultaneously or in the next period.
- Rates become **less volumetric and more fixed** with **fixed variable rate design**. Depending on the amount of fixed cost recovered in the service charge or in the first block of the rate design, this can be a purely fixed rate design.

CURRENT AND PROPOSED REVENUE STABILIZATION MECHANISMS

Louisiana

Atmos Energy's two Louisiana natural gas utilities, Louisiana Gas Service and Trans Louisiana Gas, have had a rate stabilization clause (RSC) for several years. On May 25, 2006, the Louisiana Public Service Commission (PSC) extended the RSC for three years through June 1, 2009. The PSC established a 10.4 percent return on equity for both companies through 2009. After 2009, the companies will continue operating under the RSC until the PSC revises the mechanism. The order established a 10.0 to 10.8 percent ROE dead-band for **Trans Louisiana**. If the actual ROE goes above 10.8 percent, rates will be reduced by the amount necessary to reduce the actual ROE to the upper-end of the dead-band. If the actual ROE goes below 10 percent, rates will be increased by the amount necessary to increase earnings to the low-end of the dead-band.

Louisiana Gas is not subject to a dead-band and the company's rates will be adjusted in each of the first three years the RSC is in effect by the amount required to achieve a 10.4 percent ROE. Louisiana Gas is subject to an operations and maintenance (O&M) expense benchmark sharing

mechanism, which is adjusted annually for changes in inflation and customer levels. The 10.4 percent ROE must be calculated using the adjusted O&M benchmark.

CenterPoint Energy operates in Louisiana under a rate stabilization plan that includes a 100-basis-point dead-band around a 10.5 percent ROE and a graduated rate adjustment component. The company's ROE is adjusted annually for certain known and measurable changes (e.g., salary and benefits, revenue taxes), and the change to base rates is made by adjusting the commodity charge. For differences between the actual ROE and the allowed ROE of up to 200 basis points, rates are increased or decreased by 50 percent of the difference necessary to bring the allowed ROE to the end point of the dead-band. For example, if earnings are 200 basis points above the allowed ROE, rates are reduced by the amount necessary to reduce the actual ROE by 75 basis points (or one half the difference between 200 basis points and 50 basis points above the allowed ROE).

For differences of more than 200 basis points above or below the allowed ROE, rates are adjusted by 100 percent of the amount necessary to eliminate the return differential in excess of 200 basis points plus one half of the difference between 200 basis points and the end point of the dead-band. For example, if the earned ROE is 250 basis points below the allowed ROE, rates are increased by an amount equal to that necessary to increase the return by the 50 basis points in excess of the allowed ROE, minus 200 basis points plus 75 basis points for one half of the difference between 200 basis points and 50 basis points below the allowed ROE.

Entergy New Orleans' current rate stabilization plan is similar to the plan for CenterPoint Energy and includes a 100-basis-point dead-band around a 10.5 percent return on equity and a graduated rate adjustment component. The current mechanism, which is in effect until 2008, will continue operating after that until the clause provisions are revised by the Louisiana PSC.

Mississippi

CenterPoint Energy's mechanism in Mississippi features an annual recalculation of the allowed return on equity and a graduated sharing of earnings above the authorized return. The authorized ROE is determined annually by taking the average of three ROE calculation methods: the discounted cash flow method, the capital asset pricing model method, and the regression analysis method. There is a 200-basis-point dead-band around the authorized ROE.

Once the annual authorized ROE has been determined, if the actual ROE is more than 100 basis points below the allowed ROE, then rates are adjusted up to 25 basis points below the allowed ROE. If the actual ROE is greater than 100 basis points but less than or equal to 200 basis points above the authorized ROE, the company returns 25 percent of those earnings to customers. If the actual ROE is greater than 200 basis points but less than or equal to 400 basis points above the authorized ROE, the company refunds 50 percent of those earnings to customers. Under the mechanisms, all earnings greater than 400 basis points above the ROE are returned to customers.

Atmos Energy operates in Mississippi under a rate regulation adjustment clause that is similar to CenterPoint Energy's mechanism.

Oklahoma

CenterPoint Energy's performance based regulation plan, which is in effect until 2009, works in much the same way as a revenue stabilization mechanism. The plan includes a 100-basis-point dead-band around the authorized return of 10.25 percent, and a sharing of earnings above

the authorized ROE. Seventy-five percent of incremental returns above 10.75 percent are returned to customers, while 25 percent of incremental returns above 10.75 percent flow to shareholders. When an increase in revenues is authorized under the plan, the amount is allocated 80 percent to residential customers and 20 percent to general service customers. One half of the revenue increase is added to the monthly customer charge and the other half is added to the commodity rate for the first block of the rate schedule. For returns below the dead-band, the company is allowed to surcharge rates to earn up to 10.25 percent.

Alabama

Mobile Gas Service has had a rate stabilization mechanism since 2002. The company's rates for recovering its total cost of service and allowed return are adjusted annually based on a formulary rate-setting mechanism approved by the Alabama Public Service Commission. All operational costs are included in the annual operations budget and are recovered through current rates established through the rate-setting mechanism. Costs included in the annual rate formula, which are supported by third-party quotes and internal work estimates, are disallowed above a benchmark based on the consumer price index. The plan incorporates a dead-band of 50-basis-points.

Alabama Gas Co.'s current rate stabilization plan is similar to the plan for Mobile Gas Service and was originally implemented in 1983. Since its implementation, Alagasco's plan has been subject to public hearing and comment, and has been modified three times. When an increase in revenues is authorized, the plan caps the amount of increase. Rates can be adjusted upward only once a year, but can be adjusted downward quarterly if year-end net income will exceed the authorized ROE range. The plan has a dead-band of 50 basis points.

South Carolina

South Carolina legislated a Natural Gas Stabilization Act in February 2005 that permits natural gas utilities, upon PSC approval, to adjust rates once per year if their earned ROE is outside a 100-basis-point dead-band around the last authorized ROE. On June 15, 2006, **Piedmont Natural Gas** filed for an increase in rates under the provisions of the legislation. The increase was necessitated due to significant system strengthening investment, residential and commercial customer growth, and continued reduction in normalized use per customer. In September, the company and Office of Regulatory Staff reached a settlement, subsequently approved by the commission, whereby residential rates increased 3.8 percent and commercial rates increased 2.9 percent.

Also on June 15, 2006, **South Carolina Electric and Gas**, which currently is authorized a 10.25 percent ROE, filed to increase its rates under the provisions of the legislation. Residential and commercial customer growth and utility infrastructure investment, specifically liquefied natural gas facilities to help meet peak demand and additional natural gas storage capacity, are the incremental cost elements that led to the requested rate adjustment. The 3.26 percent rate increase would be allocated differentially among customer classes, with residential rates increasing 4.2 percent, small and medium commercial rates rising 2.8 percent, and large commercial and industrial rates increasing 2 percent.

Texas - Pending

Atmos – Mid-Texas Division
In May 2006, Atmos Energy filed a proposal with the Texas Railroad Commission for several rate design changes, including a weather normalization adjustment and a revenue stabilization adjustment. The company's filing, if approved, would authorize an overall ROE of 11.75 percent and would not be subject to a dead-band. The revenue stabilization adjustment would adjust revenues twice a year based on the difference between actual revenues and authorized revenues as adjusted for customer growth. The adjustment periods would be seasonal, with recovery in the following season and reconciliation in the next period. The WNA has already been approved on an interim basis. The new rates would be for the 440 incorporated cities and approximately 1.5 million customers that Atmos Energy serves throughout its Mid-Tex Division service territory, including the Dallas-Fort Worth area.

DENIED MECHANISMS

- **Arkansas Western** in Arkansas – Although the rate stabilization mechanism was denied for Arkansas Western, the Arkansas Public Service Commission recently completed a generic investigation and industry collaborative on energy efficiency mechanisms. A report is expected soon.
- **Atmos Energy** in Georgia – Straight fixed variable, an innovative rate design that decouples the recovery of utility fixed costs from volumetric throughput, is a similar rate design that is accepted in Georgia.
- **CenterPoint Energy Southern Operations** in Arkansas – Arkansas recently completed a generic investigation and industry collaborative on energy efficiency mechanisms. A report is expected soon.

HOW WELL HAVE THEY WORKED?

- **Revenue stabilization mechanisms have reduced the cost of regulation.** In his written opinion, Commissioner Robert Anthony (OK) stated that plans like the one approved for CenterPoint by the Oklahoma Commerce Commission allow for annual streamlined reviews of the company's operations without the expense of a full-blown rate case.
- **Revenue stabilization has reduced regulatory lag and has stabilized recovery of utility earnings** while at the same time **has stabilized customer** rates when increased utility earnings have exceed the authorized ROE.
- The volatility of customer rates has been reduced by revenue stabilization mechanisms that allow **more efficient recovery of costs associated with maintaining and expanding natural gas service infrastructure.**

RESOURCES: COMPANIES, RATE ORDERS, WEBSITES, CONTACTS, ETC.

- Alabama Gas – **Alabama** – Approved – www.psc.state.al.us *Amy Stewart @ 205-326-8144*
- Atmos Energy – **Georgia** – Denied – Georgia Order No. 20298-U, February 2, 2006; *Contact Pat Childers @ 615-771-8332*
- Atmos Energy – **Louisiana** – Approved – Louisiana PSC Case No. U-28814, May 18, 2006; *Contact Christine Tabor @ 225-376-4605;*
https://pslpsc.org/Workplace/WcmJavaViewer.jsp?vsId=%7BE5A00668-D2CD-4729-A5C4-

E8A012B60FFC%7D&objectStoreName=Dockets&objectType=document&id=%7B3100C462-AA37-40B4-9543-06429D7F716A%7D

- **Atmos Energy – Mississippi** – Approved – Mississippi PSC Docket No. 05-UN-0503, October 7, 2005; *Contact Bill Senter @ 601-360-1461*
- **Atmos Energy Mid-Tex – Texas** – Pending – Texas Railroad Commission Docket No. GUD 9670, May 31, 2006; *Contact Charles Yarbrough @ 214-206-2809*
- **CenterPoint Energy Southern Operations– Arkansas** – Denied – Arkansas PSC Docket No. 04-121-U, September 19, 2005; *Contact Chuck Harder @ 713-207-7273*
- **CenterPoint Energy – Louisiana** – Approved – Louisiana PSC Order No. U-26720 Subdocket A, Rider RSP-R3, September 16, 2004; *Contact Chuck Harder @ 713-207-7273*
- **CenterPoint Energy – Mississippi** – Approved – Mississippi PSC Schedule #2, Rider RRA: Feb 1998; *Contact Chuck Harder @ 713-207-7273*
- **CenterPoint Energy – Oklahoma** – Approved – Oklahoma CC Cause No. PUD-200400187, Order No. 499253; December 28, 2004; *Contact Chuck Harder @ 713-207-7273*
- **Entergy New Orleans, Inc. – Louisiana** – Approved – Rider Schedule GFRP-2, August 25, 2005; *Contact Al Eiffert @ 504-670-3673*
- **Mobile Gas Service – Alabama** – Approved –Alabama PSC Docket No. 28101, June 10, 2002, www.psc.state.al.us, *Contact Danny Ford @ 251-450-4637*
- **Piedmont Natural Gas – South Carolina** – Approved – South Carolina PSC Docket No. 2005-113-G; *Contact David Carpenter @ 704-731-4242;* http://dms.psc.state.sc.us/attachments/F736538C-C702-4F87-F8A6D0E7456EF171.pdf
- **South Carolina Electric and Gas – South Carolina** – Approved – South Carolina PSC Docket No. 2005-113-G, October 31, 2005; http://dms.psc.state.sc.us/attachments/F736538C-C702-4F87-F8A6D0E7456EF171.pdf

ADDITIONAL INFORMATION

If you would like more information about a particular program or would like to speak to another AGA member regarding the details of the program, please contact: *Cynthia Marple*, AGA director of rates and regulatory affairs, cmarple@aga.org or 202-824-7228.

Previous Editions:

The June 2006 Rate Round-Up on Innovative Rate Designs for Fixed Cost Recovery can be found at: http://www.aga.org/Template.cfm?Section=Rate_Round-Up&Template=/MembersOnly.cfm&ContentID=20563g

The July 2006 Rate Round-Up was an updated version of the November 2005 article on revenue decoupling. Find this Round-Up at: http://www.aga.org/Template.cfm?Section=Rate_Round-Up&template=/ContentManagement/ContentDisplay.cfm&ContentID=20693

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 61
Witness: Gary Smith

Data Request:

Refer to the Application, Volume 1, Tab 6, FR 10(1)(b)(7) Original Sheet 42.3, Section 5(b).

a. Atmos has offered to include all costs incurred by the AG and the Commission in the review of the annual filings under the CRS mechanism in its operating and maintenance costs. For clarification, does this mean that the costs will be included as part of the surcharge under the mechanism and paid for by ratepayers?

b. If yes, explain in what manner all costs incurred by the AG and Commission will be identified by Atmos and recovered in the CRS mechanism.

Response:

a. Yes.

b. The Company anticipates that the AG and Commission would submit any projected incremental costs associated with the annual review to be used in the prospective review. Those projections would then be subsequently trued-up a year later based upon actual costs.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 62
Witness: Gary Smith

Data Request:

Refer to Smith Testimony, page 24. Mr. Smith testifies that the CRS "will reduce the costs associated with the alternative rate cases for the Company and its regulators." Provide any analyses that Atmos performed to support this statement. If no analyses were performed, explain the statement.

Response:

Please see Company's responses to KPSC DR 2-56(h) and 2-58(d). While there would still be substantial costs associated with a traditional rate case, it is expected that such costs would be lower because the Commission's and AG's increased familiarity with the Company's finances should result in a less litigious and therefore less costly process.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 63
Witness: Gary Smith

Data Request:

Refer to the Smith Testimony, page 29. Provide copies of the tariffs in Tennessee, Virginia, Kansas and Amarillo, Texas that allow for recovery of the gas cost portion of bad debt through the gas cost adjustment ("GCA") mechanism.

Response:

Please see attachment AG DR 1-63 for the tariff sheets for the Virginia, Kansas and Amarillo, Texas jurisdictions. For Tennessee, a copy of the Tennessee Regulatory Authority Order is provided.

Virginia S.C.C. No. 1
5th Revised Sheet No. 34
ATMOS ENERGY CORPORATION Cancelling 4th Revised Sheet No. 34

PURCHASED GAS ADJUSTMENT RIDER (Continued)

G. Actual Cost Adjustment (ACA)

1. For each twelve month period ending October 31, the Company shall calculate, in accordance with the formula set forth below, the amount by which the revenues recovered by the Company under this Rider were greater or less than the cost of the gas sold by the Company during such period. This amount, hereinafter referred to as the "ACA", shall if positive (i.e., an over recovery) be subtracted from, if negative (i.e., an under recovery) be added to, the current Purchased Gas Adjustment. The "ACA" shall be separated into its Demand and Commodity components when applied to the Current Cost.

2. ACA Formula:

$B_1 = [R - P - N + W - E + U + I - B_0] / S$

Where:

B_1 = ACA for the current twelve-month period

B_0 = ACA for the preceding twelve- month period

R = Revenues recovered under this Rider during the current twelve-month period

P = Costs of all gas when purchased from Suppliers during the current twelve-month period

N = Costs when purchased from Suppliers of gas injected into storage during the current twelve-month period

W = Inventory costs of storage gas, Liquefied Natural Gas (LNG) and Liquefied Petroleum Gas (LPG) withdrawn from storage during the current twelve-month period

E = Residual balances of expired refunds.

I = Interest on the monthly average ACA balance. The interest rate shall be the interest rate on customer deposits prescribed by the Commission.

U = The gas cost portion of uncollectible accounts written-off during the ACA period, less any gas cost portion of collections from accounts previously written-off. Factor U shall be treated as a commodity cost.

S = Sales

Issued by: Thomas R. Blose, Jr., President, Mid-States Division
Date Issued: January 28, 2005 Effective Date: February 1, 2005

Form RF | Index No.

THE STATE CORPORATION COMMISSION OF KANSAS

SCHEDULE V: Purchased Gas Adjustment (PGA)

ATMOS ENERGY CORPORATION
(Name of Issuing Utility)

ENTIRE SERVICE AREA
(Territory to which schedule is applicable)

Consolidation of PGA into Kansas Division and Southwest Division

No supplement or separate understanding shall modify the tariff as shown hereon.

Sheet 4 of 8 Sheets

E. COSTS INCLUDED

The formula includes only costs which are properly included in FERC Accounts 800, 801, 802, 803, 804, applicable to Kansas; 805, 806, 808, and 809.

F. SETTLEMENT PROVISIONS

Subsequent to the effective date of this clause, the Company shall maintain a continuing monthly comparison of the actual (as billed) cost of gas as shown on the books and records of the Company, exclusive of refunds, and the cost recovery for the same month calculated by applying to the volumes sold during said month the purchased gas cost adjustments calculated pursuant to these purchased gas cost adjustment provisions. For each twelve month period ended August 31, the differences of the comparisons described above including any balance or credit for the previous year shall be accumulated to produce a cumulative balance of over-recovered or under-recovered costs.

An "Actual Cost Adjustment" (ACA) shall be computed by dividing the cumulative balance of under-recovered or over-recovered costs by the volume of total sales during the twelve month period ending on that date. This adjustment shall be rounded to the nearest $.0001 per Ccf and applied to sales billed on or after the first day of the month following the month in which the adjustment has been approved by the Commission. The "Actual Cost Adjustments" shall remain in effect until superseded by subsequent "Actual Cost Adjustments" calculated according to this provision.

The cumulative balance of over-recovered or under-recovered costs shall include the Gas Cost portion of uncollectible accounts billed to customers under this Schedule during the preceding Computation Year and which remain unpaid. The Gas Cost portion of uncollectible accounts is recoverable through the ACA to the extent that it is greater than bad debt expense allowed in base rates, which are included in the Account 904 balance filed in the Company's most recent rate case. If the Gas Cost portion of uncollectible accounts is less than the bad debt expense allowed in base rates, the difference shall be included as a credit to the cumulative balance. This sub-component of the ACA will be a separate line item on Sheet 1 of the Purchased Gas Adjustment.

Issued: August 23, 2005

Effective: September 1, 2005

By _____ VP-Rates & Reg Affairs
Signature of Officer Title

ATMOS ENERGY CORPORATION
Amarillo Distribution System - ICL **Rate Schedule: 6931 AMA GCA RIDER I**
Page 14

Gas Cost Adjustment Rider

Application

Gas bills issued under rate schedules to which this Rider applies will include adjustments to reflect decreases or increases in purchased gas costs or taxes. Accumulated Deferred Gas Costs shall also be adjusted for gas costs amounts which are uncollectible. Any such adjustments shall be filed with the City's Secretary before the beginning of the month in which the adjustment will be applied to bills. The amount of each adjustment shall be computed as follows:

Gas Cost Adjustment (GCA)
The GCA to be applied to each Ccf billed shall be computed as follows and rounded to the nearest $0.01:

$$GCA = (G/S + CF) \times TF$$

Where:

1. "G", in dollars, is the expected cost of gas for the expected sales billing units.
2. "S", in Ccf as measured at local atmospheric pressure, is the expected sales billing units to be billed to customers in the Company's Amarillo Inside City Limits Service Area.
3. "CF", in $/Ccf as measured at local atmospheric pressure, is the correction factor charge per Ccf to adjust for the cumulative monthly difference between the cost of gas purchased by the Company and the amount of gas cost billed to the customer plus any gas cost which is uncollectible.

More specifically, CF shall be calculated as follows:

$$CF = (a/b) + (c/b)$$

a = over (under) collection dollar amount for the 12 month period ending September.

b = expected estimated sales volumes for the future 12 month period ending November.

c = net collectible gas cost, that is:

(uncollectible gas cost for the previous 12 months ended September) – (subsequently collected gas cost for the previous 12 months ended September)

Once a year, on a 12 months ended September basis, the Company shall review the percentage of lost and unaccounted for gas. If this percentage exceeds 5% of the amount metered in, the correcting account balance will be reduced so that the customer will effectively be charged a maximum of 5% for lost and unaccounted for gas and the Company will absorb the excess.

4. "TF" is a tax factor of 1.07301 for customers inside the city limits.

EFFECTIVE: Bills rendered on and after September 1, 2003 Inside City Limits, Amended October 1, 2005

ISSUED BY: C.W. Guy, Vice President - Rates & Regulatory Affairs

Motion of Chairman Ron Jones in Docket No. 03-00209 - *In re: Petition of Chattanooga Gas Co., Nashville Gas Co., a Division of Piedmont Natural Gas Co., Inc. and United Cities Gas Co., a Division of Atmos Energy Corp. for a Declaratory Ruling Regarding the Collectibility of the Gas Cost Portion of Uncollectible Accounts Under the Purchase Gas Adjustment ("PGA") Rules*

During the February 9, 2004 deliberations, the panel ruled in favor of modifying the refund adjustment formula contained in Authority Rule 1220-4-7-.03(1)(b) to allow Petitioners to recover actual uncollected gas costs. The panel further determined to leave the docket open for one year after which time the panel would decide whether the modification should be permanently adopted. At the April 5, 2005 Conference, the panel recognized the need for further investigation and extended the experimental period for one year. The panel also ordered Petitioners to file by June 1, 2005, a joint proposal setting forth accounting procedures for uncollectible costs in the actual cost adjustment annual filing. Petitioners filed the required procedures on June 1, 2005.

Today, we are here to determine how to proceed. A review of the formula and the jointly proposed procedures reveals that the process should function properly. The Authority has noticed, though, several failures in application of the formula and procedures that significantly detract from the accuracy of the accounting. Two examples are a failure to net eligible uncollected costs with the gas costs included in a company's authorized allowance for uncollectible costs and a failure to allocate subsequent payments at the same percentage as the original write-off. The ill-effects of these failures, however, will be removed if the use of the modified refund adjustment is conditioned on the following: (1) the accounting procedures jointly proposed by the Petitioners, (2) some additional procedures; and (3) reporting requirements.

Before proceeding with my motion, I note that I have for the Directors' review and the Court reporter's record two documents. The first is titled "Procedures for Uncollected Gas Cost Recovery in the Annual ACA Filing" and lists the jointly proposed accounting procedures and three

additional procedures, which are numbered 7, 8 and 10. The second document is titled "Uncollectible Gas Cost Recovery Reporting Forms and Instructions."

Based on the foregoing, I move that the panel permanently adopt as an alternative the modified refund adjustment formula and condition its use by any company on compliance with the "Procedures for Uncollected Gas Cost Recovery in the Annual ACA Filing" and the "Uncollectible Gas Cost Recovery Reporting Forms and Instructions." Further, I move that the Authority initiate a rulemaking to incorporate into the appropriate rule section the modified formula and the conditions of using that formula. To move the rulemaking along, I move also that the panel authorize General Counsel to forward a notice of rulemaking to the Office of the Secretary of State containing rules consistent with the "Procedures for Uncollected Gas Cost Recovery in the Annual ACA Filing" and the "Uncollectible Gas Cost Recovery Reporting Forms and Requirements" adopted today.

PROCEDURES FOR UNCOLLECTED GAS COST RECOVERY IN THE ANNUAL ACA FILING

Recovery of uncollected gas costs using the modified Refund Adjustment Formula is optional. Any regulated gas company electing to recover uncollected gas costs in its annual ACA filing using the modified formula shall comply fully with the following procedures:

1. At the time of write-off, the gas cost and the margin portion of the uncollected account shall be specifically identified from the customer's bill(s) and a percentage of gas costs to the total account written-off established.

2. For purposes of the calculation in No. 1, other charges, such as late fees, applicable state taxes, and collection fees shall not be included in the calculation of the percentage of gas costs to the total account written-off.

3. If the account balance is later collected in full, the uncollected gas costs shall be credited with the full amount of the gas cost portion of the account.

4. If the account balance is not collected in full, the partial payment shall be allocated and credited to uncollected gas costs using the same percentage (ratio) established for gas costs in No. 1.

5. If a company's billing system is not capable of accurately prorating a partial payment, the partial payment shall be credited 100% to uncollected gas costs first, with any remainder treated as recovered margin.

6. For those companies whose allowance for uncollectible accounts contains a gas cost portion, the amount of that portion must be netted with the eligible uncollected gas costs included for recovery in the ACA. Each such company must submit its calculation during the ACA audit for review and acceptance by the TRA compliance staff.

7. Each company that wishes to submit its uncollected gas costs for recovery through the ACA shall separately track each account that is written-off in sufficient detail, so as to permit the TRA compliance staff to audit write-offs and subsequent payments on written-off accounts. Each company shall submit a monthly summary report detailing each write-off and each payment to written-off accounts for that month and the total amount eligible for recovery in the ACA no later than the first business day of the third month following the reporting month, using the format prescribed by the Authority in the Uncollectible Gas Cost Recovery Reporting Forms and Instructions. Corrections or adjustments to these reports shall be timely filed.

8. Any deviation in amounts charged in the annual filing of the ACA from those recorded in these monthly reports shall be documented for review by the TRA compliance staff during the annual audit of the ACA.

9. The gas cost portion of written-off accounts and the amount recovered from payments on these accounts shall be charged or credited, as appropriate, to the ACA account at least annually for inclusion in the ACA filing.

10. All companies electing to adopt the modified Refund Adjustment Formula shall electronically file monthly reports in accordance with the instructions contained in the Uncollectible Gas Cost Recovery Reporting Forms and Instructions.

Uncollectible Gas Cost Recovery Reporting Forms and Instructions

Name of Company
Month and Year
Accounts Written-Off Report

A	B	C	D	E (C + D)	F (C / E)	G (D / E)
Customer Number	Write-off Date	Gas Cost Written-off	Margin Written-off	Total Gas Cost and Margin Written-off	Gas Cost % of Total Gas Cost and Margin Written-off	Margin % of Total Gas Cost and Margin Written-off
				0.00	#DIV/0!	#DIV/0!
				0.00	#DIV/0!	#DIV/0!
				0.00	#DIV/0!	#DIV/0!
				0.00	#DIV/0!	#DIV/0!
				0.00	#DIV/0!	#DIV/0!
				0.00	#DIV/0!	#DIV/0!
				0.00	#DIV/0!	#DIV/0!
Total		0.00	0.00	0.00	#DIV/0!	#DIV/0!

Name of Company
Month and Year
Recoveries of Accounts Previously Written-Off Report

A	B	C	D	E	F (D + E)	G (D / F)	H (E / F)
Customer Number	Payment Date	Original Write-off Date	Gas Cost Payment Amount	Margin Payment Amount	Total Gas Cost and Margin Payment	Gas Cost % of Total Gas Cost and Margin Payment	Margin % of Total Gas Cost and Margin Payment
					0.00	#DIV/0!	#DIV/0!
					0.00	#DIV/0!	#DIV/0!
					0.00	#DIV/0!	#DIV/0!
					0.00	#DIV/0!	#DIV/0!
					0.00	#DIV/0!	#DIV/0!
					0.00	#DIV/0!	#DIV/0!
					0.00	#DIV/0!	#DIV/0!
Total			0.00	0.00	0.00	#DIV/0!	#DIV/0!

General Instructions

- Monthly reports must be submitted in an Excel spreadsheet format.
- Monthly reports should be sent via email to paul.greene@state.tn.us and copied to pat.murphy@state.tn.us .
- Monthly reports are due by the first business day (excluding weekends and State holidays) of the third month following the month reported (e.g., May 2006 reports would be due August 1, 2006).
- Hard copy submissions are not required (unless subsequently requested by Staff).
- If you desire formatted Excel spreadsheets to utilize in reporting, please email paul.greene@state.tn.us .
- Any deviation from the prescribed format requires the prior approval of Staff.

Accounts Written-off Report (refer to page 1 of 4)

- Column A - Customer Number. Spreadsheet must be sorted by customer number in ascending order prior to submission.
- Column B - Write-off Date.
- Column C – Amount of Gas Cost written-off.
- Column D – Amount of Margin written-off.
- Column E - *Total amount of Gas Cost and Margin written-off* (Column C + Column D).
- Column F – Gas Cost % of total Gas Cost and Margin written-off (Column C divided by Column E) rounded to 2 decimal places.
- Column G - Margin % of total Gas Cost and Margin written-off (Column D divided by Column E) rounded to 2 decimal places.
- Columns C, D and E should contain only costs related to the delivery of gas. Late fees, taxes, collection fees, or other charges must not be included.
- Totals – Columns C, D and E should be totaled. The amount shown in Column F total should equal the total of Column C divided by the total of Column E rounded to 2 decimal places. The amount shown in Column G should equal the total of Column D divided by the total of Column E rounded to 2 decimal places.

Recoveries of Accounts Previously Written-off Report (refer to page 2 of 4)

- Column A - Customer Number. Spreadsheet must be sorted by customer number in ascending order prior to submission.
- Column B - Payment Date.
- Column C - Original Write-off Date.
- Column D – Amount of payment credited to Gas Costs.
- Column E – Amount of payment credited to Margin.
- Column F – Total amount of payment (Column D + Column E).
- Column G – Percent of total payment credited to Gas Cost (Column D divided by Column F) rounded to 2 decimal places.

- Column H – Percent of total payment credited to Margin (Column E divided by Column F) rounded to 2 decimal places.
- Columns C, D and E should contain only costs related to the delivery of gas. Late fees, taxes, collection fees, or other charges must not be included.
- Totals – Columns D, E and F should be totaled. The amount shown in Column G total should be the total of Column D divided by the total of Column F rounded to 2 decimal places. The amount shown in Column H should be the total of Column E divided by the total of Column F rounded to 2 decimal places.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 64
Witness: Gary Smith

Data Request:

Refer to the Smith Testimony, page 32. Atmos proposes to discontinue its Large Volume Sales ("LVS") services and its High Load Factor ("HLF") sales option.

a. Has Atmos contacted the customers currently taking service under these options to inform them that the option will cease if approved by the Commission?

b. If yes, have any of the customers stated an objection to being required to switch to another service if the Commission approves Atmos's request? If so, provide a summary of those objections.

Response:

a. Even prior to the December 2006 filing of this case, Atmos Energy has been in consistent contact with each customer, one currently using LVS service and one currently using the HLF sales option. The discussions have addressed alternative service choices and the economic merits of those alternatives. Recently, the HLF customer requested a service change as a result of our discussions. We are in the process of finalizing the service agreement to effectuate their request. Assuming that process is completed in coming weeks, Atmos Energy will no longer have any customers using the HLF sales option. Similarly, we believe the lone LVS customer will soon request a service change due to the economic benefits of tariff alternatives. Because Atmos anticipates that both customers will elect to switch services, the company has not advised either customer of the proposed discontinuance of LVS and HLF effective December 31, 2007.

b. Not applicable. See response to KPSC DR 2-64(a) above.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 65
Witness: Gary Smith

Data Request:

Refer to the Application, Volume 1, Tab 7, FR 10(1)(b)(8)a, First Revised Sheet No. 24, Rider GCA.

a. Item 3 indicates a change in the text. Identify the revision.

b. Will Atmos delete references to the LVS and HLF services if Atmos's proposal to discontinue these services is approved?

Response:

a. There is no language change. The text note (T) only relates to movement of existing text on the page to accommodate the new text section below without adding a new tariff sheet.

b. Yes, Atmos will delete references to the LVS and HLF services at such time as these tariffs are no longer applicable.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 66
Witness: Gary Smith

Data Request:

Refer to the Application, Volume 1, Tab 7, FR 10(1)(b)(8)a, First Revised Sheet No. 25. The proposed tariff indicates that there is a text change in the paragraph describing the RF. Explain the text change.

Response:

There is no language change. The text note (T) only relates to movement of existing text to accommodate the new text section on Sheet No. 25 without adding a new tariff sheet.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 67
Witness: Dan Meziere

Data Request:

Refer to the Application, Volume 8, Tab 2, the independent auditor's opinion report. In its November 20, 2006 letter, the auditor identified several control deficiencies he had noted as well as other control deficiencies previously communicated to Atmos's management.

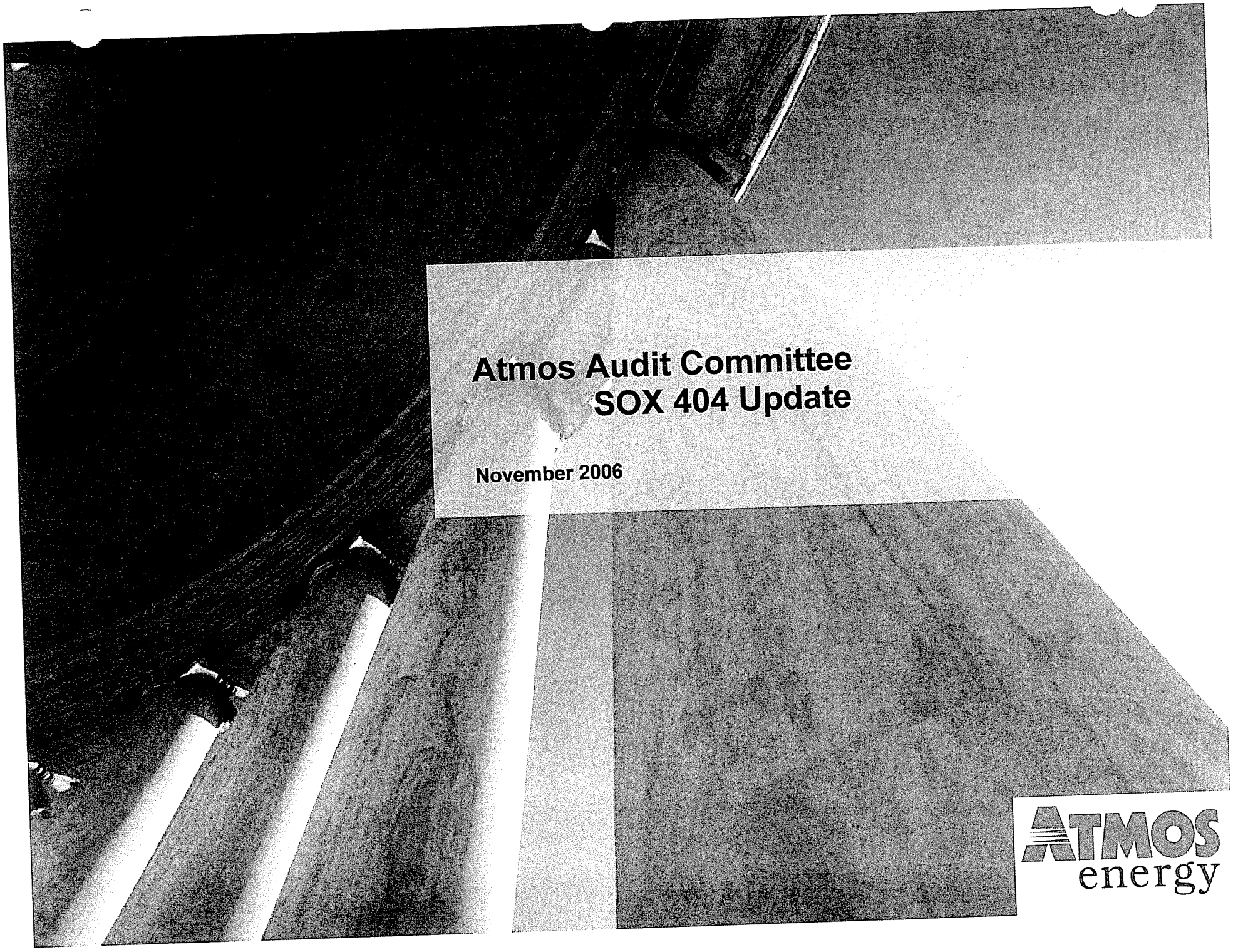
a. Provide a schedule similar to the one attached to the November 20, 2006 auditor's letter listing the additional control deficiencies that had been previously communicated to Atmos's management.

b. Describe what actions were taken by Atmos's management to address both groups of control deficiencies. Provide an explanation in those instances where no action was taken on the cited control deficiency.

Response:

The schedule referred to in the external auditor report represents the control deficiencies identified by the Company's internal auditors. A copy of this schedule, in the format that was provided to the Audit Committee, is attached (See attachment Case 2006-00464 KPSC DR2-67). None of the control deficiencies identified were determined to be significant weaknesses or material weaknesses.

During the second quarter of the fiscal year, the Company meets with the internal auditors to plan the current year's SOX compliance work and to address the control deficiencies identified in the prior year. This process is underway and all of these control deficiencies are currently being evaluated.



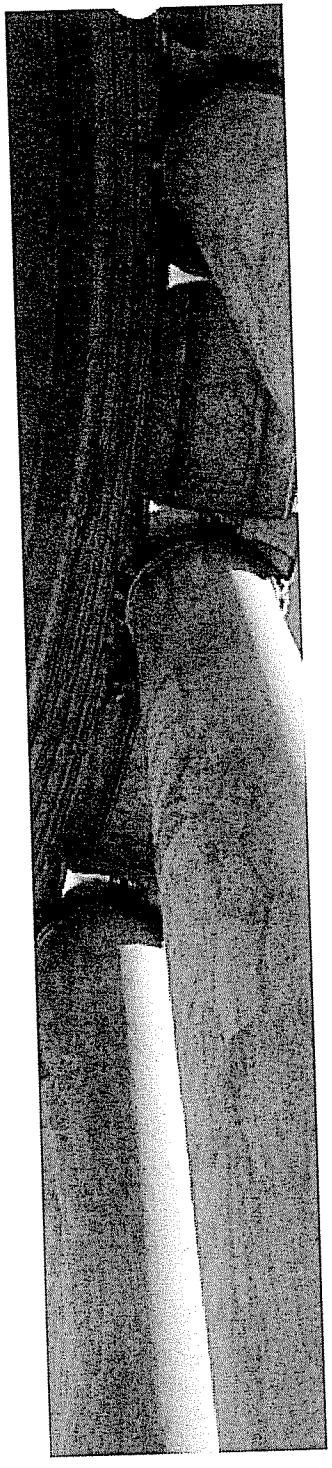
Atmos Audit Committee
SOX 404 Update

November 2006

ATMOS energy

Current Status – Atmos 404 Process

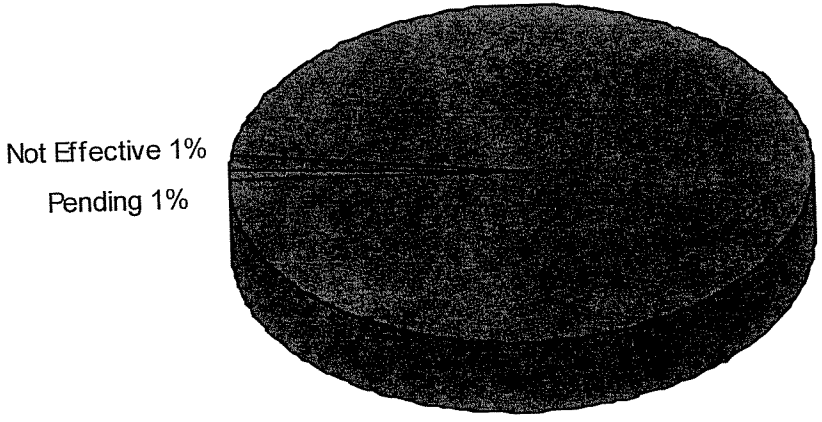
- **Remaining Testing (As of October 25, 2006)**
  - 5 controls pending initial test (related to Entity and Tax processes)
  - 40 controls pending monitor testing (Fourth quarter control execution)
  - 1 control to retest
  - Expected to be complete by November 14, 2005.
- **Key Activities to Complete**
  - Management's Assertion
  - Management's final evaluation of controls
    - No Material Weaknesses identified
    - No Significant Deficiencies identified
    - 6 Deficiencies identified (2 presented on page 4, Critical Issues)



Current Status – Atmos Corp.

ATMOS energy

Division	Key Controls	Design Evaluation			Test of Operating Effectiveness		
		In Process	Design Gap	Test Failure	Pending	Not Effective	Effective
Utility	157	0	0	0	3	2	152
Non-Utility	161	0	0	0	0	2	159
Entity Level	29	0	0	0	2	0	27
General IT	70	0	0	0	0	2	68
TOTAL (As of Oct 25, 2006)	417	0	0	0	5	6	406
TOTAL (As of Oct 31, 2005)	676	-	-	-	0	33	632



Design Evaluation

In Process
Process walkthrough and test of design not complete

Design Gap
Design of control does not mitigate the identified risk

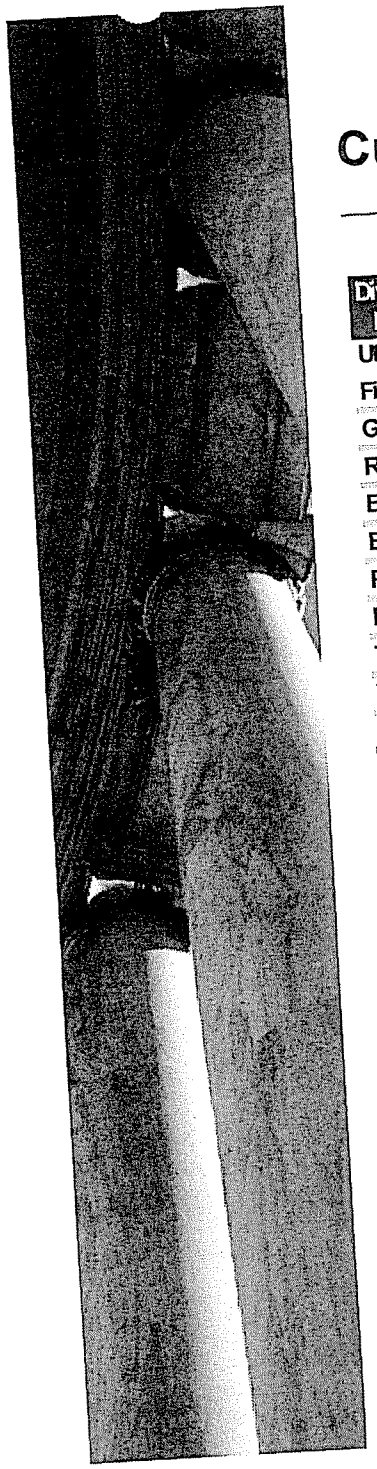
Test Failure
Test of one failed to validate effective control execution

Test of Operating Effectiveness

Pending
Design is effective, control testing not complete

Not Effective
Control sample tested with at least one exception

Effective
Control sample tested without exception



Current Status – Division detail

Division Process	Key Controls	Design Evaluation			Test of Operating Effectiveness		
		In - Process	Design Gap	Test Failure	Pending	Not Effective	Effective
Utility	18	0	0	0	0	0	18
Financial Reporting	21	0	0	0	0	0	21
General Accounting	36	0	0	0	0	0	36
Revenue	26	0	0	0	0	1	25
Expenditure - Shared Services	17	0	0	0	0	0	17
Expenditure - Gas Supply	8	0	0	0	0	0	8
Payroll	11	0	0	0	0	0	11
Fixed Assets	10	0	0	0	0	1	9
Treasury	10	0	0	0	3	0	7
Tax	157	0	0	0	3	2	152
Sub - Total							
Non - Utility	31	0	0	0	0	1	30
Energy Risk Management	33	0	0	0	0	0	33
Gas Accounting	20	0	0	0	0	0	20
Financial Accounting	12	0	0	0	0	0	12
Treasury	65	0	0	0	0	1	64
Atmos Texas Pipeline	161	0	0	0	0	2	159
Sub - Total	29	0	0	0	2	0	27
Entity Level	70	0	0	0	0	2	68
General IT - Atmos	417	0	0	0	5	6	406
TOTAL							

Critical Issues

Division	# of ctrls	Issue / Control	Observation	Management's Evaluation of Potential Impact	Management Action Plan / Mitigating Controls
Atmos Utility	1	Cash bank reconciliation	Bank cash reconciliations (7 out of 45 accounts, $500,000 unreconciled of $25 million cash balance) were not completed, reviewed, and approved timely.	Deficiency	Daily cash receipt reconciliations are satisfactorily prepared as of 9/30/2006, however reconciling items identified on older daily cash reconciliations are still being researched. These items must be resolved prior to completing the bank reconciliations. Internal Audit will perform a review of the payment application process during the first quarter of fiscal 2007.
Non Utility	1	Timeliness and valuation of deal entry	Deal entry documentation and validation was not always completed within one day.	Deficiency	The mitigating controls in month-end procedures ensure the identification of any material variances.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 68
Witness: Tom Petersen & Greg Waller

Data Request:

Refer to the Application, Volume 9, Tab 2, and the response to the Commission Staff's First Data Request dated November 21, 2006 ("Staff First Request"), Item 3. Prepare a schedule that cross-references each schedule presented in Tab 2 with the corresponding workpaper or supporting document provided in the response to Item 3.

Response:

See attached Case 2006-00464 KPSC DR2-68 ATT

Atmos Energy Corporation, KY
Case No. 2006-00464
KPSC DR 2-68

Application Vol 9 Tab 2	Supporting WorkPapers		
B.1 B	Sections B-2 Through B-5		
B.1 F	Sections B-2 Through B-5		
B.2 B	B.2.1 B		
B.2 F	B.2.1 F		
B.2.1 B	B.2.2 B	B.3 B	
B.2.1 F	B.2.2 F	B.3 F	
B.2.2 B	B.2.3 B Series		
B.2.2 F	B.2.3 F Series		
B.2.3 B 09	wpB.2 B 09		
B.2.3 B 02	wpB.2 B 02		
B.2.3 B 12	wpB.2 B 12		
B.2.3 B 91	wpB.2 B 91		
B.2.3 F 09	wpB.2 F 09		
B.2.3 F 02	wpB.3 F 02		
B.2.3 F 12	wpB.2 F 12		
B.2.3 F 91	wpB.2 F 91		
B.3 B	B.3.1 B 09	wpB.3 B 02	
B.3 F	B.3.1 F 09	wpB.3 F 02	
B.3.1 B 09	wpB.2 B 09	wpB.3.1 B 09	
B.3.1 B 02	wpB.2 B Series	wpB.3.1 B Series	
B.3.1 F 09	wpB.2 F 09	wpB.3.1 F 09	
B.3.1 F 02	wpB.2 F Series	wpB.3.1 F Series	
B.3.2 B	wpB.2 B Series	wpB.3.1 B Series	wpB.3.2 B Series
B.3.2 B 09	wpB.2 B 09	wpB.3.1 B 09	wpB.3.2 B 09
B.3.2 B 02	wpB.2 B 02	wpB.3.1 B 02	wpB.3.2 B 02
B.3.2 B 12	wpB.2 B 12	wpB.3.1 B 12	wpB.3.2 B 12
B.3.2 B 91	wpB.2 B 91	wpB.3.1 B 91	wpB.3.2 B 91
B.3.2 F	B.3 F	wpB.3.2 F Series	
B.4 B	B.4.2 B	B.4.1 B	
B.4 F	B.4.2 F	B.4.1 F	
B.4.1 B	wpB.4.1 B		
B.4.1 F	wpB.4.1 F		
B.4.2 B	C.2		
B.4.2 F	C.2		
B.5 B	wpB.5 B		
B.5 F	wpB.5 F		

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 69
Witness: Greg Waller & Gary Smith

Data Request:

Refer to the Application, Volume 9, Tab 4. Provide all workpapers, calculations, assumptions, and other documentation that support the adjustments to the base and forecasted test periods as shown on Schedules D-2.1, D-2.2, and D-2.3. If the requested information has already been supplied, provide specific cross-references to the location of the supporting information.

Response:

For base and forecasted revenues shown on Schedule D-2.1, please refer to the Company's response to KPSC DR 2-54(a) for Base Period assumptions and workpaper references. For the Test Period revenues, please refer to Smith Testimony, pages 10-17, and Exhibits GLS 1-7 attached to the Smith Testimony, (electronic copies of all the GLS Exhibits are provided in response to KPSC DR 2-51, and include supporting workpapers). These documents, plus the Company's gas cost projections were provided in response to KPSC DR 1-3.

Please see attached Case 2006-00464 KPSC DR2-69 ATT for additional support for D-2.2 and other tax calculations in D-2.3.

Depreciation expense workpapers for D-2.3 can be found in the AG response Case 2006-00464 AG DR1-173 ATT.

Schedule KPSC DR2-69

		Base Year	Test Year	Difference
ADJ 1				
Labor and Benefits				
	Labor	5,592,987	6,056,915	463,928
	Benefits	2,409,712	2,570,636	160,924
	Total	8,002,700	8,627,551	624,852
ADJ 2				
Rent, Maintenance and Utilities		754,281	752,583	-1,698
ADJ 3				
Other O&M	Materials & Supplies	473,284	459,910	-13,375
	Vehicles & Equip	838,715	903,058	64,343
	Print & Postages	25,769	27,280	1,511
	Insurance	101,599	195,245	93,646
	Marketing	184,163	205,346	21,183
	Employee Welfare	534,293	494,348	-39,945
	Information Technologies	59,557	66,326	6,769
	Directors & Shareholders &PR	20,407	9,490	-10,916
	Telecom	302,728	303,779	1,051
	Travel & Entertainment	391,063	313,155	-77,908
	Dues & Donations	169,702	166,876	-2,825
	Training	175,631	142,079	-33,552
	Outside Services	1,961,445	2,014,737	53,292
	Miscellaneous	161,292	186,304	25,013
	Total	5,399,646	5,487,933	88,287
ADJ 4				
Bad Debt		860,159	1,007,867	147,709
ADJ 5				
Shared Services		5,128,032	5,133,922	5,890
	Total O&M	20,144,818	21,009,856	865,039

							29%	41%	41%	41%	41%	41%	41%	41%	41%
port for DR KPSC2-69-ATT		Fiscal 2006 April	Fiscal 2006 May	Fiscal 2006 June	Fiscal 2006 July	Fiscal 2006 August	Fiscal 2006 September	Fiscal 2007 October	Fiscal 2007 November	Fiscal 2007 December	Fiscal 2007 January	Fiscal 2007 February	Base Period Ending March	Fi ...ch	al 2007 April
		463,046.00	556,574.82	526,498.94	351,166.40	335,790.02	378,953.52	492,101.74	509,948.64	484,794.92	528,885.68	466,169.82	5,592,987.46	499,056.95	471,459.06
Labor		215,749.83	243,590.11	237,622.61	193,282.59	139,077.87	114,640.62	209,010.24	216,272.23	206,108.78	223,908.94	198,604.37	2,409,712.28	211,844.09	200,684.76
Benefits	Benefits Load	207,137.17	233,588.63	228,513.04	185,785.81	132,832.18	109,863.28	201,761.71	209,078.94	198,765.92	216,843.13	191,129.63	2,319,912.79	204,613.35	193,298.22
	A&G-Injuries & dama - Worker's Comp Insurance 9250-01221	8,612.66	10,001.48	9,109.57	7,496.78	6,245.69	4,777.34	7,248.52	7,193.29	7,342.86	7,065.81	7,474.75	89,799.49	7,230.74	7,386.55
		50,106.08	35,796.91	29,050.62	33,047.16	51,155.17	45,902.01	39,017.38	36,117.02	40,303.54	36,792.98	38,079.14	473,284.48	37,916.46	39,756.46
Materials & Supplies	Inventory	3,605.06	4,423.87												
	Warehouse loading	1,261.78	1,548.38												
	Non inventory	34,833.69	13,161.98												
	Office Supplies	10,405.55	16,662.68												
	Other	0.00	0.00												
		77,645.16	79,809.97	79,480.58	50,327.09	53,138.74	54,399.88	74,884.34	73,790.54	73,058.94	75,265.34	74,054.74	838,714.86	72,859.54	75,018.34
Vehicles & Equip	Depreciation	0.00	5,321.86												
	Vehicle Expense	76,537.12	73,931.79												
	Heavy Equipment	88.54	556.32												
	Other	1,019.50	0.00												
		1,405.98	1,579.44	4,684.60	1,293.18	1,877.69	1,751.93	2,724.36	1,962.74	2,088.90	2,467.72	1,962.74	25,768.64	1,969.38	2,520.84
Print & Postages		15,018.06	15,692.93	37,736.59	16,468.61	13,332.21	-90,754.99	15,183.72	15,230.72	15,236.72	16,135.77	16,188.77	101,598.90	16,129.77	16,126.77
Insurance		14,532.53	17,179.17	15,695.76	13,731.13	14,447.87	15,466.61	16,431.37	12,291.02	12,913.17	16,446.57	21,801.57	184,162.95	13,226.17	21,082.77
Marketing		35,742.23	27,702.90	36,106.05	21,022.53	26,514.04	21,096.12	57,669.21	68,638.95	79,666.00	70,078.38	62,817.50	534,293.30	27,239.39	18,098.84
Employee Welfare	Restricted Stock	7,623.85	9,260.54												
	MIP/VVP	67,662.00	0.00												
	NQ retirement	8,871.83	8,871.83												
	Other	-48,415.45	9,570.53												
		6,863.99	-8,839.23	6,692.24	6,376.37	8,964.63	5,135.76	5,332.58	4,086.59	5,414.59	5,913.58	4,338.58	59,557.09	9,277.41	8,452.39
Information Technologies		90,475.01	47,268.01	71,118.54	56,865.82	56,347.04	55,315.86	57,440.14	58,147.06	61,820.34	65,158.14	66,039.14	754,281.26	68,286.14	63,288.14
Rent, Maint., & Utilities	Leases/Rents	87,585.46	71,733.18												
	Utilities	23,897.13	16,940.50												
	Other	-21,007.58	-41,405.67												
		857.08	0.00	1,747.73	2,351.60	1,155.12	11,373.45	332.00	531.20	332.00	332.00	664.00	20,406.58	730.40	1,328.00
Directors & Shareholders &PR		32,367.54	27,334.98	26,339.79	21,185.65	21,779.26	24,543.22	24,847.88	24,800.88	24,930.88	24,772.88	24,896.88	302,727.74	24,927.88	24,801.88
Telecom		32,634.39	49,606.63	38,897.11	31,976.32	42,603.35	40,824.69	27,740.11	25,988.53	24,349.45	26,430.69	24,831.96	391,062.81	25,179.56	25,888.32
Travel & Entertainment		9,927.42	3,434.92	8,947.82	9,052.01	3,286.42	12,540.42	12,132.11	18,512.63	8,611.25	53,941.99	6,468.13	169,701.53	22,846.39	6,404.31
Dues & Donations		1,837.50	5,633.17	14,543.04	17,668.56	18,297.48	24,012.77	23,369.73	11,291.53	22,922.27	18,020.53	9,796.01	175,630.64	8,238.07	9,076.33
Training		171,219.68	164,827.10	154,428.28	175,177.69	151,364.90	169,244.90	163,116.31	194,603.11	144,796.31	177,091.11	152,804.31	1,961,444.83	142,771.11	171,850.31
Outside Services	Gas Supply Contract	24,839.34	25,296.13												
	Contract Labor	19,924.61	26,020.22												
	Collection fees	38,904.45	29,583.25												
	Bill Print	85,254.06	83,927.50												
	Legal	2,297.22	0.00												
	Other	0.00	0.00												
		12,079.00	16,884.00	23,328.00	21,686.00	24,910.00	90,350.00	39,663.98	74,420.08	116,239.97	155,366.77	165,616.50	860,158.59	119,614.29	61,379.86
Provision for Bad Debt		59,317.56	895.41	7,420.87	12,423.95	-3,250.38	8,482.43	16,317.79	4,579.15	3,583.15	43,299.75	3,556.59	161,291.75	4,665.47	79,522.31
Miscellaneous		1,290,825.04	1,284,971.24	1,320,339.17	1,035,102.66	960,791.43	983,279.20	1,277,315.02	1,351,212.64	1,327,171.19	1,540,308.84	1,338,690.78	15,016,785.68	1,306,778.48	1,296,739.72
Total O&M															

41%	41%	%	41%	41%											
al 2007 May	Fiscal 200. June	al 2007 July	Fiscal 2007 August	Fiscal 2007 September	Escalation	Fiscal 2008 October	Fiscal 2008 November	Fiscal 2008 December	Fiscal 2008 January	Fisc Febr...y	...l 2008 March	Fiscal 2008 April	Fiscal 2008 May	Fiscal 2008 June	Test period Ending 6/30/08
7,731.37	471,459.06	494,595.22	513,269.65	455,015.50	3.5%	511,468.96	525,547.74	499,919.78	545,934.72	479,172.11	516,641.12	489,107.36	537,135.49	489,107.36	6,056,915.01
19,372.43	200,684.76	210,029.10	217,557.45	194,065.70		216,923.18	222,742.65	212,171.45	231,103.51	203,813.31	219,131.50	207,778.57	227,470.11	207,849.82	2,570,636.35
12,269.86	193,298.22	202,784.04	210,440.56	186,556.36		209,702.27	215,474.57	204,967.11	223,833.24	196,460.56	211,822.86	200,534.02	220,225.55	200,534.02	2,483,335.15
7,102.57	7,386.55	7,245.06	7,116.89	7,509.35		7,220.90	7,268.07	7,204.34	7,270.28	7,352.74	7,308.64	7,244.56	7,244.56	7,315.80	87,301.19
35,228.13	38,740.69	36,827.05	36,184.29	36,397.80	2.5%	39,992.82	37,019.95	41,311.13	37,712.81	39,031.12	38,864.37	40,750.37	36,108.83	39,709.21	459,909.75
73,402.54	72,735.54	74,876.74	73,158.14	73,326.07	2.5%	76,756.45	75,635.30	74,885.41	77,146.97	75,906.11	74,681.03	76,893.80	75,237.60	74,553.93	903,057.55
					2.5%										
					2.5%										
1,969.38	1,969.38	2,724.36	1,969.38	2,460.05	2.5%	2,792.46	2,011.80	2,141.12	2,529.41	2,011.80	2,018.61	2,583.86	2,018.61	2,018.61	27,280.07
16,188.03	16,208.03	16,386.98	16,298.58	16,365.58	2.5%	15,563.32	15,611.49	15,617.64	16,539.17	16,593.49	16,533.02	16,529.94	16,592.73	16,613.23	195,245.15
14,603.97	11,447.97	21,741.97	14,956.57	24,896.91	2.5%	16,842.16	12,598.30	13,236.00	16,857.74	22,346.61	13,556.83	21,609.84	14,969.07	11,734.17	205,346.16
18,295.85	18,044.87	19,898.43	25,341.23	18,045.54	2.5%	59,110.94	70,354.92	81,657.65	71,830.34	64,387.94	27,920.37	18,551.31	18,753.25	18,495.99	494,347.93
					2.5%										
4,266.53	4,266.53	5,160.28	4,266.53	4,266.53	2.5%	5,465.90	4,188.75	5,549.95	6,061.42	4,447.04	9,509.34	8,663.70	4,373.20	4,373.20	66,325.84
64,064.14	59,608.14	61,619.14	60,653.34	61,485.94	0.0%	57,874.36	58,593.43	62,358.52	65,780.24	66,618.91	68,987.94	63,862.39	64,658.49	60,090.39	752,583.09
					2.5%										
					2.5%										
					2.5%										
332.00	1,859.20	896.40	830.00	1,162.00	2.5%	340.30	544.48	340.30	340.30	680.60	748.66	1,361.20	340.30	1,905.68	9,490.22
24,771.88	24,923.88	24,788.88	24,755.88	24,967.21	2.5%	25,469.08	25,420.91	25,554.16	25,392.21	25,519.31	25,551.08	25,421.93	25,391.18	25,546.98	303,778.81
24,646.70	25,607.18	25,761.16	24,890.06	26,074.46	2.5%	28,433.61	26,638.25	24,958.19	27,091.46	25,452.76	25,809.05	26,535.53	25,262.87	26,247.36	313,154.78
8,276.99	6,675.43	6,030.61	5,571.45	7,808.11	2.5%	12,435.42	18,975.45	8,826.54	55,290.54	6,629.84	23,417.55	6,564.42	8,483.92	6,842.32	166,876.17
7,780.17	7,346.73	8,440.67	5,872.83	6,977.93	2.5%	23,953.97	11,573.81	23,495.32	18,471.04	10,040.91	8,444.02	9,303.23	7,974.67	7,530.39	142,078.79
160,269.91	153,473.71	190,449.11	166,850.31	160,142.04	2.5%	167,194.22	199,468.19	148,416.22	181,518.39	156,624.42	146,340.39	176,146.57	164,276.66	157,310.56	2,014,737.10
					2.5%										
					2.5%										
					-100.0%										
					2.5%										
32,199.73	25,699.51	27,298.80	27,542.41	28,607.56	3.3%	44,983.98	87,000.55	135,730.57	177,584.08	177,521.50	128,354.53	91,300.30	50,942.55	31,000.40	1,007,867.24
4,798.27	4,632.27	7,798.27	4,632.27	4,795.27	2.5%	16,725.74	4,693.63	3,672.73	44,382.25	3,645.51	4,782.11	81,510.37	4,918.23	4,748.08	186,304.45
1,228,198.04	1,145,382.90	1,235,323.18	1,224,600.39	1,146,860.20		1,322,326.86	1,398,619.61	1,379,842.67	1,601,566.60	1,380,443.28	1,351,291.53	1,364,474.71	1,284,907.76	1,185,677.68	15,875,934.46

Atmos Energy Corporation, KY
Case No. 2006-00464
Monthly Taxes Other by Sub-Account
For the Base Period 12 Months ended March 31, 2007

line	Account No. 4081 & Title	actual Apr-06	actual May-06	actual Jun-06	actual Jul-06	actual Aug-06	actual Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Total
		$	$	$	$	$	$	$	$	$	$	$	$	$
1	FICA	35,949	19,031	45,345	20,290	27,434	24,598	44,146	45,715	43,545	42,231	38,080	45,575	431,940
2	FUTA	(44)	4	19	32	30	39	30	30	30	3,600	3,000	600	7,370
3	SUTA	(39)	(2)	13	39	18	27	20	20	20	3,000	2,200	20	5,336
4	Ad Valorem - Accrual	216,804	216,804	216,804	216,804	216,804	216,804	219,285	219,285	1,619,285	334,285	334,285	334,285	4,361,534
5	Taxes Property and Other	0	0	0	0	0	800,000							800,000
6	Public Service Commission Assessment	27,645	27,645	27,645	33,470	33,470	33,470	33,470	33,470	33,470	33,470	33,470	33,470	384,165
7	Allocation for taxes other	14,341	10,286	16,494	9,649	8,907	10,104	10,258	10,242	10,215	17,982	16,223	14,527	149,228
8	Allocation for taxes other CSC	0	5,444	0	5,071	4,532	4,762	4,720	4,720	4,720	4,720	4,720	4,720	48,132
9	Allocation from taxes other Div. 091							11,837	8,601	9,185	11,556	10,139	10,463	61,781
10	Allocation for Other							0	0	0	0	38,200	0	38,200
	Total	294,656	279,212	306,320	285,355	291,195	1,089,804	323,767	322,083	1,720,471	450,843	480,318	443,661	6,287,686
11	**Div 002**	136,177	147,002	152,053	127,500	172,123	123,363	176,208	176,208	176,208	176,208	176,208	176,208	1,915,466
12	FICA	373	656	820	754	1,038	795	1,042	1,042	1,042	1,042	1,042	1,042	10,688
13	FUTA	2,519	2,552	2,224	1,938	-44,730	20,738	2,678	2,678	2,678	2,678	2,678	2,678	1,311
14	SUTA	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	35,000	420,000
15	Ad Valorem	(13,776)	(9,649)	(9,904)	(8,607)	(8,515)	(9,373)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(120,008)
16	Allocated to Kentucky Div.													
17														
18	**Div 012**	88,444	93,713	102,244	87,426	107,878	70,193	120,825	120,825	120,825	120,825	120,825	120,825	1,274,846
19	FICA	228	417	551	517	652	455	715	715	715	715	715	715	7,107
20	FUTA	1,591	1,620	1,502	1,329	(28,736)	13,194	1,837	1,837	1,837	1,837	1,837	1,837	1,520
21	SUTA	85	100	0	0	0	0	0	0	0	0	0	0	185
22	Benefit		(5,444)	(5,924)	(5,071)	(4,532)	(4,762)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(54,056)
23	Allocated to Kentucky Div.													
24														
25	**Div 091**	5,039	2,231	5,395	5,521	4,745	8,656	21,615	13,731	14,915	18,401	16,001	17,601	133,852
26	FICA	(5)	1	4	6	6	11	9	3	36	1,862	954	461	3,347
27	FUTA	(54)	8	3	7	(212)	92	564	(346)	24	1,158	614	388	2,246
28	SUTA	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	120,000
29	Ad Valorem	(14,980)	(12,240)	(15,402)	(15,534)	(14,539)	(18,759)	(32,188)	(23,388)	(24,975)	(31,421)	(27,569)	(28,450)	(259,445)
30	Expense Allocation													

Atmos Energy Corporation, KY
Case No. 2006-00464
Monthly Taxes Other by Sub-Account
For the Forecasted Period 12 Months ended June 30, 2008

line	Account No. & Title	actual Jul-07	actual Aug-07	actual Sep-07	actual Oct-07	actual Nov-07	actual Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Total
		$	$	$	$	$	$	$	$	$	$	$	$	$
		43,335	44,865	38,794	36,660	36,660	36,660	29,982	31,782	36,360	36,660	36,660	36,660	445,079
	FICA	219	191	145	22	22	22	3,600	2,800	322	22	22	22	7,409
	FUTA	0	0	0	0	0	0	3,100	2,100	0	0	0	0	5,200
	SUTA	334,285	334,285	334,285	334,285	344,314	344,314	344,314	344,314	344,314	344,314	344,314	344,314	4,091,648
	Ad Valorem	33,470	33,470	33,470	33,470	33,470	33,470	33,470	33,470	33,470	33,470	33,470	33,470	401,640
	Public Service Commission Assessment	10,403	10,360	10,290	10,459	10,459	10,459	10,459	10,459	10,459	10,459	10,459	10,459	125,182
	Allocation for taxes other	4,720	4,720	4,720	4,720	4,720	4,720	4,720	4,720	4,720	4,720	4,720	4,720	56,645
	Allocation for taxes other CSC	10,198	10,428	9,186	9,864	9,779	9,378	11,831	10,365	10,681	10,223	10,778	10,132	122,843
	Allocation from taxes other Div91	436,630	438,319	430,889	429,480	439,424	439,023	441,476	440,010	440,326	439,868	440,423	439,777	5,255,646
	Total													
	Div 002	149,507	142,889	153,686	202,183	209,509	217,221	202,183	202,183	202,183	152,930	164,024	172,912	2,171,410
	FICA	542	508	576	773	732	689	773	773	773	585	627	661	8,015
	FUTA	136	127	136	179	186	192	179	179	179	136	146	153	1,930
	SUTA	35,000	35,000	35,000	36,050	36,050	36,050	36,050	36,050	36,050	36,050	36,050	36,050	429,450
	Ad Valorem	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(10,031)	(120,372)
	Allocated to Kentucky Div.													
	Div 012	97,102	91,091	103,342	138,636	131,310	123,598	138,636	138,636	138,636	104,863	112,470	118,565	1,436,883
	FICA	854	798	857	1,128	1,168	1,209	1,128	1,128	1,128	853	915	965	12,129
	FUTA	83	81	92	123	117	110	123	123	123	93	100	105	1,272
	SUTA													0
	Benefit	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(4,720)	(56,640)
	Allocated to Kentucky Div.													
	Div 091	17,601	18,249	14,890	16,730	16,514	15,437	19,045	16,561	18,217	17,389	19,045	17,389	207,067
	FICA	79	65	54	57	48	37	1,927	987	477	240	150	93	4,215
	FUTA	51	40	33	34	29	25	1,199	635	350	168	113	67	2,744
	SUTA	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	120,000
	Ad Valorem	(27,731)	(28,354)	(24,977)	(26,821)	(26,591)	(25,499)	(32,171)	(28,184)	(29,044)	(27,797)	(29,308)	(27,549)	(334,026)
	Expense Allocation													

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 70
Witness: Greg Waller & Jim Cagle

Data Request:

Refer to the Application, Volume 9, Tabs 6 through 8. Several of the schedules included under these Tabs reference workpapers; however, it does not appear that those workpapers were submitted with the application. Provide all referenced workpapers that support the schedules contained in Tabs 6 through 8.

Response:

The work paper references on the schedules identified above were the result of a typographical error. There are no additional work papers for tabs 6 through 8.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 71
Witness: Dan Meziere

Data Request:

Refer to the response to the Staff First Request, Item 4. The copy of the Account Code Manual indicates it was revised on January 10, 2007. Explain why the Kentucky and Mid-States divisions are still recorded as separate cost centers, even though the two were consolidated effective October 1, 2006.

Response:

The account coding manual has not been updated since the combination of the Kentucky and Mid-States divisions. The revision date of January 10, 2007 reflects the date the account coding manual was printed rather than an actual revision to the manual. The company is in the process of updating the Account Coding Manual.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 72
Witness: Robert R. Cook Jr.

Data Request:

Refer to the response to the Staff First Request, Item 12, Schedule 1(b). Does Atmos believe its budgeting process for capital expenditures produces a reasonable estimate of its actual expenditures, given that the information on this schedule shows an average budget overrun of over 16 percent during the past 10 years? Explain the response.

Response:

Yes, please see testimony of Mr. Robert R. Cook Jr. for budgeting process for capital expenditures.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 73
Witness: Robert R. Cook Jr.

Data Request:

Refer to the response to the Staff First Request, Item 14. For each project where it is indicated that the "Percent of Total Exp." is 150 percent or greater, explain why the actual expenditures were greater than the budget estimate.

Response:

Please see attached DR2-72 ATT for explanation of projects 150 percent or greater. The project list contains Kentucky projects and our Shared Service projects. Shared Service projects allocation to KY BU is 5.2%. Our Call Center projects allocation to KY BU is 5.6%.

DR2-73 AT 1
Project Variances =>150%

R. Cook

Project Description	Original Budget Est.	Most Recent Budget Est	Total Project Expenditures (To Date)	Percent of Total Exp.	Project Explanation
040.12198 - CHANGING OVER FARMTAPS	117,910.09	117,910.09	177,218.47	150.30%	Mandated by PSC project found additional out of compliance farm taps
040.12386 - Replace 2,550' - 1" bare with 830' - 2" P.E along Blackburn St in Marion, KY	14,443.95	14,443.95	21,714.61	150.34%	Increase in Material Cost from original project estimate; directional bore issues
010.11011 - Purchase headsets	11,841.00	11,841.00	17,830.06	150.58%	SS Project: purchased additional headset for CSA
040.12389 - INSTALL 1400' OF 2" PE ON HWY 44 ACROSS FROM SAVE-A-LOT	11,610.00	11,610.00	17,578.06	151.40%	Encountered rock not expected and increased depth of cover
040.12518 - INSTALL 2500' OF 2" PE IN MEADOWBROOK S III	31,255.00	31,255.00	47,764.58	152.82%	Additional Contractor labor required to complete project
040.12607 - INSTALL6,360' 4" STL.	152,512.67	152,512.67	237,762.25	155.90%	Reimbursement of $96,500 not received
040.12391 - INSTALL 1000' OF 2" AND 900' OF 4" TO SERVE FIRE STATION	16,360.00	16,360.00	25,920.77	158.44%	Installed larger regulator station than estimate
040.12573 - INSTALL 1800' OF 2" PE IN LOCUST CRK 5a	18,150.00	18,150.00	28,794.74	158.65%	Encountered additional rock, increase in contractor cost
010.11122 - PC Replacement 2006	98,031.00	98,031.00	156,252.51	159.39%	SS Project: purchased additional routers and telephones for CSA
010.11065 - Develop systems to manage data requests	308,850.00	308,850.00	499,806.88	161.83%	Scope of project and number of consulting hours under estimated.
040.12794 - INSTALL 3160' OF 6" STEEL FOR ALCAN	178,100.00	178,100.00	288,618.74	162.05%	$ 70,000 in AIC encounter rock during directional bore, increase in cost
010.11132 - Develop systems to reduce time required for gathering data	109,000.00	109,000.00	178,458.65	163.72%	SS Project
040.12432 - INSTALL 2000' 2" pe	7,797.09	7,797.09	13,446.33	172.45%	Need Reimbursement $1,788
040.12599 - SQUEEZE OFF TOOLS & LINE LOCATORS - B.G.	20,482.00	20,482.00	35,679.55	174.20%	Approval to order additional equipment for workers (safety and compliance)
010.11163 - Develop automation of daily operating metrics	85,000.00	85,000.00	148,676.46	174.91%	SS Project
040.12631 - Office furniture and accessories for the new Mayfield, KY office	48,124.48	48,124.48	84,725.96	176.06%	Ordered additional furniture and warehouse supplies for new office/warehouse
040.12535 - INSTALL 2000' OF 2" PE IN FAIRWAY X-ING OFF MT EDEN RD	15,600.00	15,600.00	27,958.01	179.22%	Extra labor cost and scheduled increased
040.12563 - REPLACE BOOTS AND REPAIR REGULATORS IN THE DANVILLE REGION	24,400.00	24,400.00	44,045.95	180.52%	increased material and labor cost
010.11129 - Oracle 11.5.10 Upgrade	1,086,490.20	1,086,490.20	2,112,234.90	194.41%	Hardware for Oracle's new RAC operating environment under estimated, as well as a mirrored environment for disaster recovery.
040.12822 - Outsourcing of Meter repair for 2006 PC Year	67,200.00	67,200.00	133,307.88	198.37%	changed vendor and increase in shipping cost
040.12616 - INSTALL EFM @ NESTAWAY	5,521.24	5,521.24	11,578.36	209.71%	Need Reimbursement
040.12601 - SQUEEZE OFF TOOLS & LINE LOCATORS - HOPKINSVILLE	20,335.00	20,335.00	43,139.11	212.14%	Approval to order additional equipment for workers (safety and compliance)
040.12230 - Install 615' - 8" T'line (400 maop)/ Abandon 496' - 8" Steel	41,212.72	41,212.72	87,801.98	213.05%	Extra labor cost, materials, and scheduled increased
040.13017 - Install 2,865' - 2" PE	35,363.08	35,363.08	76,036.73	215.02%	Estimate was reduced No re-imbursement shown in Project Budget
040.13016 - install 1,150 ' of 8" T'Line	73,675.49	73,675.49	162,458.62	220.51%	Reimbursement of $29,144 not received
040.12408 - Outsourcing of meter Testing	56,025.00	56,025.00	125,740.98	224.44%	Shipping cost of meters for testing increased due to miles traveled
040.12954 - Paint and install carpet at Paducah warehouse	17,228.61	17,228.61	38,842.81	225.46%	Changed scope of work to include cabinets and some contractor help
040.12024 - RELOCATE 2", 4", 6" MAIN	32,969.98	32,969.98	76,455.77	231.90%	Reimbursement of $38087not received
050.17537 - FY06 Laptop Replacements	22,156.00	22,156.00	51,906.39	234.28%	Replaced additional laptops than first budgeted
040.12549 - 4760 FT. OF 2" PE - REMINGTON PL. - B.G.	15,264.00	15,264.00	35,906.80	235.24%	Encountered rock and increased depth of cover
040.12397 - EFM Installation @ Kolbe Steel	4,909.10	4,909.10	11,757.90	239.51%	No Reimbursement Yet
040.10728 - state highway relocation	31,208.48	31,208.48	78,955.72	252.99%	Need Reimbursement
040.13022 - Warehouse Improvements II incl ceiling, blinds, rear door, office furniture, ref	28,490.00	28,490.00	73,893.29	259.37%	Changed scope of work to include additional gravel in lot and extra shelves; some contractor work
040.12785 - INSTALL 800' OF 4" STEEL ON INDUSTRIAL DR IN THE HUNT INDUSTRIAL PARK	21,500.00	21,500.00	61,325.36	285.23%	Not collected $29000 AIC
040.12918 - INSTALL 2200' OF 4" PE FOR WAL-MART OUTPARCELS	8,860.00	8,860.00	25,651.99	289.53%	Not collected $10,900 AIC
050.16291 - FY05 pc replacements	19,757.00	19,757.00	62,155.48	314.60%	Not a KY Project- Appears to be old Mid-States prior to merger
010.10947 - Upgrade and enhancement of Comshare(Planit)	35,000.00	35,000.00	117,125.24	334.64%	SS Project added additional upgrade to capital tracking system
040.13019 - D.O.T project to relocate 2" pe and two services along north friendship rd	4,513.37	4,513.37	16,317.22	361.53%	Waiting for reimbursement from DOT of $14,999
040.12922 - Overhaul St. Charles Compressor Engine	245,177.00	245,177.00	896,645.24	365.71%	12" pipe was charged to this project incorrectly. Project has been corrected
040.12232 - Replace 3 "bad" farm taps in Fredonia w/ 2" PE	5,683.83	5,683.83	23,203.02	408.23%	Changed scope of work to include all farm taps instead installing on individual projects
040.12575 - REBUILD 6 FARM TAPS USING REGULATORS AND SERVICES	16,450.00	16,450.00	74,643.63	453.76%	Original estimate was $79,800. Change did not get updated in the system
010.11138 - Implementation of SOX control and monitoring software (funds approved '06 capital budget)	45,529.30	45,529.30	256,200.17	562.71%	SS project Not a KY Project
010.10846 - Configure and implementation of Oracles Enterprise Asset Mgt syst	1,200,002.00	1,200,002.00	9,740,414.28	811.70%	Budget estimate was for 2006 and total to date is for the life of the project originating in February of 2003.
040.12534 - RELOCATE 610' OF 2" PE ON CORNISHVILLE ROAD AT THE BRIDGE	214.50	214.50	12,549.65	5850.65%	Waiting for reimbursement from DOT of $14,140.50
040.12832 - INSTALL 1075' OF 4" STEEL FROM 3B TOWARDS HWY 34	145.00	145.00	77,247.40	53274.07%	Bailey Industrial Park- Waiting for $62,055 AIC (Aid In Construction)

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 74
Witness: Greg Waller

Data Request:

Refer to the response to the Staff First Request, Item 16. The 2007 Total Rewards Guide states that the sole performance goal for the Variable Pay Plan would be return on equity expressed as earnings per share.

a. Provide the performance goals for fiscal years 2004, 2005, and 2006. Describe how those performance goals operated and whether the performance goals were achieved.

b. Provide the actual expenses for Atmos's Kentucky operations for fiscal years 2004, 2005, and 2006 for the performance goals.

c. Indicate how much was incorporated into the base and forecasted test periods for the performance goal expenses. If a different performance goal was reflected in the forecasted test period, provide a complete description of the goal and what was required to achieve the goal.

Response:

Item a

Please see response to Item No. 62(a) of the Attorney General's Initial Data Request.

Item b:

Please see AG DR 1-62 attachment labeled AG DR 1-62 ATT5 item d for the requested information.

Item c:

Please see the attachment labeled AG DR 1-62 ATT4 item c for the requested information.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 75
Witness: Greg Waller

Data Request:

Refer to the response to the Staff First Request, Item 17. Explain why the requested information was not provided for the executive employee group.

Response:

The executive group was included in the exempt category on the original response. Their increase occurs January 1 of each year. Specific Information responsive to this data request (and labeled KPSC DR2-75 ATT) is being filed subject to the terms of a confidentiality petition accompanying Atmos' responses to the KPSC's Second Set of Data Requests.

KPSC DR2-75 ATT (REDACTED)

	Non-exempt Increase Amount	Non-exempt Increase %	Exempt Increase Amount	Exempt Increase %	Executive Increase Amount	Executive increase amount
FY 2004						
FY 2005						
FY 2006						
FY 2007						

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 76
Witness: Greg Waller

Data Request:

Refer to the response to the Staff First Request, Item 19.

a. The request only sought information about employee fringe benefits on an annual, not monthly, basis. Resubmit the response showing the totals for the listed categories for the time periods originally requested.

b. The response does not appear to adequately explain the changes in fringe benefits occurring over the time periods identified. Supplement the response with a thorough discussion of any changes in employee fringe benefits.

Response:

a. Please see attachment Case 2006-00464 KPSC DR2-76 ATT.

b. There have been no significant changes in the level and type of benefits the company provides. However, benefit costs continue to increase. Please see Company's response to AG request DR1-76 for an explanation of benefit cost increases.

KPSC DR2-76 ATT

Gross Benefit Amounts for Atmos Energy-Kentucky	FY 2004 Total	FY 2005 Total	FY 2006 Total	Base Period	Test Period
Clearing Account - Basic Life Insuranc 1840-13821	71,772	52,281	61,157	68,305	83,975
Clearing Account - FAS/106 Clearing 1840-13822	2,466,417	1,975,056	2,186,218	1,885,966	1,941,290
Clearing Account - Medical/Dental Insu 1840-13823	133,862	860,583	1,204,101	1,628,337	1,834,689
Clearing Account - LTD Clearing 1840-13824	664,531	409,049	399,061	90,905	111,124
Clearing Account - Employer ESOP Match 1840-13826	368,178	294,833	331,055	441,415	448,347
Clearing Account - Employer ESOP Match 1840-13841	10,232	16,272	(733)	(3,429)	-
Clearing Account - ESOP-Other Clearing 1840-13827	10,362	8,471	7,243	8,367	11,099
Clearing Account - Pension Cost Cleari 1840-13828	186,428	297,812	682,377	912,186	938,944
Total Gross Benefits Cost	**3,911,782**	**3,914,358**	**4,870,481**	**5,032,052**	**5,369,468**

O&M Benefits Expense by Benefit Type - Kentucky Division - 009DIV	FY 2004 Total	FY 2005 Total	FY 2006 Total	Base Period	Test Period
Basic Life Insurance	17,683	23,206	27,615	31,338	38,528
FAS 106	644,054	847,453	1,023,497	865,281	890,664
Medical/Dental	280,734	461,546	550,007	747,081	841,755
Long Term Disability (LTD, STD, FMLA)	179,559	177,711	200,015	41,707	50,984
Employer ESOP Match	81,740	130,316	147,045	202,521	205,702
Employer ESOP Match Accrual	10,468	7,978	2,144	(1,573)	-
Employer ESOP - Other	2,553	3,761	3,246	3,839	5,092
Pension Cost	45,932	132,194	308,123	418,511	430,788
Retirement Plan-Other Exp - 01244	-	-	-	-	-
O&M Benefits Expense by Benefit Type - Kentucky Division - 009DIV	**1,262,723**	**1,784,164**	**2,261,694**	**2,308,705**	**2,463,512**

Note: The above data excludes worker's comp

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 77
Witness: Greg Waller

Data Request:

Refer to the response to the Staff First Request, Item 21. Provide copies of the referenced "Summary Plan Description" which was not attached to the response.

Response:

Please see the attachment labeled Case 2006-00464 KPSC DR2-77 ATT1 Retiree_Medical_SPD_BCBS for the referenced Summary Plan Description.

ATMOS energy

Retiree Medical Plan for Retirees and Disabled Employees of Atmos Energy Corporation

Summary Plan Description

Effective January 1, 2005

TABLE OF CONTENTS

SCHEDULE OF COVERAGE

LOW DEDUCTIBLE PLAN

Deductibles and Out-of-Pocket Maximums	
Individual Deductible	$300
Family Deductible *	$600
Individual Co-Share Stop Loss Amount (Out-of-Pocket Maximum)	$2,500
Family Co-Share Stop-Loss Amount (Out-of-Pocket Maximum)	$5,000
Percentage of Covered Medical Expenses Payable After Deductibles are Satisfied	80%
Percentage of Covered Expenses Payable After Out-of-Pocket Maximum is Reached	100%
Calendar Year Maximum Benefits	
Outpatient Physical Therapy **	20 visits
Outpatient Speech Therapy **	20 visits
Outpatient Occupational Therapy **	20 visits
Preventive Health Care	$300
Skilled Nursing Facility	$10,000
Spinal Manipulations (Chiropractic Services) **	20 visits
Temporomandibular Joint Dysfunction (TMJ)	$1,000
Employee Assistance Program	Up to 6 visits at no charge
Inpatient Mental Health	30 days
Outpatient Mental Health	50 visits
Inpatient Chemical Dependency	30 days
Outpatient Chemical Dependency	30 visits
Lifetime Maximum Benefits	
Durable Medical Equipment	$50,000
Private Duty Nursing Services	$50,000
All Other Covered Expenses	$1,000,000
Inpatient Mental Health	90 days
Inpatient Chemical Dependency	3 series of treatment

* The family deductible must be met by at least two family members. In other words, at least one family member must meet a $300 deductible, and at least one or more family members must meet the other $300 deductible for the family deductible of $600 to be satisfied.

**Additional benefits may be available if approved by Medical Management.

SCHEDULE OF COVERAGE

HIGH DEDUCTIBLE PLAN

Deductibles and Out-of-Pocket Maximums	
Individual Deductible	$1,250
Family Deductible *	$2,500
Individual Co-Share Stop-Loss Amount (Out-of-Pocket Maximum)	$5,000
Family Co-Share Stop-Loss Amount (Out-of-pocket Maximum)	$10,000
Percentage of Covered Expenses Payable After Deductibles are Satisfied	80%
Percentage of Covered Expenses Payable After Out-of-pocket Maximum is Reached	100%
Calendar Year Maximum Benefits	
Outpatient Physical Therapy **	20 visits
Outpatient Speech Therapy **	20 visits
Outpatient Occupational Therapy **	20 visits
Preventive Health Care	$300
Skilled Nursing Facility	$10,000
Spinal Manipulations (Chiropractic Services) **	20 visits
Temporomandibular Joint Dysfunction (TMJ)	$1,000
Employee Assistance Program	Up to 6 visits at no charge
Inpatient Mental Health	30 days
Outpatient Mental Health	50 visits
Inpatient Chemical Dependency	30 days
Outpatient Chemical Dependency	30 visits
Lifetime Maximum Benefits	
Durable Medical Equipment	$50,000
Private Duty Nursing Services	$50,000
All Other Covered Expenses	$1,000,000
Inpatient Mental Health	90 days
Inpatient Chemical Dependency	3 series of treatment

* The family deductible must be met by at least two family members. In other words, at least one family member must meet a $1,250 deductible, and at least one or more family members must meet the other $1,250 deductible for the family deductible of $2,500 to be satisfied.

**Additional benefits may be available if approved by Medical Management.

SCHEDULE OF COVERAGE

PREFERRED PROVIDER ORGANIZATION PLAN

Deductibles and Out-of-Pocket Maximums		
	Network	Non-Network
Combined Individual Deductible	$250	
Combined Family Deductible *	$500	
Individual Co-Share Stop-Loss Amount (Out-of-Pocket Maximum)	$1,250	$2,500
Family Co-Share Stop-Loss Amount (Out-of-Pocket Maximum)	$2,500	$5,000
Percentage of Covered Expenses Payable for Specialized Providers/Facilities	90%	
Percentage of Covered Expenses Payable after Deductibles are Satisfied	90%	70%
Percentage of Covered Expenses Payable after Out-of-pocket Maximum is Reached	100%	100%
Calendar Year Maximum Benefits		
Outpatient Physical Therapy **	20 visits	
Outpatient Speech Therapy **	20 visits	
Outpatient Occupational Therapy **	20 visits	
Preventive Health Care (applies when a Non-Network Provider is used)	$300	
Skilled Nursing Facility	$10,000	
Spinal Manipulations (Chiropractic Services)**	20 visits	
Employee Assistance Program	Up to 6 visits at no charge	
Temporomandibular Joint Dysfunction (TMJ)	$1,000	
Inpatient Mental Health	30 days	
Outpatient Mental Health	50 visits	
Inpatient Chemical Dependency	30 days	
Outpatient Chemical Dependency	30 visits	
Lifetime Maximum Benefits		
Durable Medical Equipment	$50,000	
Private Duty Nursing Services	$50,000	
All Other Covered Expenses	$1,000,000	
Inpatient Mental Health	90 days	
Inpatient Chemical Dependency	3 series of treatment	

* The family deductible must be met by at least two family members. In other words, at least one family member must meet a $250 deductible, and at least one or more family members must meet the other $250 deductible for the family deductible of $500 to be satisfied.

**Additional benefits may be available if approved by Medical Management.

SCHEDULE OF COVERAGE

EXCLUSIVE PROVIDER ORGANIZATION PLAN

Copayments	
Office Visit Copayment	$15
Mental Health Individual Visit Copayment	$15
Emergency Room Copayment	$75
Per-admission Deductible (Inpatient Copayment)	$200 per hospital confinement
Percentage of Covered Expenses Payable for Network Covered Services (There are no benefits payable for services received outside the network)	100%
Calendar Year Maximum Benefits	
Outpatient Physical Therapy *	20 visits
Outpatient Speech Therapy *	20 visits
Outpatient Occupational Therapy *	20 visits
Skilled Nursing Facility	$10,000
Spinal Manipulations (Chiropractic Services) *	20 visits
Temporomandibular Joint Dysfunction (TMJ)	$1,000
Employee Assistance Program	Up to 6 visits at no charge
Inpatient Mental Health	30 days
Outpatient Mental Health	50 visits
Inpatient Chemical Dependency	30 days
Outpatient Chemical Dependency	30 visits
Lifetime Maximum Benefits	
Durable Medical Equipment	$50,000
Private Duty Nursing Services	$50,000
All Other Covered Expenses	$1,000,000
Inpatient Mental Health	90 days
Inpatient Chemical Dependency	3 series of treatment

*Additional benefits may be available if approved by Medical Management.

SCHEDULE OF COVERAGE

PRESCRIPTION DRUG BENEFIT

The Prescription Drug benefits outlined below are included with all benefit options in the Medical Plan.

Retail Pharmacy	
25% Co-Share Amount for all medical plans for a ***30-day supply*** or the following minimum:	
Generic	$7
Preferred Brand Name	$15
Non-Preferred Brand Name	$30
Mail Order Prescriptions	
25% Co-Share Amount for all medical plans for a ***90-day supply*** or the following minimum:	
Generic	$14
Preferred Brand Name	$30
Non-Preferred Brand Name	$60
Prescription Drug Annual Out-of-Pocket Maximum per Family (Applies to retail and mail order prescriptions combined.)	$1,500

INTRODUCTION

This booklet provides you with a summary of the benefits provided by the Retiree Medical Plan for Retirees and Disabled Employees of Atmos Energy Corporation. Blue Cross and Blue Shield of Texas is the Claims Administrator for the Plan. You should read this booklet carefully to familiarize yourself with the Plan's provisions and keep it handy for reference. To help you understand the terms of the Plan and what you need to do to get your maximum benefits, contact the Customer Service Helpline.

MANAGED HEALTH CARE IN-NETWORK BENEFITS

Network Benefits are available through Providers listed in your Network directory.

To receive In-Network Benefits, **you must** choose Providers within the Network for all care **(other than for emergencies).** The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider Directory to make your selections. You may obtain a Provider Directory by calling the Customer Service Helpline at 1-866-314-0266 or by accessing the website at www.bcbstx.com.

Remember...for Participants who elect the EPO Option, **you must** choose Providers with the Network for all care (other than for emergencies or unless otherwise authorized by the Claims Administrator).

To receive Benefits for Mental Health Care, treatment of Serious Mental Illness, or treatment of Chemical Dependency, all care must be preauthorized.

Services and supplies for Mental Health Care, treatment of Serious Mental Illness, or treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claims Administrator to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill the Claims Administrator - not you - for services provided. The Provider has agreed to accept as payment in full the lesser of:

- The billed charges,
- The Allowable Amount as determined by the Claims Administrator, or
- Other contractually determined payment amounts, and

You are responsible for paying Deductibles, Copayment Amounts, and Co-Share Amounts determined by the Plan option in which you enroll.

You may be required to pay for limited or noncovered services. No claim forms are required.

MANAGED HEALTH CARE OUT-OF-NETWORK BENEFITS

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available.

If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided. You will be responsible for...

- Billed charges above the Claims Administrator's Allowable Amount,
- Copayment and Co-Share Amounts,
- Deductibles,
- Preauthorization, and
- Limited or noncovered services.

Remember...for Participants who elect the EPO Option, if you **choose** to use Out-of-Network Providers, **no benefits will be available**. You will be responsible for all charges billed by the Out-of-Network Provider.

TRADITIONAL OUT-OF-AREA BENEFITS

Out-of-Area Benefits are provided through a traditional indemnity arrangement for Participants who elect coverage under either the Low Deductible and High Deductible option.

You may have to submit claims for the services provided. You will be responsible for:

- Billed charges above the Claims Administrator's Allowable Amount,

- Co-Share Amounts,
- Deductibles,
- Preauthorization, and
- Limited or noncovered services.

PRESCRIPTION DRUG PROGRAM

Benefits are available for Covered Drugs under the **PRESCRIPTION DRUG PROGRAM** as explained later in this Benefit Booklet.

CUSTOMER SERVICE HELPLINE

Toll free: 1-866-314-0266

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* Providers
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of your Plan
- Record comments about Providers
- Provide information regarding the Prescription Drug Program

You can reach the Customer Service Helpline Monday through Friday from 8:00 a.m. to 8:00 p.m., Central Time.

MENTAL HEALTH HELPLINE

Toll free: 1-800-528-7264

Network Physicians, Professional Other Providers, Participants, or anyone else seeking treatment for Mental Health Care, Serious Mental Illness, or Chemical Dependency for Participants can call the Mental Health Helpline at any time, day or night.

MEDICAL PREAUTHORIZATION HELPLINE

Toll-free: 1-800-441-9188

To satisfy all medical preauthorization requirements for Inpatient Hospital Admissions, *Extended Care Expense,* or Home Infusion Therapy, call the Medical Preauthorization Helpline, Monday through Friday, 7:30 a.m. – 6:00 p.m., Central Time.

INTRODUCTION

Low Deductible and High Deductible Plans

Providers Participating in a Blue Cross and Blue Shield Par Provider network.

The Claims Administrator has arranged with certain health care providers to participate in a network. These health care providers, called Network Providers, have agreed to discount their charges for Covered Expenses. There is no difference in coverages provided, whether or not you use a Network Provider, if you are enrolled in the Low Deductible or High Deductible Plan.

However, if Network Providers are used, the amount of Covered Expenses for which you are responsible will generally be less than the amount owed if Non-Network Providers had been used. The coinsurance level (the percentage of Covered Expenses for which you are responsible) remains the same whether or not Network Providers are used. However, because the total charges for Covered Expenses may be less when Network Providers are used, the portion that you owe may be less. In addition, you will not be required to pay amounts over reasonable and customary charges if a Network Provider is used.

You will be issued an Identification Card (ID Card) showing that you are eligible for the network discounts. You must show this ID Card every time health care services are given. This is how the provider knows that you are covered under a network plan. Otherwise, you could be billed for the provider's normal charge.

You may call Member Services to determine which providers participate in the Network. The telephone number for Member Services is on the ID Card.

Deductibles

Each Covered Person must satisfy certain Deductibles when enrolled in the Low Deductible, High Deductible or PPO Plan, before any payment is made for certain Covered Expenses. Then the Medical Benefits pay the percentage of Covered Expenses shown in the Schedule of Coverage. The amount of each Deductible is shown in Schedule of Coverage. A Covered Expense can only be used to satisfy one Deductible.

Individual Deductible

You must pay the Individual Deductible each Calendar Year before any benefits are payable. The Individual Deductible applies to all Covered Expenses. The amount of the Individual Deductible is shown in Schedule of Coverage.

Family Deductible

The most your whole family will have to pay for Individual Deductibles in any Calendar Year is the amount of the Family Deductible shown in Schedule of Coverage. The Family Deductible applies no matter how large a family may be, Only Covered Expenses which count toward your Individual Deductible count toward this Deductible.

Out-of-Pocket Feature

Covered Expenses are payable at the percentage shown in the Schedule of Coverage until any Out-of-Pocket Maximum shown in the Schedule of Coverage has been reached during a Calendar Year. Then, Covered Expenses, other than those shown below are payable at 100% for the rest of that year, subject to any lifetime maximums. All Covered Expenses that you pay, other than those shown below, count toward the Out-of-Pocket Maximums.

The following Covered Expenses do not count toward the Out-of-Pocket Maximum and will never be paid at 100%:

- Billed charges above the Claims Administrator's Allowable Amount,
- Mental Disorder Treatment and Chemical Dependency Treatment
- Outpatient Prescription Drugs.

Individual

When the Individual Out-of-Pocket Maximum is reached for any one person in a Calendar Year, Covered Expenses, other than those shown in the Out-of-Pocket Feature above, are payable at 100% for that same person for the rest of that year, subject to any lifetime maximums.

Family

When the Family Out-of-Pocket Maximum is reached for all Covered Family Members in a Calendar Year, Covered Expenses, other than those shown in the Out-of-Pocket Feature above, are payable at 100% for the rest of that year, subject to any lifetime maximums.

Preferred Provider Organization (PPO) Plan

The Plan pays for Covered Expenses received from both Network or Non-Network Providers. However, if you use Network Providers, the Plan pays a greater portion of Covered Expenses. This is called the Network level.

If you use Non-Network Providers, the Plan pays a lesser portion of Covered Expenses. This is called the NonNetwork level. In certain cases, a higher level of benefits are payable. For example, payment is made at the Network level for Emergency Care given at a Non-Network Hospital. Other benefits are also payable at the Network level for certain Non-Network Providers.

A directory of the Network Providers is available from the Claims Administrator. The following types of providers participate in the Network:

- Ambulatory Surgical Centers.
- Chiropractors.
- Durable Medical Equipment Providers.
- Home Health Care Providers.
- Home IV Providers.
- Hospices.
- Hospitals.
- Physical Therapists.
- Physicians.
- Podiatrists.
- Rehabilitation Facilities.
- Skilled Nursing Facilities.

This Plan also covers Specialized Providers and Specialized Facilities. These are types of providers which are not represented in the Network. These providers and facilities are not subject to the Network/Non-Network level of coverage. Instead these types of providers are covered at 80% of the allowable amount. The following are examples of Specialized Providers or Specialized Facilities:

- Birth Center
- Hospice
- Home Health Care Agency

Network Benefits

This Plan pays the Network percentage for Network Provider services as shown in the Schedule of Coverage. See Schedule of Coverage for a complete description of any deductibles that may apply under this Plan.

Non-Network Providers Paid At Network Level

- Radiology, anesthesiology, and pathology services are paid at the Network level. Services must be given in one of the settings shown below:
  - Inpatient Hospital.
  - Outpatient facility which is part of a Hospital.
  - Ambulatory Surgical Center.
  - Emergency Care.

Emergency Care is payable at the Network level, even if services are received from a Non-Network Provider.

Network Provider Charges Not Covered

A Network Provider has contracted with the Claims Administrator to participate in the Network. Under this contract a Network Provider may not charge you or the Claims Administrator for any services or supplies which are not Medically Necessary.

You may agree with the Network Provider to pay any charges for services and supplies which are not Medically Necessary. In this case, the Network Provider may make charges to you. However, these charges are not Covered Expenses under this Plan and are not payable by the Claims Administrator.

Non-Network Benefits

This Plan pays the Non-Network percentage of Covered Expenses as shown in the Schedule of Coverage for Non-Network Provider services.

Deductibles

See Schedule of Coverage for a complete description of the deductibles that apply under this Plan.

Each Covered Person must satisfy certain Deductibles before any payment is made for certain Covered Expenses. Then the Medical Benefits pays the percentage of Covered Expenses shown in the Schedule of Coverage. The amount of each Deductible is shown in Schedule of Coverage. A Covered Expense can only be used to satisfy one Deductible.

Individual Deductible

The Network Individual Deductible applies to all Covered Expenses charged by a Network Provider. It applies each Calendar Year.

Family Deductible

The most a family will have to pay for Network Individual Deductibles in any Calendar Year, no matter how large a family may be, is the amount of the Network Family Deductible. Only Covered Expenses which count toward the Covered Persons Network Individual Deductible count toward this Deductible.

Out of Pocket Feature

Covered Expenses are payable at the percentage shown in the Schedule of Coverage until any Out-of-Pocket Maximum shown in the Schedule of Coverage has been reached during a Calendar Year. Then, Covered Expenses, other than those shown below are payable, subject to any lifetime maximum, at 100% for the rest of that year. All Covered Expenses that you pay, other than those shown below, count toward the Out-of-Pocket Maximums.

The following Covered Expenses do not count toward the Out-of-Pocket Maximum and will never be paid at 100%:

- Billed charges above the Claims Administrator's Allowable Amount,
- Mental Disorder Treatment and Chemical Dependency Treatment
- Outpatient Prescription Drugs
- Non-Notification Deductible

Covered Expenses for Non-Network Providers do not count toward the Network Individual and Network Family Out-of-pocket Maximums. Likewise, Covered Expenses for Network Providers do not count toward the Non-Network Individual and Network Family Out-of-Pocket Maximums.

Network Out-of-Pocket Maximums

Individual

When the Network Individual Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, Network Covered Expenses, other than those shown in the Out-of-Pocket Feature above, are payable at 100% for that same person for the rest of that year, subject to any lifetime maximum.

Family

When the Network Family Out-of-Pocket Maximum is reached for all Covered Family Members in a Calendar Year, Network Covered Expenses, except those shown in the Out-of-Pocket Feature above, are

payable, subject to any lifetime maximum, at 100% for that same person for the rest of that year.

Non-Network Out-of-Pocket Maximums

Individual

When the Non-Network Individual Out-of-Pocket Maximum is reached for any Covered Person in a Calendar Year, Non-Network Covered Expenses, other than those shown in the Out-of-pocket Feature above, are payable, subject to the lifetime maximum, at 100% for that person for the rest of that year. Non-Network charges paid at the Network level are not paid at 100% until the Network Out-of-Pocket Maximum is reached.

Family

When the Non-Network Family Out-of-Pocket Maximum is reached for all Covered Family Members in a Calendar Year, Non-Network Covered Expenses, other than those shown in the Out-of-Pocket Feature above, subject to the lifetime maximum, are payable at 100% for all Covered Family Members for the rest of that year. Non-Network Charges paid at the Network level are not paid at 100% until the Network Out-of-Pocket is reached.

Exclusive Provider Organization (EPO) Plan

The EPO Plan pays for Covered Expenses received from Network Providers. In order to receive benefits under this Plan you must receive care from a Network Provider.

This Plan pays Mental Disorder Treatment at the Network level, as shown in the Schedule of Coverage, if you receive a referral from Magellan before receiving care from a Network Provider.

Emergency Care

In an Emergency, any Emergency Care is payable at the Network level as shown in the Schedule of Coverage regardless of whether you receive services from a Network or Non-Network Provider.

Network Provider Charges Not Covered

A Network Provider contracts with the Claims Administrator to participate in the Network. Under the terms of this contract a Network Provider may not charge you or the Claims Administrator for any services or supplies which are not Medically Necessary as determined by Medical Management.

You may agree with the Network Provider to pay any charges for services or supplies which are not Medically Necessary. In this case, the Network Provider may make charges to you. However, these charges are not Covered Expenses under the Plan and are not payable by the Claims Administrator.

Copayments

Before Medical Benefits are payable, each Covered Person must satisfy certain Copayments. A Copayment is the amount of Covered Expenses you must pay to a Network Provider at the time services are given. The amount of each Copayment is shown in the Schedule of Coverage. A Covered Expense can only be used to satisfy one copayment.

Inpatient Copayment

The Inpatient Copayment applies to each confinement in a Network Hospital or Network Rehabilitation Facility.

Office Visit Copayment

The Office Visit Copayment applies to Network Physicians Services. It also applies to Network physical therapists services if the physical therapist bills for his/her services separately from any other charges. It applies to all Covered Expenses given in connection with each office visit.

The Office Visit Copayment does not apply to the prenatal and postnatal office visits to the Network obstetrician/ gynecologist who is primarily responsible for maternity care.

Emergency Room Copayment

The Emergency Room Copayment applies to Hospital emergency room services. It applies to each emergency room visit. Emergency room services are payable only if it is determined that the services are Medically Necessary and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services. (See definition of Emergency Care.) The Emergency Room Copayment does not apply if you are admitted as a Hospital inpatient.

Urgent Care Center Copayment

The Urgent Care Center Copayment applies to Network Physician's Services given in a Network walk-in urgent care center.

WHO GETS BENEFITS

Eligibility and Participation for Retirees and Dependents

Eligibility:
Atmos Retiree:

Prior to January 1, 2002:

Any former employee of Atmos Energy Corporation who is, as of January 1, 2002, participating in the Retiree Medical Plan under the provisions in place at the time of his/her retirement.

On and After January 1, 2002:

A former employee of Atmos Energy Corporation who has completed at least ten (10) years of full-time service with Atmos Energy Corporation (as determined by Atmos Energy Corporation's written policy for determining full-time service) after reaching age 45, and who has retired from Atmos Energy Corporation. In other words, the earliest age at which participation may begin is age 55 as long as the Employee has worked for Atmos since reaching age 45.

Former TXU Gas employees will receive service credit for their service with TXU Gas at 73% of their service with TXU Gas after attaining age 45 and prior to October 1, 2004. This service will be applied toward the required credit outlined above for all Atmos former employees.

Service completed with an affiliate of Atmos Energy Corporation will not be credited toward the requirement that a former employee complete ten (10) years of full-time service with Atmos Energy Corporation after reaching age 45.

Any Retiree who is described in the preceding paragraphs shall be referred to sometimes as an "Atmos Retiree".

LGS Retiree:

A person who was eligible for retiree medical coverage under the retiree medical plan or plans maintained by Citizens Utilities Company ("Citizens") on June 30, 2001 and for whom Atmos Energy Corporation ("Atmos") agreed to provide retiree medical coverage beginning on July 1, 2001, as a result of Atmos' acquisition of certain of Citizens' assets associated with its Louisiana Gas Service operation (sometimes referred to as an "LGS Retiree").

Participation:

When an eligible Employee retires from Atmos, the new Retiree may choose to enroll in the Plan or defer participation to a later date. The eligible Retiree also may defer enrolling an eligible spouse and eligible Dependents to a date later than when the Retiree begins participation, but the eligible spouse and eligible Dependents may only be enrolled in the Plan if the eligible Retiree has enrolled in the Plan.

Only the Retiree's spouse and eligible Dependents at the time of retirement (not enrollment) from Atmos are eligible to participate in the Plan. A new spouse or any new Dependents following retirement are not eligible to participate.

Eligible Dependents:

Your eligible Dependents are the persons who meet the following classifications on the date you retire from the Company.

- Your wife or husband.
- Your unmarried children under age 19.
- Your unmarried children 19 or older but under age 25 who are registered students in regular full-time attendance (12 or more semester hours) at a licensed or accredited school ("Full-Time Students"). For coverage to continue during vacation periods, the child must be scheduled to enter school on the next enrollment date.
- Dependent children must be provided over one-half of their support by you for a calendar year. The determination of whether over one-half of a child's support has been provided is governed by the rules of Section 152 of the Internal Revenue Code of 1986, as amended.
- A Dependent child must have the same principal place of abode as you for more than one-half of the calendar year, unless the child is

not a "qualifying child" of another person for purposes of Section 152 of the Internal Revenue Code of 1986, as amended,

Children include 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 adoption.)
- Any other child who is related by blood or marriage to you, who is not a "qualifying child" of another person for purposes of Section 152 of the Internal Revenue Code of 1986, as amended, and who is living with you, as a member of your household, 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 prior to the child becoming a covered Dependent.
- A mentally or physically incapacitated child's coverage will not end due to age, and he or she shall remain a "child" for purposes of Dependent eligibility. Coverage will continue as long as Dependents coverage under this Plan continues and the child continues to meet the following conditions:

  • The child is incapacitated.

  • The child is not capable of self-support.

  The participant 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.

Extended Benefits

- A dependent who lost his or her eligibility as a Dependent but who thereafter meets the definition of a Full-Time Student may re-enroll in the Plan.
- No person who is not an eligible Dependent as of the date you retire from the Company may become a Dependent eligible for coverage under this Plan.
- No person can be covered as both a Retiree and as a Dependent under the Plan. No person can be covered as a Dependent of more than one Retiree under the Plan or any other medical plan of Atmos. Dependents must reside in the United States.

Dependents of Certain Deceased Active Employees

In the event that an active employee who meets the age and service requirements to be a Retiree under this Plan dies before retirement, that employee's Dependents then eligible for Dependent coverage under the Atmos Energy Corporation Active Employee Medical Plan shall become eligible for coverage under this Plan as if the employee had retired and elected coverage under this Plan and then died (referred to as "Deceased Employee Dependents").

- If the Retiree, spouse, or Dependent elects to discontinue coverage at any time after enrollment, they may not re-enroll at a later date. The Retiree must remain a Participant in order for a spouse or eligible Dependent to continue to participate.
- If an eligible Dependent discontinues coverage because of the loss of student status, the Dependent may re-enroll at a later date if Full-Time Student status is regained. For all other situations, if an eligible Dependent elects to discontinue coverage at any time after enrollment, the eligible Dependent may not re-enroll at a later date.
- Should the Retiree predecease the spouse and/or eligible Dependents who are then covered by the Plan, the spouse may continue to participate in the Plan as long as the spouse remains unmarried and the eligible Dependents may continue to participate in the Plan as long as they

otherwise remain eligible to participate in the Plan.

- If an eligible spouse or Dependent predeceases the Retiree, and the Retiree remarries, the new spouse and any new Dependents are not eligible to participate in the Plan.

Eligibility and Participation for Disabled Participants

- Eligibility: Initially, the Employee must be considered disabled as determined by the company's long-term disability Claims Administrator and may continue participation as long as the Employee is considered disabled by the company's long-term disability Claims Administrator or by the Social Security Administration, if the long-term disability Claims Administrator is no longer providing benefits due to a cash-out of coverage.

- When an eligible Employee is considered disabled, as outlined above, and becomes eligible for participation in the Plan, he may choose to enroll in the Plan or defer participation to a later date. The eligible disabled Employee also may defer enrolling an eligible spouse and eligible Dependents to a date later than when he begins participation, but the eligible spouse and eligible Dependents may only be enrolled in the Plan if the eligible disabled Employee has enrolled in the Plan.

- If the disabled Participant is at any point no longer considered disabled, eligibility will be forfeited unless the Participant meets the eligibility requirements to participate as a Retiree as defined above, in which case coverage as an eligible Retiree shall begin immediately. The lapsed time a disabled Participant is a participant in the Plan will count toward the ten year full-time employment after age 45 requirement.

- The provisions that apply to an eligible Retiree's spouse and Dependent(s) coverage also apply to a disabled Participant except that only the spouse and eligible Dependents at the time of disability are eligible to participate in the Plan. A new spouse or any new Dependents following the date disability begins are not eligible to participate.

- If the disabled Participant elects to discontinue coverage at any time after enrollment, the disabled Participant may not re-enroll at a later date.

- Should a disabled Participant predecease the spouse and/or eligible Dependents who are then covered by the Plan, the spouse and/or eligible Dependents will no longer be eligible to participate in the Plan unless at the time of the disabled Participant's death the disabled Participant otherwise would have met the eligibility requirements to participate as a Retiree as described above. At the time of the disabled Participant's death, if the eligible spouse and/or eligible Dependents are not then covered by the Plan, they will not be eligible to enroll in the Plan, even if the disabled Participant otherwise would have met the eligibility requirements to participate as a Retiree.

Eligibility and Participation for Survivors of Deceased Employees

- In cases where an Employee dies while in active full-time status, a surviving spouse and eligible Dependents may participate in the Retiree Medical Plan if, at the time of death, the Employee would have otherwise qualified to participate in the Retiree Medical Plan as a Retiree. A surviving spouse and /or Dependents in this situation may continue to participate in the Retiree Medical Plan as long as they remain eligible.

- In cases where the Employee did not meet the Retiree Medical Plan's eligibility requirements at the time of death, a surviving spouse and/or eligible Dependents are eligible to continue their participation in the active Employee medical plan under the plan's continuation provisions, also known as COBRA.

WHO GETS BENEFITS

WHO PAYS FOR THE COST OF BENEFITS

The contribution rates for each Plan year 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 projected net claims costs and administrative fees for that Plan year. The developed rates reflect the Company's cost sharing philosophy for participants – 20% of these costs.

The contribution rate to participate in a specific plan option and coverage level is subject to change each year based on the Participant's age.

Each Plan Year's contribution rates will be communicated during the annual enrollment period for the Plan Year.

Participant Contributions

The coverage under this Plan is contributory determined as follows:

Retired Prior to January 1, 1999

For participants under age 65, contribution rates are based on the claims experience of the Group Medical Plan for active employees and the claims experience of participants in this Plan under age 65.

For participants age 65 and older, contribution rates are based on the claims experience of participants in this Plan age 65 and older.

The company employs an outside actuary to develop the required contribution rates using the projected net claims costs and administrative fees for that Plan Year as described above.

Employees who retired on and after January 1, 1997 prior to attaining age 62 are also subject to an add-on factor that is applied to the contribution for the plan option and coverage level elected by the participant. The add-on factor is based on the retiree's age at retirement and this factor, determined at retirement, will be applied to the contribution rate in effect each year for the plan option and coverage level elected for as long as the Retiree is a participant in this Plan.

Except as provided below for Survivors of Deceased Employees, this add-on factor will also be applied to the contribution rates for the eligible surviving spouse and eligible Dependents as long as he/she/they participates in this Plan. The add-on factor does not apply if you are a Disabled Employee participant in this Plan. The add-on factors are as follows:

Age at Retirement	Add-on Factor
62	0%
61	2%
60	4%
59	8%
58	12%
57	16%
56	20%
55	24%

Retired On and After January 1, 1999

For participants under age 65, the contribution rates are based on the claims experience of participants in this Plan under age 65 and the Plans administrative expenses attributable to this group of participants.

For Participants age 65 and older, the contribution rates are based on the claims experience of participants in this Plan age 65 and older and the Plan's administrative expense attributable to this group of participants.

To minimize the impact of adding administrative expenses in determining the contribution rates for Employees who retired on and after January 1, 1999, the full impact of this change will be phased in over a ten year period. The contribution rates in 2008 will reflect the full impact of adding the administrative costs for both groups and the claims experience for participants in this Plan under age 65 to determine that year's contribution rates.

Employees who retire after January 1, 1999 and prior to attaining age 62 are also subject to an add-on factor that is applied to the required contribution for the plan option and coverage elected by the participant. The add-on factor is based on the retiree's age at retirement and this factor, determined at retirement, will be applied to the required contribution for the plan option and coverage level in effect each year for as long as the Retiree is a participant in this Plan. The add-on factors are the same as those shown above.

WHO GETS BENEFITS

Survivors of Deceased Employees

The contribution rate for a surviving spouse and Dependents of an Employee who, at the time of death, would have otherwise qualified to participate in the Retiree Medical Plan as a Retiree will be the Retiree rate plus the add-on factor based on the Retiree's age at the time of his death.

Disabled Employees From and After January 1, 2002

From and after January 1, 2002, for Disabled Employees who have not yet become eligible for benefits under Medicare, the contribution rate to participate in a specific plan option and coverage level shall be the same as the contribution rates in effect from time to time for eligible Employees under the Atmos Energy Corporation Active Employee Medical Plan (the "Active Plan"). The contribution rates under the Active Plan are based on the claims experience of participants in the Active Plan, the claims experience for the Disabled Employees under this Plan, the Active Plan's administrative expenses attributable to the Participants under the Active Plan, and this Plan's administrative expenses attributable to the Disabled Employees.

From and after January 1, 2002, for Disabled Employees who have become eligible for Medicare, the contribution rate to participate in a specific plan option and coverage level shall be the same as the contribution rates in effect from time to time for Participants in this Plan who are age 65 and older and who retired on or after January 1, 1999.

WHO GETS BENEFITS

You must enroll for coverage under the Plan.

HOW TO ENROLL

You enroll by filing a written request with Atmos Energy Corporation to deduct the required contribution from your benefit check or to bill you for coverage.

You must enroll for Retiree and Disabled Employee benefits in order to enroll for the Dependent benefits. You must enroll each Dependent you want covered under the Plan.

WHEN COVERAGE STARTS

Your Coverage

You must enroll for coverage under the Plan.

Coverage starts on the later of:

- The date you become a Retiree or Disabled Employee
- The date you enroll for coverage

You are not required to enroll for coverage when you first become eligible. If you choose to defer participation in the Plan to a later time, you will need to contact Atmos Energy Human Resources at that time to request enrollment materials.

ANNUAL ENROLLMENT PERIOD

An Annual Enrollment Period is a period of time each year during which you may change the Plan option you elected under the Plan. The Annual Enrollment Period is agreed on by Atmos Energy Corporation. This enrollment period occurs once each Calendar Year and you will be notified as to when it is scheduled.

During the Annual Enrollment period, you will have the right to change your election of the Low Deductible, High Deductible, Preferred Provider Organization, or Exclusive Provider Organization Plans.

You and your eligible Dependents must enroll in the same plan.

Once enrolled, if you elect to stop your coverage in the Plan at any time, you will no longer be eligible to participate.

Your Dependent's Coverage

You must enroll your Dependents for coverage under the Plan.

Coverage starts on

- The date you enroll your Dependents for coverage.

You may not enroll your Dependents in the Plan unless you are enrolled.

WHEN COVERAGE STOPS

Coverage will stop on the earliest of the following:

- When you stop being an eligible Retiree (as defined above) or a Disabled Employee (as defined above).
- When you stop making contributions.
- When the Plan stops.
- Your Dependent's coverage will stop when he is no longer an eligible Dependent, or when your coverage stops, if earlier.

HOW TO RECEIVE HEALTH CARE BENEFITS

CONTRACTING/NON-CONTRACTING FACILITIES

The Claims Administrator has written contracts with many (but not all) Hospitals and Facility Other Providers. Those institutions are Contracting Facilities. An institution without a written contract with the Claims Administrator is a Non-Contracting Facility.

In an emergency situation, the immediate, initial treatment necessary to stabilize the Participant furnished by any Hospital is subject to the benefits provided by the Plan.

PARPLAN

For Retirees residing in the state of Texas

When you consult a Physician or Professional Other Provider, you should inquire if he participates in the Claims Administrator's *ParPlan...* a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan,* he agrees to:

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

You will be responsible for any applicable Deductibles, Co-Share Amounts, or services that are limited or not covered under the Plan.

If your Physician or Professional Other Provider does not participate in the *ParPlan*, you will be responsible for filing the claims as described in **CLAIM FILING PROCEDURES** in this section and you may be billed for charges above the Claims Administrator's Allowable Amount determination.

Note: For Retirees residing outside the state of Texas, check with your Physician or Professional Other Provider to determine if he participates as a contracting provider with Blue Cross and Blue Shield.

OTHER BLUE CROSS AND BLUE SHIELDS' SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

BLUE CARD

Other Blue Cross and Blue Shield Plans outside of Texas ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

HOW TO RECEIVE HEALTH CARE BENEFITS

SPECIALTY CARE PROVIDERS

Applies to In-Network and Out-of-Network

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If specialty care by an Out-of-Network Provider is needed, In-Network Benefits may still be available if a Network Physician notifies the Claims Administrator and the Claims Administrator acknowledges your visit to an Out-of-Network Provider prior to the visit; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate. For Participants who elect the EPO Plan, **no benefits will be paid by the Plan**; or

- If the services you require are covered by this Plan, but not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers, if prior authorization is received.

Participants electing the PPO Plan

- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Participants electing the EPO Plan

- Network Benefits for authorized Out-of-Network services will be paid based on the Allowable Amount for Hospitals and Facility Other Providers, and Physicians or Professional Other Providers **not** contracting with BCBSTX (or any other Blue Cross and Blue Shield Plan outside of Texas.) If the Allowable Amount is less than the amount charged by the Provider, you may be billed for the balance. (See Allowable Amount definition.) If you **choose** to see an Out-of-Network Provider without prior authorization, **no benefits will be paid by the Plan.**

AUTHORIZATION

Participants electing the EPO Plan

- If authorization to use Out-of-Network Providers is needed, you or your Network Provider must contact the Claims Administrator to receive a referral authorization **prior** to use of the Out-of-Network Provider. If you receive the referral authorization, Network benefits will be paid, **otherwise no benefits will be paid by the Plan.** To request authorization ask your Network Provider to contact the Claims Administrator or you may contact Customer Service at the number shown on your Identification Card.

MEDICAL NECESSITY

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claims Administrator.

Charges for services and supplies which the Claims Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co-Share Stop-Loss Amount.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury. Sickness, mental illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary used in this booklet relates only to coverage for Mental Health and Prescription Drug Benefits, and may differ from the way in which a Physician engaged in the practice of medicine may define medically necessary.

PREEXISTING CONDITIONS PROVISIONS

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the initial Effective Date of this Plan.

New enrollees must serve the preexisting waiting period.

HOW TO RECEIVE HEALTH CARE BENEFITS

PREAUTHORIZATION REQUIREMENTS

Preauthorization establishes in advance the Medical Necessity of certain care and services covered under this Plan. It ensures that the preauthorized care and services described below will not be denied on the basis of Medical Necessity. However, preauthorization does not guarantee payment of benefits. **Coverage is always subject to other requirements of the Plan, such as preexisting conditions, limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.**

Preauthorization is simple. You, your Physician, Provider of services, or a family member calls one of the toll-free numbers listed on the back of your Identification Card. The call should be made between 7:30 a.m. and 6:00 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. In most cases, preauthorization is made within minutes on the telephone with your Provider's office.

The following types of services require preauthorization:

- All inpatient admissions,
- Extended Care Expense,
- Home Infusion Therapy,
- All treatment of Chemical Dependency,
- All treatment of Mental Health Care preauthorized by the Employee Assistance Program (EAP) (including Serious Mental Illness), and
- If you transfer to another facility or to or from a specialty unit within the facility.

Participants electing the PPO Plan

The following types of services require preauthorization:

Out-of-Area coverage

- All inpatient admissions,
- Extended Care Expense,
- Home Infusion Therapy,
- Inpatient treatment of Chemical Dependency,
- Inpatient treatment of Serious Mental Illness and Mental Health Care preauthorized by the EAP,
- If you transfer to another facility or to or from a specialty unit within the facility.

In-Network: In-Network Benefits will be available if you use a Network Provider or Specialty Care Provider. In-Network Providers will preauthorize services for you, when required.

Out-of-Network: If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. Failure to preauthorize services will be subject to guidelines described below.

However, if care is not available from Network Providers as determined by the Claims Administrator, and the Claims Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Out-of-Area: If you receive your care in a Contracting Facility and the services have been preauthorized, Out-of-Area Benefits will be available, subject to all Plan provisions. Failure to preauthorize services will be subject to guidelines described below.

Participants electing the EPO Plan

Network Providers will preauthorize services for you, when required.

Out-of-Network: If you **choose** to use Out-of-Network Providers for services and supplies available in the Network, **no benefits will be paid under this Plan.**

However, if care is not available from Network Providers as determined by the Claims Administrator, and the Claims Administrator authorizes your visit to an Out-of-Network Provider **prior to the visit**, Network Benefits will be paid based on the Allowable Amount for Out-of Network Providers. You may be billed for any difference between the Allowable Amount and the amount charged by the Provider. If you are receiving any of the services listed above, you are responsible for ensuring the services are preauthorized. Failure to preauthorize services will be subject to guidelines described below.

Failure to Preauthorize

If preauthorization for ***each inpatient Hospital Admission, Extended Care Expense, Home***

Infusion Therapy, and Chemical Dependency, Mental Health Care (including Serious Mental Illness), as described, is not obtained:

- The Claims Administrator will review the Medical Necessity of your treatment prior to the final benefit determination;
- If the Claims Administrator determines the treatment or service is not Medically Necessary, benefits will be denied; or
- If a Hospital Admission or extension for any treatment or service described below is not preauthorized and it is determined that the admission or extension was not Medically Necessary, benefits will be reduced or denied.

Inpatient Admissions
In the case of an elective inpatient admission, the call for preauthorization should be made at least two working days before you are admitted, unless it would delay Emergency Care. In an emergency, preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

When an inpatient admission is preauthorized, a length-of-stay is assigned. Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection

If you require a longer stay than was first preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Extended Care Expense and Home Infusion Therapy
Preauthorization for *Extended Care Expense* and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claims Administrator to request preauthorization. The request should be made:

- Prior to initiating *Extended Care Expense* or Home Infusion Therapy;
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

The Claims Administrator will review the information submitted prior to the start of *Extended Care Expense* or Home Infusion Therapy. The Claims Administrator will send a letter to you and the agency or facility confirming preauthorization or denying benefits.

If *Extended Care Expense* or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the **MEDICAL PREAUTHORIZATION HELPLINE.**

If the Claims Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

To satisfy all medical preauthorization requirements for Inpatient Hospital Expense, *Extended Care Expense*, or Home Infusion Therapy, call:

Toll-free: 1-800-441-9188

Chemical Dependency, Mental Health Care (including Serious Mental Illness)
(In-Network, Out-of-Network, and *Out-of-Area)*
All inpatient treatment of Chemical Dependency and Mental Health Care (including Serious Mental Illness) should be preauthorized.

In-Network and Out-of-Network
All outpatient treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care should be preauthorized. Your Provider should contact the EAP for the names of Network Providers.

HOW TO RECEIVE HEALTH CARE BENEFITS

You or your Provider should contact the Mental Health Helpline for a referral to Network Providers who have entered into a managed care arrangement with the EAP to furnish services and supplies for Mental Health Care (including Serious Mental Illness) or treatment of Chemical Dependency. When your services have been preauthorized and are provided by the Network Provider, In-Network Benefits will be available.

To satisfy preauthorization requirements for Mental Health Care (including Serious Mental Illness) or Chemical Dependency, call the Magellan EAP

Toll-free: 1-800-421-1768

CASE MANAGEMENT

Under certain circumstances, the Plan allows the Claims Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claims Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claims Administrator anticipates future expenditures for Eligible Expenses that may be reduced by such benefits.

Any decision by the Claims Administrator to provide such benefits shall be made on a case-by-case basis. The case coordinator for the Claims Administrator will initiate case management in appropriate situations.

CLAIM FILING PROCEDURES

Filing of Claims Required

Notice of Claim
You must give written notice to the Claims Administrator within 12 months, or as soon as reasonably possible, after any Participant receives services for which benefits are provided under the Plan.

Claim Forms
Claim forms for filing Proof of Loss are available on the Atmos Energy intranet and may also be obtained by calling customer service at 1-866-314-0266.

The Claims Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with the Claims Administrator and some other health care Providers (such as *ParPlan* Providers in the state of Texas) will submit your claims directly to the Claims Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers
When you receive treatment or care from a Provider or Covered Drugs dispensed from a Pharmacy that contracts with the Claims Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

Non-Contracting Providers
When you receive treatment or care from a health care Provider or Covered Drugs dispensed from a Pharmacy that does not contract with the Claims Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled ***Participant-Filed Claims*** below for instruction on how to file your own claim forms.

Mail Service Prescription Drug Program
When you receive Covered Drugs dispensed through the Mail Service Prescription Drug Program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from Human Resources at Atmos Energy, from the BCBSTX website, or by calling the Customer Service Helpline at 1-866-314-0266.

HOW TO RECEIVE HEALTH CARE BENEFITS

Participant-Filed Claims

- Medical Claims
  If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a Subscriber-filed claim form provided by the Plan. You can obtain copies from Human Resources at Atmos Energy, from the BCBSTX website (**www.bcbstx.com**) or by calling the Customer Service Helpline at 1-866-314-0266.

  Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

- Prescription Drug Claims
  When you receive Covered Drugs dispensed from a Non-Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from Human Resources at Atmos Energy, from the BCBSTX website, or by calling the Customer Service Helpline at 1-866-314-0266.

  This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

  Instructions for completing the claim form are provided on the back of the form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

  Bills for Covered Drugs should show the name, address and telephone number of the pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and, the name of the Participant using the drug.

Visit the BCBSTX Website for Subscriber Claims Forms and other useful information
www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims
Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, Texas75266-0044

Prescription Drug Claims
Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 64812
St. Paul, MN 55164-0812

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claims Administrator. Written agreements between the Claims Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits,** rights and benefits under the Plan are not be assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator
Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claims Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claims Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claims Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment.

Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to the participant, showing what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claims Administrator within twelve (12) months of the date that services or supplies are received. Claims not submitted and received by the Claims Administrator within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claims Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Administrative Office of the Claims Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claims Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claims Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

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 you or your Dependent's life or health or ability to regain maximum function or, in the opinion of a physician with knowledge of you 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 do not agree with the denial, you must submit your claim for review by following 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:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- 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;
- 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);
- 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;
- 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
- 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.

MEDICAL BENEFITS PROVIDED

ELIGIBLE OR COVERED EXPENSES

This portion of the Plan provides benefits for three major categories of Eligible or Covered Expenses:

- *Inpatient Hospital Expense*
- *Medical-Surgical Expense*
- *Extended Care Expense*

This section generally explains the medical benefits that are available under the Plan. Please remember to refer to **DEFINITIONS** for a description of terms such as *Inpatient Hospital Expense, Medical-Surgical Expense*, and *Extended Care Expense*.

Wherever Schedule of Coverage is mentioned, please refer to the Schedule on pages ___ of this Benefit Booklet.

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

DEDUCTIBLES

The benefits of the Plan will be available after satisfaction of the applicable Deductible as shown on your Schedule of Coverage.

Deductibles

1. The individual Deductible shown on your Schedule of Coverage must be met by each Participant each Calendar Year. This Deductible will also apply to *Extended Care Expense*.

2. If you have several covered Dependents, all charges used to apply toward each Participant's *Medical-Surgical Expense* Deductible will be applied toward the "Family Deductible" amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for that Calendar Year. No Participant will contribute more than the individual Deductible amount to the family Deductible amount.

   This is an exception to the individual Deductible described in the paragraph 1 above.

CO-SHARE STOP-LOSS

Most of your Eligible Expense payment obligations are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss benefits.

1. Co-Share Amounts will **not** include:

   - Services, supplies, or charges limited or excluded by the Plan;
   - Expenses not covered because a benefit maximum has been reached;
   - Any Eligible Expenses paid by the Primary Claims Administrator when the Plan is the Secondary Plan for purposes of coordination of benefits; or
   - Penalties applied for failure to preauthorize; or
   - Any Copayment Amounts under the Prescription Drug Program.

2. When the Co-Share Amount benefit for a Participant in a Calendar Year equals the individual Co-Share Stop-Loss Amount shown on your Schedule of Coverage, the benefit percentage automatically increases to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant during the remainder of that Calendar Year.

3. When the Co-Share Amounts for all Participants under your coverage equal the amount shown on your Schedule of Coverage as "Family Co-Share Stop-Loss Amount" during a Calendar Year, the benefit percentages automatically increase to 100% for additional Eligible Expenses for all family Participants for the remainder of that Calendar Year. No Participant will be required to contribute more than the individual Co-Share Amount to the family Co-Share Stop-Loss Amount.

MAXIMUM LIFETIME BENEFITS

The total amount of benefits available to any one Participant under the Plan shall not exceed the "Maximum Lifetime Benefits" amount shown on your Schedule of Coverage.

This maximum lifetime benefits amount includes all payments made under any benefit provisions of the Plan including payments toward any other benefit maximums under the Plan.

Depending on the terms of the Plan, it may also include any benefits provided under the Employer's health care plan with another Claims Administrator prior to the Participant's Effective Date of coverage under this Plan.

CHANGES IN BENEFITS

Changes to covered benefits will apply to all services provided to each Participant under the Plan.

Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

BENEFITS FOR INPATIENT HOSPITAL EXPENSE

Among those expenses normally included under *Inpatient Hospital Expense* as defined in this Benefit Booklet are intensive and coronary care units, operating room, lab and x-ray, and blood. Please note that if you are confined in a private room, only the Hospital's average semiprivate room rate is allowed as *Inpatient Hospital Expense*. Remember, each Hospital Admission requires preauthorization.

The benefit percentage of your total eligible *Inpatient Hospital Expense* in excess of any Deductible indicated on your Schedule of Coverage is the Plan's obligation. The remaining unpaid *Inpatient Hospital Expense* including any Deductible is your obligation to pay. This amount will be applied to the Co-Share Amount.

BENEFITS FOR MEDICAL-SURGICAL EXPENSE

Included under *Medical-Surgical Expense* as defined in this Benefit Booklet are services such as Physicians and Professional Other Providers, speech and hearing services, diagnostic x-ray and laboratory examinations, Prosthetic Appliances, and Home Infusion Therapy. Remember that certain services require preauthorization, and any Deductibles and Co-Share Amounts shown on your Schedule of Coverage will also apply.

The benefit percentages of your total eligible *Medical-Surgical Expense* shown on your Schedule of Coverage in excess of your Co-Share Amount and any Deductible shown are the Plan's obligation. The remaining unpaid *Medical-Surgical Expense* in excess of the Co-Share Amount and any Deductible is your obligation to pay.

To calculate your benefits, subtract any Deductibles from your total eligible *Medical-Surgical Expense* and then multiply the difference by the benefit percentage shown on your Schedule of Coverage Most remaining unpaid *Medical-Surgical Expense* including the Deductible is your Co-Share Amount.

BENEFITS FOR EXTENDED CARE EXPENSE

When *Extended Care Expense* has been preauthorized, the Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expense Benefits," and

2. Up to the amount of the combined benefit maximums shown for each category of *Extended Care Expense* on your Schedule of Coverage.

> ***Remember...*** for Out-of-Area services, benefits are not available unless services are rendered by a Contracting Facility and have been preauthorized and approved by the Claims Administrator.

If shown on your Schedule of Coverage, the Deductible will apply. Any unpaid *Extended Care Expense* in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co-Share Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be *Extended Care Expense* but will be considered *Medical-Surgical Expense*.

MEDICAL BENEFITS PROVIDED

Services and supplies for *Extended Care Expense*:

1. For Skilled Nursing Facility:

   a. All usual nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
   b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
   c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
   b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
   c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
   d. Supplies and equipment routinely provided by the Home Health Agency.

   Benefits will **not** be provided for Home Health Care for the following:

   - Food or home delivered meals;
   - Social case work or homemaker services;
   - Services provided primarily for Custodial Care;
   - Transportation services;
   - Home Infusion Therapy;
   - Durable medical equipment.

3. For Home Hospice Care:

   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
   b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
   c. Physical, speech, and respiratory therapy services by licensed therapists;
   d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

4. For Facility Hospice Care:

   a. All usual nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
   b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
   c. Physical, speech, and respiratory therapy services by licensed therapists.

OTHER BENEFIT PROVISIONS

Benefits available under this **OTHER BENEFIT PROVISIONS** section are generally determined on the same basis as for other *Inpatient Hospital Expense, Medical-Surgical Expense*, and *Extended Care Expense*, except to the extent described in the following subsections. Benefits will be determined as indicated on your Schedule of Coverage. Remember that certain services require preauthorization and that any Co-Share Amounts and Deductibles shown on your Schedule of Coverage will also apply.

1. ***Benefits for Treatment of Complications of Pregnancy***
   Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for benefits for treatment of Complications of Pregnancy.

2. ***Benefits for Maternity Care***
   a. Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for Maternity Care benefits,

   b. Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan,

   c. The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

      - 48 hours following an uncomplicated vaginal delivery; and

- 96 hours following an uncomplicated delivery by caesarean section.

Inpatient Hospital Expense incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother's Hospital Admission for the delivery. These charges will be considered *Inpatient Hospital Expense* of the child and will be subject to the benefits provisions and benefit maximums as described elsewhere in this section.

3. ***Benefits for Mental Health Care (including Serious Mental Illness) and Chemical Dependency Treatment***
Benefits for *Inpatient Hospital Expense* and *Medical-Surgical Expense* for Mental Health Care (including Serious Mental Illness) and for treatment of Chemical Dependency are available as indicated.

NOTE: Refer to **PREAUTHORIZATION REQUIREMENTS** to determine what services require preauthorization.

Mental Health Care (including Serious Mental Illness) provided as part of the Medically Necessary treatment of Chemical Dependency will be considered for benefit purposes to be treatment of Chemical Dependency until completion of the series of Chemical Dependency treatments. (Mental Health Care after completion of a series of treatments will be considered Mental Health Care.)

Coverage for treatment of Chemical Dependency will be limited to a maximum of three separate series of treatments for each covered individual. The Plan may use state guidelines to administer benefits for treatment of Chemical Dependency.

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **BENEFITS FOR INPATIENT HOSPITAL EXPENSE.**

Inpatient Hospital Expense for Mental Health Care (including Serious Mental Illness) and Chemical Dependency will be limited to 30 inpatient days per Calendar Year.

Benefits for *Medical-Surgical Expense* incurred for Mental Health Care (including Serious Mental Illness) and Chemical Dependency Treatment will be limited to the number of inpatient Physician/Professional Other Provider visits.

Benefits for *Medical-Surgical Expense* incurred for Mental Health Care (including Serious Mental Illness) and Chemical Dependency Treatment will be limited to the combined number of outpatient Physician and/or Professional Other Provider or other outpatient visits per Calendar Year.

Medically Necessary treatment of Chemical Dependency and/or Mental Health Care (including Serious Mental Illness) in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered *Inpatient Hospital Expense. Inpatient Hospital Expense* benefit percentages for this Plan, and the per-admission Deductible, ***if any***, as shown on your Schedule of Coverage will apply.

Each full day of treatment in such facility will be considered equal to one-half of one day of a regular Hospital Admission for Mental Health Care (including Serious Mental Illness) and Treatment of Chemical Dependency.

The benefits provided for Mental Health Care (including Serious Mental Illness) and Chemical Dependency will not exceed the maximum lifetime benefit amount shown on your Schedule of Coverage.

4. ***Benefits for Emergency Care and Treatment of Accidental Injury***
The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack,

sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician before going to the Hospital emergency room. He can help you determine if you need Emergency Care and recommend that care. If not reasonably possible to contact your Network Physician, go to the nearest emergency facility, whether or not the facility is in the Network. A copayment Amount may be required if you go to a Hospital emergency Room.

Whether you require hospitalization or not, you should notify your Network Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In-Network Benefits. After 48 hours, In-Network Benefits will be available only if you use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency and if you can safely be transferred to the care of a network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.

Remember... For Participants who have elected the EPO Plan, after 48 hours, Network Benefits will be available only if you use Network Providers or receive authorization from the Claim Administrator to remain in an Out-of-Network Hospital. If you continue unauthorized treatment in the Out-of-Network Hospital, **no benefits will be payable by the Plan.**

Benefits for Eligible Expenses incurred for treatment of an Accidental Injury will be considered on the same basis as any other sickness.

5. ***Benefits for Preventive Care***
Benefits are available for *Medical-Surgical Expense* incurred for:

- well-baby care;
- routine physical examinations;
- vision examination;
- hearing examinations, except for benefits as provided under ***Benefits for Screening Test for Hearing Impairment***;
- immunizations for Participants age six and over.

Benefits for childhood immunizations for children from birth to age 6 years of age will be provided as described in ***Benefits for Childhood Immunizations***.

Benefits are not available for *Inpatient Hospital Expense* or *Medical-Surgical Expense* for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Benefits for preventive care services will be determined for Physician office visits, diagnostic lab and x-rays.

Injections for allergies are not considered immunizations under this benefit provision.

6. ***Benefits for Screening Test for Hearing Impairment***
Benefits are available for Eligible Expenses incurred by a Dependent child:

1. For a screening test for hearing loss from birth through the date the child is 30 days old; and
2. Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months.

7. ***Benefits for Childhood Immunizations***
Benefits for *Medical-Surgical Expense* incurred by a Dependent child for childhood immunizations from birth through the date the child turns six years of age will be determined at 100% of the Allowable Amount. Benefits are available for:

- Diphtheria
- Hemophilus influenza type b
- Hepatitis B
- Measles
- Mumps
- Pertussis
- Polio

- Rubella
- Tetanus
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

8. ***Benefits for Mammography Screening***
If a Participant age 35 years of age or older incurs a *Medical-Surgical Expense* for a screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other *Medical-Surgical Expense*, except that benefits will not be available for more than one mammography screening each Calendar Year.

9. ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery***
Eligible Expenses for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness for the following services only:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant, but only if initial treatment is sought within 24 hours of the Accidental Injury; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

10. ***Benefits for Dental Services***
If a Participant incurs Eligible Expenses for dental services, benefits will be the same as for treatment of any other sickness.

Benefits are provided only for:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, unrestored natural teeth and supporting tissues but only if initial treatment is sought within 24 hours of the Accidental Injury and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs *Inpatient Hospital Expense* for a Medically Necessary Hospital Admission, will be determined as described in **BENEFITS FOR INPATIENT HOSPITAL EXPENSE.**

11. ***Benefits for Organ and Tissue Transplants***
a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant (donor and/or recipient) by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if:

(1) The transplant procedure is not Experimental/Investigational in nature;

(2) Donated human organs or tissue are used;

(3) The recipient is a Participant under the Plan (benefits are also available to the donor who is a Participant under the Plan);

(4) The transplant procedure is preauthorized as provided in paragraph e below;

(5) The Participant meets all of the criteria established by the Claims Administrator; and

(6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory, chemotherapy, radiation therapy, prescription drugs, and complications arising from such transplant.

b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is for the following:
   - Liver
   - Heart
   - Heart - Lung (heart and one lung or heart and both lungs)
   - Kidney
   - Cornea
   - Lung
   - Bone Marrow

c. Covered services and supplies include services and supplies provided for the:

   (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
   (2) Removal of organs or tissues from deceased donors; and
   (3) Transportation and storage of donated organs or tissues.

d. No benefits are available for a Participant for the following services or supplies:

   (1) Living and/or travel expenses of the live donor or recipient;

   (2) Donor search and acceptability testing of potential living donors;

   (3) Expenses related to maintenance of life for purposes of organ or tissue donation; and

   (4) Purchase of the organ or tissue.

e. Preauthorization is required for any organ or tissue transplant and is the process by which the Medical Necessity of the transplant and the length of stay of the admission is approved or denied. Preauthorization does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the preauthorized length of stay will not be denied on the basis of Medical Necessity.

   At the time of preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary.

f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such procedure) which the Claims Administrator considers to be Experimental/Investigational.

12. ***Benefits for Detection and Prevention of Osteoporosis***
If a Participant is a *Qualified Individual*, benefits will be determined on the same basis as any other sickness for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

a. A postmenopausal woman not receiving estrogen replacement therapy;

b. An individual with:
   (1) vertebral abnormalities,
   (2) primary hyperparathyroidism, or
   (3) a history of bone fractures; or

c. An individual who is:
   (1) receiving long-term glucocorticoid therapy, or
   (2) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

13. ***Benefits for Certain Tests for Detection of Prostate Cancer***
If a male Participant incurs *Medical-Surgical Expense* for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided only for a:

a. physical examination for the detection of prostate cancer; and

b. prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:

   (1) 50 years of age and asymptomatic; or
   (2) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

14. ***Benefits for Speech and Hearing Services***
Benefits are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function.

15. ***Benefits for Treatment of Acquired Brain Injury***
Benefits for Eligible Expenses incurred for Medically Necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition.

Eligible Expenses include the following services as a result of and related to an acquired brain injury:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neurophysiological, neuro-psychological, and psycho-physiological testing or treatment;
- Neurofeedback therapy;
- Remediation;
- Post-acute transition services; and
- Community reintegration services.

16. ***Benefits for Tests for Detection of Colorectal Cancer***
Benefits for *Medical-Surgical Expense* incurred for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer, will be determined on the same basis as any other sickness for:

a. A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
b. A colonoscopy performed every ten years.

17. ***Benefits for Treatment of Diabetes***
Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant,* shall include but not be limited to the following:

a. *Diabetes Equipment*

   (1) Blood glucose monitors (including noninvasive glucose monitors and monitors designed to be used by blind individuals);

   (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:

- Insulin infusion devices,
- Batteries,
- Skin preparation items,
- Adhesive supplies,
- Infusion sets,
- Infusion cartridges,
- Durable and disposable devices to assist in the injection of insulin, and
- Other required disposable supplies;

(3) Insulin infusion devices; and

(4) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetes Supplies*

(1) Test strips for blood glucose monitors,

(2) Visual reading and urine test strips and tablets for glucose, ketones and protein,

(3) Lancets and lancet devices,

(4) Insulin and insulin analog preparations,

(5) Injection aids, including devices used to assist with insulin injection and needleless systems,

(6) Biohazard disposable containers,

(7) Insulin syringes,

(8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and

(9) Glucagon emergency kits.

NOTE: *Insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents will be covered under the Prescription Drug Program.*

c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

e. *Medical-Surgical Expense* provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant are limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning:

(1) The physical cause and process of diabetes;

(2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;

(3) Prevention and treatment of special health problems for the diabetic patient;

(4) Adjustment to lifestyle modifications; and

(5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family or caretaker) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A *Qualified Participant* means an individual eligible for coverage under this Contract who has been

diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

MENTAL HEALTH BENEFITS (APPLIES TO ALL PLAN OPTIONS)

The Claims Administrator has contracted with Magellan to coordinate care for personal problems under the Employee Assistance Program (EAP). Magellan works to ensure treatment is provided by qualified providers at the proper level of care. By doing so, Magellan helps to keep out-of-pocket expenses as low as possible. Magellan contracts with licensed counselors, certified social workers, clinical psychologists, psychiatrists, and psychiatric facilities.

All Mental Health services must be accessed by first contacting Magellan. Mental Health services not coordinated through Magellan will not be covered.

Employee Assistance Program Benefits

EAP is a benefit offered to Retirees and Disabled Employees and their Dependents who are covered under the Atmos Energy Corporation Group Medical Plan to help those persons address personal problems.

During your assessment visit, the counselor will try to determine the underlying reasons for your problem and develop a treatment plan. If the problem cannot be adequately resolved with the additional EAP visits, the EAP counselor may recommend other qualified specialists to help you. You are allowed up to six (6) visits per calendar year when you contact Magellan. Depending on your needs, you may be referred to the mental health network prior to the completion of six visits. Therefore, when you need more assistance than is available through the EAR your Mental Health Benefits are there to help resolve Medically Necessary, longer-term chronic or acute mental health or chemical dependency problems. All care beyond the EAP evaluation must be coordinated through Magellan.

If you or a Dependent has a psychiatric problem, you can call Magellan at the number listed on your ID card. Magellan is available to take calls 24 hours a day.

If children under age 18 call Magellan, the procedures involved in accessing a counselor will be explained. However, without a signed release of parental consent, Magellan will not discuss educational needs or enter into any problem resolution. Magellan will, however, give children suggestions on how to approach their parents and encourage them to do so.

Magellan telephone is answered by trained intake specialists under the direction of a full-time psychiatric medical director.

These specialists will listen to your problem and ask a few questions so they can match you with an EAP counselor. Then they will give you all the information you need to discuss your situation in person. If your symptoms require hospitalization, Magellan will arrange for an emergency evaluation or hospital admission.

By providing prepaid professional assessment and short-term counseling, the EAP addresses almost any type of crisis or concern, including:

Personal Problems	Emotional Problems
Depression	Aging
Family	Terminal Illness
Children	Legal
Adolescent Emotional/Drug Abuse	Disabilities in Children
Alcohol – Personal or Family	Marriage/Divorce
Drugs - Personal or Family	Premarital
Codependency	Persistent Anxiety, Stress, Worries or Fears
Sexual Addiction	Work-related Problems
Eating Disorders	Gambling
Bed-wetting	Learning Disabilities
Loneliness	Budget/Credit
Sleep Problems	Smoking/Nicotine
Rape or Battered Spouse	Grief/Loss

Confidentiality

Magellan's services are completely confidential. Magellan is bound by the same laws of confidentiality as lawyers and physicians.

MEDICAL BENEFITS PROVIDED

Cost of EAP

Atmos Energy Corporation pays the full cost of the EAP as a benefit to you; therefore, there is no charge to you for EAP evaluation, and up to six counseling visits with a Magellan EAP counselor.

Mental Health Benefits

Mental Health Benefits include, but are not limited to: Assessment, Diagnosis, Treatment planning, Medication management, Individual, family and group psychotherapy, Psychological education, Psychological testing. After coverage under this Plan stops, extended benefits for Mental Health Benefits are the same as for Sickness. Covered Expenses for Mental Disorder Treatment are subject to the following limitations:

Maximum Benefits each Calendar Year	
Inpatient Mental Health	30 days
Outpatient Mental Health	50 visits
Inpatient Chemical Dependency	*30 days
Outpatient Chemical Dependency	30 visits

Lifetime Maximum Benefits	
Inpatient Mental Health	90 days
Inpatient Chemical Dependency	3 series of treatments

The Out-of-Pocket Feature shown in Schedule of Coverage does not apply to Mental Health Benefits. Covered Expenses incurred for Mental Disorder Treatment do not count toward the Out-of-pocket Maximums. After the Out-of-Pocket Maximums are reached, benefits for Mental Disorder Treatment are not payable at 100%.

* Mental Health Benefits for inpatient chemical dependency treatment are payable for only three confinements per lifetime. If a confinement should follow another within one month, these two confinements will be considered as one.

Additional Covered Expenses specific to Mental Disorder Treatment are listed below. These Additional Covered Expenses are subject to the same requirements as Covered Expenses listed in Covered Expenses.

Additional Covered Expenses

Licensed Counselor Services of a Licensed Counselor for Mental Disorder Treatment.

Treatment Center Services
- Room and Board.
- Other Services and Supplies.

Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.

PRESCRIPTION DRUG BENEFITS (APPLIES TO ALL PLAN OPTIONS)

Benefits are payable for Covered Drugs.

Certain Covered Drugs require Prior Authorization by a pharmacist or physician from the Claims Administrator or its designee.

The Eligible Employee or Covered Dependent ("Covered Person") must be covered under this Prescription Drug Benefit when the prescription is filled.

Copayments and Coinsurance

Retail Pharmacy Applies to all Plan Options Payments for up to a 30 Day Supply	
All Generic and Brand Name Drugs	25% of each prescription cost
But Not Less Than	
Generic Drugs	$7
Preferred Brand Name Drugs	$15
Non-Preferred Brand Name Drugs	$30

Mail Service Pharmacy Applies to all Plan Options Payments for up to a 90 day supply	
All Generic and Brand Name Drugs	25% of each prescription cost
But Not Less Than	
Generic Drugs	$14
Preferred Brand Name Drugs	$30
Non-Preferred Brand Name Drugs	$60

Out-of-Pocket Maximum

The annual Prescription Drug Out-of-Pocket Maximum is $1,500.00.

When the Prescription Drug Out-of-Pocket Maximum is reached either for an Eligible Employee or for an Eligible Employee and other covered Dependents in a Calendar Year, Prescription Drugs that are Covered Expenses are thereafter payable, subject to any lifetime maximum, at 100% for the Eligible Employee and all other Covered Family Members for the rest of that year.

Network Pharmacy

When a Network Pharmacy is used, you pay the Coinsurance, but not less than the specified copayment amount for the type of drug, as set forth in the applicable chart (i.e., 30 day or 90 day supply). The Coinsurance amount is 25% of each prescription cost as shown above.

For example, if a Covered Person orders a 30 day supply of a Preferred Brand Name Drug which costs $100, since the 25% Coinsurance amount of the cost ($25) is more than the minimum copayment amount of $15, the Covered Person pays the $25 Coinsurance amount. On the other hand, if the cost had been $50, the 25% Coinsurance amount of the cost ($12.50) is less than the minimum $15 copayment amount, so the Covered Person would pay $15.

Non-Network Pharmacy

When a Non-Network Pharmacy is used, you must pay for the entire cost of each prescription at the time it is filled. Then you must submit a claim. Benefits are payable at the predominant contracted reimbursement rate (including any sales tax) for Network Pharmacies minus the applicable copayment.

Mail Service Network Pharmacy

If the mail service pharmacy is used, the Covered Person must pay the copayment.

There is no coverage for Prescription Drugs dispensed by a Non-Network Mail Service Pharmacy.

Supply Limits

Retail Pharmacy

If the Prescription Drug is dispensed by a retail Pharmacy, the following limits apply:

- Up to a 31 day supply of a Prescription Drug, unless adjusted based on the drug manufacturer's packaging size. Some products may be subject to additional supply limits adopted by the Claims Administrator. A list of current additional supply limits may be obtained from the Claims Administrator.

- A one cycle supply of an oral contraceptive. Up to three cycles can be purchased at one time if a copayment is paid for each cycle supplied.

There is a $200 per Calendar Year maximum on smoking cessation products.

Mail Service Pharmacy

If the Prescription Drug is dispensed by a mail service pharmacy, the supply limit is up to a 90 day supply of a Prescription Drug, unless adjusted based on the drug manufacturers packaging size or any additional supply limits adopted by the Claims Administrator. A list of current supply limits may be obtained from the Claims Administrator.

DEFINITIONS

*(In addition to the applicable terms provided in the **DEFINITIONS** section of this Benefit Booklet, the following terms will apply specifically to this **PRESCRIPTION DRUG PROGRAM**.)*

Allowable Amount means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular Covered Drug.

- As applied to Participating Pharmacies and the Mail Service Prescription Drug Program, Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy/mail service pharmacy in effect on the date of service.

- As applied to Non-Participating Pharmacies, Allowable Amount is based on the amount BCBSTX would have considered for payment for the same Covered Drug received at a Participating Pharmacy.

Copayment Amount means the dollar amount or percentage amount paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy, a Non-Participating Pharmacy, or under the Mail Service Prescription Drug Program, if applicable to this Plan.

HOW IT WORKS

When you need a Prescription Order filled, you can elect to go to a Participating Pharmacy or a Non-Participating Pharmacy or use the Mail Service Prescription Drug Program.

Participating Pharmacy
When you go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log, and
- pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference, if any.

The Participating Pharmacy will take care of the rest.

Participating Pharmacies have agreed not to bill you for any Covered Drug expenses in excess of:

- the appropriate Copayment Amounts, and
- any pricing differences that may apply.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card. **You must present your Identification Card to your Participating Pharmacy in order to receive full Plan benefits.**

Non-Participating Pharmacy
If you have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit to the Claims Administrator a claim form and itemized receipt verifying that the prescription was filled. The Plan will reimburse you for Covered Drugs equal to:

- 80% of the Allowable Amount,

- less any applicable Pharmacy Deductible,

- less the appropriate Copayment Amount, and

- less any pricing differences that may apply.

Mail Service Prescription Drug Program
Your Employer has chosen to provide a Mail Service Prescription Program to you and your covered Dependents. Any pricing differences, as explained in the subsection, *How Copayment Amounts Apply*, will also apply. Your Employer will provide you with a separate brochure that contains all the information necessary to help you start using the Program.

When you mail your Prescription Orders to the address provided on the *Mail Service Prescription*

Drug Program Claim Form, you must send in your payment. If you need assistance in determining the amount of your payment, you may either contact the Customer Service Helpline for assistance or send the amount of payment you determine will be needed.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

If you have any questions about the Program, please call the 1-800 number shown in your Mail Service Prescription Program Brochure.

Prescription Drug Calendar Year Out-of-Pocket Maximum

Once this Calendar Year Out-of-Pocket Maximum amount has been reached, no additional Copayment Amounts for Covered Drugs will be required by you for retail Pharmacy or mail service drugs until the next Calendar Year benefit period begins.

Copayment Amounts
There are three Copayment Amounts shown on the Schedule of Coverage for retail Pharmacy or mail service drugs. The amount you pay depends on the Covered Drug dispensed. If the Covered Drug dispensed is a:

1. Generic Drug - You pay the Generic Drug Copayment Amount,

2. Preferred Brand Name Drug - You pay the Preferred Brand Name Drug Copayment Amount and any pricing difference described below, if applicable,

3. Non-Preferred Brand Name Drug - You pay the Non-Preferred Brand Name Drug Copayment Amount.

Preferred Brand Name Drug List
The *Preferred Brand Name Drug List* is the list of drugs maintained by the Claims Administrator in connection with the Prescription Drug Program. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other pharmacy and medical related organizations, describing clinical outcomes, drug efficacy; and side effect profiles.

BCBSTX will routinely review the *Preferred Brand Name Drug List* and periodically adjust it to modify the Preferred or Non-Preferred Brand Name Drug status of existing or new drugs. Changes to this list will be implemented on the Employer's Contract Anniversary. The *Preferred Brand Name Drug List* is a way for Participants to determine which drugs are subject to the Preferred Brand Name Drug Copayment Amount.

Participants may also call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on the Identification Card to find out which drugs are on the *Preferred Brand Name Drug List.*

How Copayment Amounts Apply
Prescription Drugs are covered in all four plan options through Prime Therapeutics. The following co-payments apply:

Retail Pharmacy

25 % Co-Share Amount for all medical plans for a ***30-day supply*** or the following minimums:

- $7 Generic
- $15 Preferred Brand
- $30 Non-preferred Brand

Mail Order Prescriptions

25 % Co-Share Amount for all medical plans for a ***90-day supply*** or the following minimums:

- $14 Generic
- $30 Preferred Brand
- $60 Non-preferred Brand

If the brand name drug is a Non-Preferred Brand Name Drug, you pay the Non-Preferred Brand Name Drug Copayment Amount.

YOUR IDENTIFICATION CARD

The Identification Card you received is the key to your use of the Plan. It tells Participating Pharmacies that you are entitled to prescription drug benefits under the Prescription Drug Program. Participating Pharmacies are not permitted to file claims with the Claims Administrator unless you

present the Identification Card with your Prescription Order.

Note: If you do not have your Identification Card, you must pay your Participating Pharmacy directly for your prescription charges. You must then file a claim with the Claims Administrator. You will then be reimbursed for your payments less the appropriate Copayment Amount, and any applicable pricing difference.

> ***Remember...*** be sure to use your Participating Pharmacy every time, even if you have not received your Identification Card, or do not have it with you.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you. (Refer to the section entitled **WHO GETS BENEFITS** for additional instructions when changes are made). Upon receipt of the change information, the Claims Administrator will issue a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered family members will include, but not be limited to, the following actions, when intentional:

    a. Use of the Identification Card prior to your Effective Date;
    b. Use of the Identification Card after your date of termination of coverage under the Plan;
    c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
    d. Obtaining prescription drugs or other benefits which are not covered under the Plan;
    e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
    f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
    g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
    h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
    i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.

2. The fraudulent or intentionally unauthorized, improper, or abusive use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

    a. Denial of benefits;
    b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
    c. Limitation on the use of Identification Card to one designated Participating Pharmacy of your choice;
    d. Recoupment from you or any of your covered family members of any benefit payments made;
    e. Pre-approval of drug purchases for all Participants receiving benefits under your coverage; and
    f. Notice to proper authorities of potential violations of law or professional ethics.

3. Other unauthorized, improper, or abusive use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

    a. Limitation on the use of Identification Card to one designated Participating Pharmacy of your choice;
    b. Recoupment from you or any of your covered family members of any benefit payments made; and
    c. Pre-approval of drug purchases for all Participants receiving benefits under your coverage.

WHAT IT COVERS

The Plan will provide benefits for those Covered Drugs prescribed for your use by your Provider

which require a valid Prescription Order before they can be sold to you, and which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription." These drugs are commonly called "Legend Drugs." As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits.

Generic Drugs
This Plan provides a lower Copayment Amount when Generic Drugs are elected. You are encouraged to select Generic Drugs when your prescribing Provider and pharmacist feel it is safe to do so and where state or federal laws permit.

Injectable Drugs
Injectable drugs for subcutaneous self-administration are also covered under the Plan. You are responsible for any Copayment Amounts, and pricing differences that may apply. Injectable drugs include, but are not limited to, insulin and Imitrex.

The Day Supply of disposable syringes and needles you will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

Amount of Your Payment
The amount of your payment under the Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy, through the Mail Service Prescription Drug Program, or at a Non-Participating Pharmacy;
- a Generic Drug or brand name drug is dispensed;
- a Preferred or Non-Preferred Brand Name Drug is dispensed; or

If the Allowable Amount of the Prescription Drug is less than the Copayment Amount, the Participant will pay the lower cost.

LIMITATIONS ON QUANTITIES DISPENSED

Benefits for Covered Drugs obtained from a Participating Pharmacy, a Non-Participating Pharmacy, or through the Mail Service Prescription Drug Program are provided for up to a maximum of a 90-Day Supply.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Physician, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. To determine if a specific drug is subject to this limitation, contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

A Copayment Amount applies to each 30-Day Supply of drugs dispensed. This means when you receive a 90-Day Supply of drugs from the Pharmacy, you will pay three Copayment Amounts plus any pricing differences that may apply.

Payment for benefits covered under this Plan **may be denied** if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the 90-day maximum Day Supply limitation, (refer to the subsection ***Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards*** in this portion of your Benefit Booklet for additional information).

WHAT IS NOT COVERED

The benefits of the Prescription Drug Program are not available for:

1. Drugs which do not by law require a Prescription Order from a Provider (**except** injectable insulin and insulin pens); and drugs or covered devices for which no valid Prescription Order is obtained.

2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections).

3. Administration or injection of any drugs.

4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).

5. Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

7. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.

9. Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.

10. Contraceptive devices, non-prescription contraceptive materials, (**except** prescription contraceptive drugs), and oral and injectable infertility and fertility medications which are Legend Drugs.

11. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

12. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.

13. Drugs dispensed in quantities in excess of the Day Supply amounts stipulated in **LIMITATIONS ON QUANTITIES DISPENSED,** certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

14. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

15. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

16. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.

17. Drugs for the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

18. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.

19. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.

20. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

21. Services and supplies for smoking cessation programs and the treatment of nicotine addiction that exceeds the $200 Calendar Year Maximum.

22. Compounded drugs that do not meet the definition of Compound Drugs in this Benefit Booklet.

23. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

24. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s).

25. Athletic performance enhancement drugs.

26. Allergy serum and allergy testing materials.

27. Injectable drugs, except those self-administered subcutaneously.

MEDICAL LIMITATIONS AND EXCLUSIONS

Some exclusions under the provisions of the medical benefits may be included under the Prescription Drug Benefits. The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction; or any Experimental/ Investigational services and supplies.

2. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claims Administrator.

3. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

4. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality; provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

5. Any services or supplies provided for reduction mammoplasty, except when Medically Necessary.

6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution.

7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.

8. Any services or supplies provided for injuries sustained:

   a. As a result of war, declared or undeclared, or any act of war; or

   b. While on active or reserve duty in the armed forces of any country or international authority.

9. Any charges:
   a. Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
   b. For completion of any insurance forms; or
   c. For acquisition of medical records.

10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.

11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.

12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:

    a. an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claims Administrator, or

    b. ***Benefits for Treatment of Diabetes*** as described in **OTHER BENEFIT PROVISIONS**.

13. Any services or supplies provided for Custodial Care.

14. Any services or supplies provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles and nerves that are non-surgical (*dental restorations, orthodontics, or physical therapy*), non-diagnostic, or supplies (*oral appliances, oral splints, oral orthotics, devices, or prosthetics*).

MEDICAL LIMITATIONS AND EXCLUSIONS

15. Any services or supplies provided for orthognathic surgery after the Participant's 19th birthday, (except orthognathic surgery for treatment of temporomandibular joint disorders and conditions of temporomandibular joint disorders as described in item 14 above, are covered). Orthognathic surgery includes, but is not limited to, correction of congenital, developmental or acquired maxillofacial skeletal deformities of the mandible and maxilla.

16. Any items of *Medical-Surgical Expense* incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in **OTHER BENEFIT PROVISIONS**.

17. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in **OTHER BENEFIT PROVISIONS**.

18. Any services or supplies provided for:

    a. Treatment of myopia and other errors of refraction, including refractive surgery; or

    b. Orthoptics or visual training; or

    c. Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or

    d. Examinations for the prescription or fitting of eyeglasses or contact lenses, or

    e. Restoration of loss or correction to an impaired speech or hearing function, including hearing aids.

19. Except as specifically included as an Eligible Expense, any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.

20. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.

21. Travel, whether or not recommended by a Physician or Professional Other Provider, except for local ground ambulance service or air ambulance service otherwise covered under the Plan, except treatment as determined Medically Necessary by the Claims Administrator's Case Management.

22. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except as determined Medically Necessary.

23. Any services or supplies provided primarily for:

    a. Environmental Sensitivity;

    b. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or

    c. Inpatient allergy testing or treatment.

24. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

25. Any services or supplies provided for, in preparation for, or in conjunction with:
    a. Sterilization reversal (male or female);
    b. Transsexual surgery;
    c. Sexual dysfunction;
    d. In vitro fertilization;
    e. Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer, and tubal embryo transfer.

26. Any services or supplies for routine foot care, such as:

    a. The cutting or removal of corns or callouses, the trimming of nails (including mycotic nails) and other hygienic and preventive care maintenance in the realm of self-care, such as cleaning and soaking the feet, the use of

skin creams to maintain skin tone of both ambulatory or bedfast patients;

b. Any services performed in the absence of localized illness, injury, or symptoms involving the foot;

c. Any treatment of a fungal (mycotic) infection of the toenail in the absence of:

(1) Clinical evidence of mycosis of the toenail;
(2) Compelling medical evidence that documents the patient either:

(a) Has a marked limitation of ambulation requiring active treatment of the foot; or
(b) In the case of a nonambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment; and

d. Excision of a nail without using an injectable or general anesthetic.

29. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations; any Retin-A or pharmacologically similar topical drugs.

30. Any smoking cessation prescription drug products, including, but not limited to, nicotine gum and nicotine patches.

31. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

32. Any services or supplies provided for the following treatment modalities:

a. acupuncture;
b. video fluoroscopy;
c. intersegmental traction;
d. surface EMGs;
e. manipulation under anesthesia; and
f. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

33. Outpatient Contraceptive Services and prescription contraceptive devices.

34. Any benefits in excess of any specified maximums.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all Benefit Coverages unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider within 30 days after the occurrence.

Allowable Amount means the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply or procedure.

1. ***For Hospitals and Facility Other Providers, Physicians and Professional Other Providers Contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan*** - The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts or other payment methodologies.

2. ***For Hospitals and Facility Other Providers not contracting with the Claims Administrator, in Texas or any other Blue Cross and Blue Shield Plan outside of Texas*** – No payment will be made by the Claims Administrator.

3. ***For procedures, services or supplies provided in Texas by Physicians and Professional Other Providers not contracting with the Claims Administrator*** – The Allowable Amount will be the lesser of the billed charge or the amount BCBSTX, the Claims Administrator, would have considered for payment for the same covered procedure, service, or supply if performed or provided by a Physician or Professional Other Provider with similar experience and/or skill.

   If the Claims Administrator does not have sufficient data to calculate the Allowable Amount for a particular procedure, service or supply, the Claims Administrator will determine an Allowable Amount based on the complexity of the procedure, service, or supply and any unusual circumstances or medical complications specifically brought to its attention, which require additional experience, skill and/or time.

4. ***For procedures, services or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with the Claims Administrator or any other Blue Cross and Blue Shield Plan*** – The Claims Administrator will establish an Allowable Amount using, Texas regional or state allowable amounts applicable to procedures, services, or supplies of Physicians or Professional Other Providers with similar skills and experience.

5. ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day, will be the amount for the single procedure with the highest Allowable Amount *plus* one-half of the Allowable Amount *for each* of the other covered procedures performed.

6. ***For drugs administered by a Home Infusion Therapy Provider*** - The Allowable Amount will be the lesser of (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark-down from the AWP established by BCBSTX and updated on a periodic basis.

7. ***For procedures, services or supplies provided to Medicare recipients*** - The Allowable Amount will not exceed Medicare's limiting charge.

Annual Enrollment Period means the period preceding the next Plan Anniversary Date during which Retirees and Dependents may change their coverage.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Calendar Year means the period commencing each January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

Bone Scan
Cardiac Stress Test
CT Scan (with or without contrast)

MRI (Magnetic Resonance Imaging)
Myelogram
PET Scan (Positrom Emission Romography)
Ultrasound

This list is not inclusive and may be modified from time to time.

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Any Chemical Dependency Treatment Center located outside the state of Texas shall be licensed, certified, or approved as a Chemical Dependency Treatment Center by the appropriate agency of the state in which it is located and be accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations.

Chiropractic Services means any services or supplies provided by or under the direction of a Doctor of Chiropractic.

Claims Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

Claims Administrator may also mean any successor named by the Plan Administrator.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);

2. Urine auto injection (injecting one's own urine into the tissue of the body);

3. Skin irritation by Rinkel method; or

4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen);

5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
2. Termination of pregnancy by nonelective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Compound Drugs means those drugs that meet the following requirements:

1. The drugs in the compounded product have to be Food and Drug Administration (FDA) approved; and

2. The approved product must have an assigned National Drug Code (NDC); and

3. The primary active ingredient is a Covered Drug under the Prescription Drug Program.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution

with which the Claims Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

Copayment Amount, with respect to the Prescription Drug Program, means the fixed dollar amount paid by the Participant for each Prescription Order dispensed or refilled at a Participating Pharmacy or by mail order

Co-Share Amount means the dollar amount of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan. Refer to **CO-SHARE STOP-LOSS** in **MEDICAL BENEFITS PROVIDED** of this Benefit Booklet for additional information.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or

2. Is performed for psychological purposes; or

3. Restores form but does not correct or materially restore a bodily function.

Covered Drug means any Legend Drug or injectable insulin, including disposable syringes and needles needed for self-administration:

1. Which is Medically Necessary and ordered by a Provider naming a Participant as the recipient;

2. For which a written or verbal Prescription Order is prepared by a Provider;

3. For which a separate charge is customarily made;

4. Which is not entirely consumed at the time and place that the Prescription Order is written;

5. For which the U.S. Food and Drug Administration (FDA) has given approval for a particular use or purpose; and

6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of nondental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;

2. Incision and drainage of facial abscess;

3. Surgical procedures involving salivary glands and ducts and nondental related procedures of the accessory sinuses; and

4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and treatment of Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a

Participant walk, bathe, dress, eat, prepare special diets, and take medication.

Day Supply means the number of units to be dispensed. The Claims Administrator has the right to determine the Day Supply at its sole discretion. A Day Supply of a given prescription drug is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Physician.

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either *Retiree* or *Dependent* and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

Eligible or Covered Expenses means either *Inpatient Hospital Expense, Medical-Surgical Expense*, or *Extended Care Expense*, as specified in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employer means the person, firm, or institution named on the cover of this Benefit Booklet.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special nonorganic, nonrepetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment. *Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

1. Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
2. Are appropriate for the Hospital or Facility Other Provider in which they were performed; and
3. The Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

DEFINITIONS

The Claims Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/ Investigational, and will consider the guidelines and practices of Medicare, Medicaid or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, such services, supplies, or treatment may still be considered to be Experimental/ Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/ Investigational.

Extended Care Expense means the services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in **BENEFITS FOR EXTENDED CARE EXPENSE.**

Formulary means a list of drugs for which a health benefit plan provides coverage, approves payment, or encourages or offers incentives for Providers to prescribe.

Generic Drug means a drug pharmaceutically and therapeutically equivalent to the brand name drug prescribed, and which usually costs less than the brand name drug.

Health Status Related Factor means:

1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of good health (insurability), including conditions arising out of acts of family violence; and
8. Disability.

Home Health Agency means a business that provides Home Health Care and is licensed by the Department of Health. A Home Health Agency located in another state must be licensed, approved, or certified by the appropriate agency of the state in which it is located and be certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health care services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education;
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); and
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

DEFINITIONS

Hospital means a short-term acute care facility which:

1. Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a hospital provider under Medicare;

2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;

3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;

4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;

5. Has in effect a Hospital Utilization Review Plan; and

6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Plan.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Retiree by the Claims Administrator of the Plan indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

In-Network (Network) Benefits means the benefits available under the Plan for services and supplies that are provided by or referred by a network Provider or referred through the Mental Health Helpline.

Inpatient Hospital Expense means charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant; provided that such items are:

1. Furnished at the direction or prescription of a Physician or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during a Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made. *Inpatient Hospital Expense* shall include:

1. Room accommodation charges. *If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge is not an Eligible Expense.*

2. All other usual Hospital services which are Medically Necessary and consistent with the

condition of the Participant. *Personal items are not an Eligible Expense.*

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be *Inpatient Hospital Expense*.

Legend Drugs means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

Medical Social Services means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment and adjustment to care; and

2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expense means the Allowable Amount incurred for the items of service or supply listed below for the care of a Participant, provided such items are:

- Furnished by or at the direction or prescription of a Physician or Professional Other Provider; and
- Not included as an item of *Inpatient Hospital Expense* or *Extended Care Expense* in the Plan.

A service or supply is furnished at the direction of a Physician or Professional Other Provider if the listed service or supply is:

- Provided by a person employed by the directing Physician or Professional Other Provider; and

- Provided at the usual place of business of the directing Physician or Professional Other Provider; and

- Billed to the patient by the directing Physician or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medical-Surgical Expense shall include:

1. Services of Physicians or Professional Other Providers, and in case of a Professional Counselor or Licensed Marriage and Family Therapist, a professional recommendation has been obtained from the Physician.

2. Services of a certified registered nurse-anesthetist.

3. Physical Medicine Services

4. Chiropractic Services, as shown on your Schedule of Coverage.

5. Diagnostic x-ray and laboratory procedures.

6. Radiation therapy.

7. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
8. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan.

The term "durable medical equipment" shall not include:

- Equipment primarily designed for alleviation of pain or provision of patient comfort; or
- Home air fluidized bed therapy.

Examples of noncovered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

9. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.

10. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.

11. Oxygen and its administration provided the oxygen is actually used.

12. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.

13. Prosthetic Appliances, excluding all replacements of such devices other than those necessitated by growth to maturity of the Participant.

14. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

    Noncovered items include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a nonhospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts. NOTE: This does not apply to podiatric appliances when provided as Diabetic Equipment.

15. Home Infusion Therapy when the treatment plan is preauthorized by the Home Infusions Therapy Provider in accordance with the Claims Administrator's established procedures. Any item of Home Infusion Therapy covered under this subsection will not be eligible for benefits under any other provision of the Plan.

16. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center.

17. Certain Diagnostic Procedures.

18. Injectable drugs that are Legend Drugs to be administered in the spine, joint, or muscle when given in the Physician's office. These medications may be purchased at a Pharmacy and charges submitted on a member/Subscriber claim form for reimbursement of eligible benefits.

19. Bariatric Surgery when Medically Necessary

20. Reduction Mammoplasty when Medically Necessary.

21. Reasonable and necessary transportation, lodging, meals, and expenses for the patient and a companion during the period of required Medically Necessary treatment, as determined by the Claims Administrator's Case Management, of the patient for travel to the nearest medical facility qualified to give the required treatment when it is Medically Necessary for the patient to receive special treatment or services. Benefits payable for up to a total of $200 per day for both the patient and companion.

Transportation must be:

- To and from the site of the required treatment
- For the purposes of an evaluation, treatment or the necessary post-treatment follow up

These services must be given within the United States, Puerto Rico or Canada. There is an overall lifetime maximum of $10,000 per covered patient for transportation, lodging and meal expenses incurred in connection with all covered treatment.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and

2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and

3. Not primarily for the convenience of the Participant, his Physician, the Hospital or the Other Provider; and

4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The Claims Administrator for the Plan shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Claims Administrator, whether or not the cause of the disease, disorder or condition is physical, chemical, or mental in nature or origin;

2. The diagnosis or treatment of any symptom, condition, disease or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible Expense is:

   a. Individual, group, family or conjoint psychotherapy,
   b. Counseling,
   c. Psychoanalysis,
   d. Psychological testing and assessment,
   e. The administration or monitoring of psychotropic drugs, or
   f. Hospital visits or consultations in a facility listed in subsection 5, below;

3. Electroconvulsive treatment;

4. Psychotropic drugs;

5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Network means identified Physicians, Professional Other Providers, Hospital, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

Network Provider means a Hospital, Physician, or Other Provider who has entered into an agreement with BCBSTX to participate as a managed care Provider.

Non-Participating Pharmacy means a Pharmacy which has not entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

Non-Preferred Brand Name Drug means a brand name drug which does not appear on the *Preferred Brand Name Drug List.*

Non-Preferred Brand Name Drug Copayment Amount means the Copayment Amount applicable if a Non-Preferred Brand Name Drug is dispensed.

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** - an institution or entity, only as listed:

   - Birthing Center
   - Chemical Dependency Treatment Center
   - Crisis Stabilization Unit or Facility
   - Durable Medical Equipment Provider
   - Home Health Agency
   - Home Infusion Therapy Provider
   - Hospice
   - Imaging Center
   - Independent Laboratory
   - Prosthetics/Orthotics Provider
   - Psychiatric Day Treatment Facility
   - Renal Dialysis Center
   - Residential Treatment Center for Children and Adolescents
   - Skilled Nursing Facility
   - Therapeutic Center

2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
   - Advanced Practice Nurse
   - Doctor of Chiropractic
   - Doctor of Dentistry
   - Doctor of Optometry
   - Doctor of Podiatry
   - Doctor in Psychology
   - Licensed Audiologist
   - Licensed Chemical Dependency Counselor
   - Licensed Clinical Social Worker
   - Licensed Dietitian
   - Licensed Hearing Instrument Fitter and Dispenser
   - Licensed Marriage and Family Therapist
   - Licensed Midwives
   - Licensed Occupational Therapist
   - Licensed Physical Therapist
   - Licensed Professional Counselor
   - Licensed Speech-Language Pathologist
   - Licensed Surgical Assistant
   - Nurse First Assistant
   - Physician Assistant
   - Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, Other Providers must be licensed by the appropriate state administrative agency.

Out-of-Area Benefits means the benefits available under the Plan for services and supplies that are provided when a Participant resides outside of the Managed Care Plan Service Area and therefore does not have access to Network Providers.

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

Out-of-Network Provider means a Hospital, Physician, or Other Provider, who has not entered into an agreement with BCBSTX as a managed care Provider. For the EPO Plan, **no benefits are paid to an Out-of-Network Provider** under this Plan unless use of such Provider is authorized by BCBSTX **prior** to the visit or for Emergency Care.

Outpatient Contraceptive Service means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means a retired Employee whose coverage has become effective under this Plan.

Participating Pharmacy means an independent Pharmacy or chain of Pharmacies that have entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs, and devices under the laws of the state in which he practices.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010-97799), whether the service or supply is provided by a Physician or Professional Other Provider and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan Administrator means the named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and each 12-month period thereafter.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claims Administrator.

Plan Month means each succeeding monthly period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area designated by the Employer which determines eligibility for In-Network and Out-of-Network benefits.

Preexisting Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the three months before the earlier of the:

1. Effective Date of coverage; or
2. First day of the Waiting Period.

Preferred Brand Name Drug means a brand name drug which appears on the *Preferred Brand Name Drug List.*

Preferred Brand Name Drug Copayment Amount means the Copayment Amount applicable if a Preferred Brand Name Drug is dispensed.

Prescription Order means a written or verbal order from a Physician/Professional Other Provider to a pharmacist for a drug or device to be dispensed. Orders written by Physician/Professional Other Providers located outside the United States to be dispensed in the United States are not covered under the Plan.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;

2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and

3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract

lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and treatment of Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provision of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual* (DSM):

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Pervasive developmental disorders;
7. Schizo-affective disorders (bipolar or depressive); and
8. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or

2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with BCBSTX to participate as a managed care Provider for specialty services.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

GENERAL INFORMATION

PARTICIPANT/PROVIDER RELATIONSHIP

The choice of a health care Provider should be made solely by you or your Dependents. The Claims Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claims Administrator is not liable for any act or omission by any health care Provider. The Claims Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claims Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claims Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claims Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

ASSIGNMENT AND PAYMENT OF BENEFITS

If a written assignment of benefits is made by a Participant to a Provider and the written assignment is delivered to the Claims Administrator with the claim for benefits, the Claims Administrator will make any payment directly to the Provider. Payment to the Provider discharges the Plan's responsibility to the Participant for any benefits available under the Plan.

SUBROGATION

In the event you or your Dependents suffers an injury or Sickness as a result of an allegedly negligent or wrongful act or omission of a third party, the Claims Administrator has the right to pursue subrogation where permitted by law.

Upon payment of the benefits under this Plan, the Claims Administrator as the Plan's third party administrator, shall be subrogated to you or your Dependent's right to recovery from any third party alleged to be legally responsible to you or your Dependent. The Claims Administrator may use this right to the extent of the benefits paid under this Plan for your injury or Sickness that was the result of the third party's allegedly negligent or wrongful act.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

You and your Dependent acknowledge that the Claims Administrator's subrogation rights under this Section shall be considered as the first priority claims against any such third party and shall extend to any amounts you or your Dependent receive from such third party. Such first priority claim shall be paid before any other claims which may exist are paid, including claims for general damages by you or your Dependent. The Plan's recovery shall be prior to and without regard to whether you or your Dependent has received a full recovery and shall not be reduced by any expenses incurred by you or your Dependent in obtaining the recovery. The Plan's claim also shall not be reduced for any "make whole," common fund or similar doctrine. You and your Dependent agree that as a condition of receiving benefits hereunder, you shall hold any recovery you receive in a constructive trust for the benefit of the Plan and its subrogation right, regardless of whether you are fully compensated for your injuries or losses.

You or your Dependent shall cooperate and assist the Claims Administrator in protecting the Claims Administrator's legal rights under these subrogation provisions, and will do nothing to prejudice the Claims Administrator's rights under these provisions, either before or after the request for services or receipt of benefits under this Plan. You or your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer. You, your Dependent or

your attorney will notify the Plan before settling any claim or suit so as to enable the Claim Administrator to enforce the Plan's rights by participating in the settlement of the claim or suit.

The Claims Administrator may require an assignment from you or your Dependent of any right of recovery to the extent of the reasonable value of services and benefits provided by the Plan plus the Plan's reasonable costs of collection, including attorney's fees as described below. The Claims Administrator may require you or your Dependent to assign your rights to the first dollars received from third parties up to the full amount paid by the Plan. The Plan may require an escrow of funds to cover future claims arising from the same incident giving rise to the subrogation claim. Failure to execute a subrogation agreement or other assignment or reimbursement agreement shall be grounds for termination of the coverage of the party refusing to so execute such an agreement.

The Plan Administrator and/or the Claims Administrator may, at its option, take such action as may be necessary and appropriate to preserve its rights under these subrogation provisions, including the right to bring suit on your or your Dependent's behalf. The Claims Administrator, may at its option, collect such amounts from the proceeds of any settlement or judgment that may be recovered by you or your Dependent or by any representative. Any such proceeds of settlement or judgment shall be held in trust by you, your Dependent, or any representative, for the benefit of the Claims Administrator under these subrogation provisions. The Claims Administrator shall be entitled to recover all amounts the Plan expended on behalf of you or your Dependent, and also shall be entitled to recover from the proceeds held by you or your Dependent, without reduction, the Plan's reasonable attorney fees which the Claims Administrator incurred in pursuing its claim under this section.

REFUND OF BENEFIT PAYMENTS

If the Claims Administrator pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claims Administrator may deduct any refund due it from any future benefit payment.

COORDINATION OF BENEFITS

(This provision does not apply to Prescription Drug Benefits.)

This provision will coordinate the health benefits payable under the Plan with similar benefits payable under other plans.

You or any Dependent may be covered under another group health plan. It may be sponsored by another Employer who makes contributions or payroll deductions for it. The other plan could also be a government or tax-supported program. This does not include Medicare or Medicaid. (See section entitled Effect of Medicare and Government Plans to determine how this plan coordinates with Medicare.)

This provision applies when benefits for the same charges are payable under this Plan and another plan.

Which Plan is Primary

One of the plans involved will pay the benefits first. (The plan that pays first is called Primary.) The other plans will pay benefits next. (These plans are called Secondary.)

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 which covers that person as a Dependent of the person whose birthday is earlier in the Calendar Year will be Primary to a plan which 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 which covered one of the parents longer will be Primary to the plan which 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.

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:

  1. The plan of the parent with custody will pay benefits first.

  2. The plan of the stepparent with custody will pay benefits next.

  3. The plan of the parent without custody will pay benefits next.

- There may be a court decree which has specific terms giving one parent financial responsibility for the medical, dental or other health 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 which covers that Dependent child.

- A plan may cover a person as an Employee who is not laid-off or retired, or as a Dependent of that Employee. The Plan will be Primary to any plan which covers the person as a laid-off or retired Employee, or as a Dependent of that Employee. The other plan may not have a rule for laid-off 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.

You will have to give information about any other plans when you file a claim.

Out-of-Pocket Feature

(Applicable to Coordination of Benefits section only)

This section applies when the Plan is Secondary. You may still be required to pay for some charges after the Plan pays its benefits. However, if either of the following situations occur, benefits will be paid for the rest of that Calendar Year as described below:

The amount you pay for the Cash Deductible and the remaining charges the Plan would have paid without this provision reaches $2,000 for any person in a Calendar Year.

The amount you pay for the Cash Deductible and the remaining charges the Plan would have paid without this provision reaches $3,000 for all Covered Family Members in a Calendar Year.

Whenever there is more than one plan, the total amount of benefits paid for the rest of that Calendar Year under all plans cannot be more than the reasonable expenses charged for the rest of that year.

The amount of reasonable expenses will be determined first. Then the amount of benefits paid by plans Primary to the Plan will be subtracted from this amount. The Plan will pay you the difference but no more than the amount it would have paid without this provision.

How Coordination Works Under the Low Deductible, High Deductible and PPO Plans

If this Plan is Primary, it will pay benefits first. Benefits under the Plan will not be reduced due to benefits payable under other plans.

If the Plan is Secondary, it pays only the difference between the plans normal benefit and any amount paid by the primary plan. This is called Non-duplication coordination of benefits. The covered individual is responsible for any remaining balance up to the allowable expense amount. The primary plan pays its normal benefits; the secondary plan calculates its normal benefits, then subtracts the amount paid by the primary plan and pays the difference (if any) between the two amounts. The non-duplication method is designed to provide a certain level of cost sharing by imposing covered individual liability. Non-duplication plans do not have a reserve on secondary plan savings. See the example on the next page for more information on Non-duplication coordination of benefits.

Example:

Total Charge:	$100.00
Primary Allowable:	$100.00
Primary Paid	$80.00
Balance:	$20.00
This Plan's Allowable Charge: (based on Primary allowable)	$100.00
This Plan's Benefit: (PPO in-network coverage at 90%)	$90.00
Benefit Payable: (The difference between what the primary plan paid and what our plan would have paid.)	$10.00

This Plan will pay no more than our normal plan benefit. (If this Plans benefit is less than or equal to the Primary plans payment, no payment is due by this Plan.)

How Coordination Works Under the EPO Plan

The Primary plan will pay benefits first. The Primary plans rate will be the allowable expense. This is called Come out Whole coordination of benefits. The Primary plan pays its normal benefit; the Secondary plan pays the difference between the allowable expense and the amount paid by the Primary plan, provided the difference does not exceed the normal plan benefit which would have been payable had no other coverage existed. Generally, the member does not incur out-of-pocket costs.

The computation of "Come out Whole" coordination of benefits is based upon a calendar year accumulation period. Any unpaid benefits accumulated by the Secondary plan during a calendar year can be applied to a reserve. The reserve grows when the Secondary plan benefit is saved because the Primary Claims Administrator reimburses the member for eligible medical expenses in the calendar year that are not reimbursed in full between the two plans normal benefits. This benefit accumulation is even applied to allowable expenses that are not covered by the Secondary plan to the extent that they are covered in full or in part by the Primary plan. The reserve will decrease when the Secondary plan pays more than its normal benefit in order to reimburse the member in full for medical expenses.
Example:

Total charge:	$600.00
Primary Allowable:	$600.00 (applies to $500 deductible)
Primary Allowable Left Over:	$100.00
Primary Paid:	$80.00
Balance:	$520.00
This Plan's Allowable Charge:	$600.00 (based on primary allowable)
This Plan's Benefit:	$585.00 ($15 copay plan)
Amount Paid by this Plan:	$520.00
Amount in Reserve:	$65.00

The Plan receives another claim :	$100.00
Primary Allowable: (Primary Plan does not cover routine exams.)	$0
Primary Paid:	$0
Balance:	$100.00
This Plan's Allowable Charge:	$100.00
This Plan's Benefit: ($15 copay plan)	$85.00
Amount Paid:	$100.00 ($85 from this date of service + $15 from the reserve)
New Reserve Amount:	$50.00

EFFECT OF MEDICARE AND GOVERNMENT PLANS

Medicare

When you become eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

When This Plan Pays Primary to Medicare

This Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the Disabled Employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan for Covered Persons who are Medicare eligible if:

- The Employee is a Retired Employee.
- Eligibility is due to disability and the Disabled Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See How this Plan Pays When Medicare is Primary.

Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person should enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan or Medicare.

How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below, This method of payment only applies to Medicare eligibles. It does not apply to any Covered Person unless that Covered Person becomes eligible under Medicare and Medicare is the Primary payer.

First, this Plan determines the amount of charges for Covered Expenses according to the terms of the Plan. However, the amount of Covered Expenses is based on the amount of charges allowed under Medicare rules instead of the Reasonable Charges as defined by the Plan. This amount becomes the "Plan benefits". Then, this Plan subtracts the amount payable under Medicare for the same expenses from the Plan benefits. This Plan pays only the difference (if any) between the Plan benefits and Medicare benefits.

The following examples will illustrate how the Plan coordinates with Medicare:

Example 1:

Assume you incur $1,000 worth of eligible medical expenses under the method of determining the Plan's Covered Expenses as described above and the Medicare rules. Further assume you are eligible for Medicare, that Medicare Part B pays first and that it pays eligible claims at 80% after a $110 deductible.

	Medicare	This Plan
Eligible Expenses	$1,000	$1,000
Deductible	($110)	($300)
Amount Subject to Coverage	$890	$700
Benefit Rate	x .80	x .80
Result	$712	$560

The Plan would pay nothing, because Medicare paid more than the Plan would pay if you had not been covered by Medicare.

Example 2:

Assume the same facts as in Example 1; however, the Medicare Part A deductible is $912.

	Medicare	This Plan
Eligible Expenses	$1,000	$1,000
Deductible (Part A)	($912)	($300)
Amount Subject to Coverage	$88	$700
Benefit Rate	x .80	x .80
Result	$70.40	$560

The Plan would pay $489.60, because Medicare did not pay as much as the Plan would pay if you had not been covered by Medicare.

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered out-of-network services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Government Plans (other than Medicare and Medicaid)

If you are also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to you under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage other than Medicare or Medicaid which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

Refund of Overpayments

If the Claims Administrator pays 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 Claims Administrator if:

- All or some of the expenses were not paid by you or did not legally have to be paid by you or your Dependent.
- All or some of the payment made by the Claims Administrator exceeded the benefits under this Plan.
- If all or some of the expenses were recovered from or paid by a source other than the Plan as a result of charges against a third party for negligence, wrongful acts or omissions.

If the refund is due from another person or organization, you or your Dependent agrees to help the Claims Administrator get the refund when requested.

If you or your Dependent, or any other person or organization that was paid, does not promptly refund the full amount, the Claims Administrator may reduce the amount of any future benefits that are payable under this Plan.

TERMINATION OF COVERAGE

The Claims Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claims Administrator will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage
Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You elect to discontinue coverage; or
3. A Dependent ceases to be a Dependent as defined in the Plan.

The Plan Administrator may refuse to renew the coverage of an eligible Retiree or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *disabled* and Dependent on the parent will not terminate upon reaching the limiting age if the child continues to be both:

1. *Disabled,* and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claims Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a disabled Dependent beyond the limiting age, the Claims Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group
The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan. However, see **CONTINUATION OF GROUP COVERAGE** in the following section.

GENERAL INFORMATION

CONTINUATION OF HEALTH COVERAGE (COBRA) AND YOUR NOTICE OBLIGATIONS

When certain "qualifying events" occur that would cause you or your "qualified 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, known as COBRA continuation coverage, 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. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

This Section generally explains COBRA continuation coverage, when it may become available to you and members of your family, and what you need to do to protect the right to receive it.

For additional information about your rights and obligations under the Plan and under federal law, you can contact the Plan's COBRA Administrator, Conexis, at 1-877-722-2667.

QUALIFYING EVENTS

If you are the spouse of a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- You become divorced or legally separated from your spouse.

Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

AVAILABILITY OF COBRA COVERAGE

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

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

- your divorce or legal separation from your spouse; or
- the date any of your dependent children no longer qualifies as a dependent under this Plan (i.e., age 19, age 24 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).

Written notice of a qualifying event must be sent to:

Atmos Energy Corporation
P.O. Box 650205
Dallas, TX 75265
Attn: Plan Administrator

Contact the Plan's COBRA Administrator, Conexis, at 1-877-722-2667, for additional information regarding this notice, including a description of any required information or documentation.
The Company will notify the Plan Administrator within 30 days in the event one of the following other qualifying events occurs:

- you become entitled to benefits under Title XVIII of the Social Security Act; or
- the Company begins or is subject to a bankruptcy under Title XI of the United States Code.

PROVISION OF COBRA COVERAGE

Once the Plan Administrator receives notice that a qualifying event has occurred, the Plan Administrator will provide qualified beneficiaries with an option to elect to COBRA continuation coverage. COBRA continuation coverage will enable you and your qualified beneficiaries to be covered by the Plan for a limited time period upon completion of the election and payment of the premium. You and your qualified beneficiaries 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. Your rights to purchase continuation coverage may terminate if your employer terminates all its health benefit plans.

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.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. 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.

LENGTH OF COBRA COVERAGE

COBRA continuation coverage is a temporary continuation of coverage. Your right to continue to be covered by the health 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.

When the qualifying event is the retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

TERMINATION OF YOUR CONTINUATION COVERAGE

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

(1) the Company 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 (i) that does not contain any exclusion or limitation with respect to any pre-existing condition that you or your beneficiary has, or (ii) the other group health plan's preexisting condition exclusion or limitation terminates or otherwise does not apply to you or your beneficiary.

GENERAL INFORMATION

ALTERNATIVE COVERAGE UNDER THE VETERANS BENEFITS IMPROVEMENT ACT OF 2004

If you are called to active military duty, and you elect to continue your coverage during such duty, your coverage may be continued for 24 months at 102% of the applicable premium under the Veterans Benefits Improvement Act of 2004. However, this 24-month coverage is an alternative to COBRA continuation coverage, and does not provide the right to extend coverage upon a second qualifying event that is available under COBRA continuation coverage.

QUESTIONS REGARDING COBRA CONTINUATION COVERAGE

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you must keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CONTACT INFORMATION

For more information about COBRA continuation coverage, please contact your Plan's COBRA Administrator at:

Conexis
P.O. Box 226101
Dallas, TX 75222
1-877-722-2667

All notices described in this Section should be submitted to the Plan Administrator at the following address.

Atmos Energy Corporation
P.O. Box 650205
Dallas, TX 75265
Attn: Plan Administrator

AMENDMENTS

The Plan may be amended or changed at any time by the Employer with prior written notice to the Claims Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

AGENT

The Employer is not the agent of the Claims Administrator

INFORMATION CONCERNING EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If the Health Benefit Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.

2. The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information that the Claims Administrator has that will aid the Plan Administrator in making its annual reports.

3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions described in this Benefit Booklet. Claim filing and claim review procedures are found in the **HOW TO RECEIVE HEALTH CARE BENEFITS** section of this Benefit Booklet.

4. BCBSTX, as the Claims Administrator, is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.

- The Plan Administrator has given the Claims Administrator the initial authority to make certain benefit determinations in accordance with the benefits and procedures detailed in the Health Benefit Plan. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan's provisions and determining questions of eligibility and benefits. Any decision made by the Plan Administrator shall be final and conclusive.

DISCLOSURE AUTHORIZATION

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance Claims Administrator, or other entity to furnish the Claims Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

GENERAL INFORMATION

STATEMENT OF ERISA RIGHTS

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 shall be entitled to:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as division offices, worksites or union halls, all Plan documents, including insurance contracts, copies of collective bargaining agreements and a copy of the latest annual report (Form 5500 Series), filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room at the Employee Benefits Security Administration.

b. Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

You are entitled to continue health coverage for yourself and eligible spouse and 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 Coverage rights.

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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. If your Claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain, without charge, copies of documents relating to the decision and to have the Plan review and reconsider your Claim.

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 Administrator and do not receive them within 30 days, you may file suit in a federal court. In such 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, and you disagree with that denial, you must file an appeal of that denial in accordance with the claims procedures described in this Summary Plan Description. After the appeal is denied in accordance with the claims procedures, 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, after exhausting the claims appeal procedure, you may file suit in federal court.

If it should happen the Plan fiduciaries misuse the 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 you 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 you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous. If you have any questions about the Plan, you should contact the Plan Administrator.

If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension & Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.

GENERAL INFORMATION

NOTICE OF PRIVACY RIGHTS – HEALTH CARE RECORDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This statement gives you advice required by law. This Notice is effective as of April 14, 2003, and applies to health information the Atmos Energy Corporation Health Benefits Plan (the "Plan") receives about you. You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). This statement is not a consent or an authorization form. This form will not be used to release or to use your health care information in any manner that is not permitted by the Privacy Regulations. This notice is for participants and beneficiaries in the Plan. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your Protected Health Information, your privacy rights with respect to the Protected Health Information, the Plan's duties with respect to your Protected Health Information, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your Protected Health Information may be made by the Plan:

1. Your Protected Health Information may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your Protected Health Information may be disclosed to other health plans maintained by Atmos Energy Corporation who sponsors the Plan for any of the purposes described above, if the Plan is part of an organized health care arrangement with the other Plan.

2. Your Protected Health Information may be used or disclosed by the Plan for purposes of treating you. For example, if your doctor requests information on what other drugs you are currently receiving.

3. Your Protected Health Information may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances.

4. The Plan may also be required to disclose or use your Protected Health Information for certain other purposes. These purposes include uses or disclosures that are required by law. For example, if the Plan receives a court order requiring disclosure of your information. For example, if certain types of wounds occur that require reporting, or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena.

5. The Plan may disclose your Protected Health Information as authorized by you or your representative and to the extent necessary to comply with laws relating to workers' compensation and similar programs providing benefits for work-related injuries or illnesses if either (1) the health care provider provides health care to the individual at the request of the employer to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace and the health care provider is employed by the employer, or (2) if the employer is a health care provider and the health care provider is a member of the employer's work force, or (3) you authorize the

disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

Any other use or disclosure of your Protected Health Information will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

6. Your Protected Health Information may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs. Information may be provided to the sponsor of the Plan provided that the sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment related activities.

7. The Plan may disclose your Protected Health Information for purposes of referring you to case management or a pharmacy benefit manager.

8. The Plan may disclose your Protected Health Information to vendors who may work with the Plan regarding other types of products that are available for marketing purposes. This type of disclosure may only be made with your authorization.

9. The Plan may also disclose your information for the purpose of underwriting, premium rating and other activities with respect to creating, renewing and replacing the health insurance contract or health benefit coverage, including creating, renewing and replacing stop loss or excess loss insurance coverage.

Rights You May Exercise

1. You have the right to request restrictions on certain uses and disclosures of your protected health information in writing. However, the Plan is not required to agree to any restriction you may request.

2. You have the right to request access to your Protected Health Information and to inspect and copy your Protected Health Information under the policies and procedures established by the Plan.

3. You have the right to request an amendment to your Protected Health Information under the policies established by the Plan.

4. You have the right to receive an accounting of any disclosures of your Protected Health Information, other than those for payment, treatment and health care operations.

5. You have a right to receive this notice electronically and to obtain a paper copy from the Plan upon request.

6. You have the right to request to receive confidential communications of your Protected Health Information. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

7. You have the right to request to inspect a copy of your Protected Health Information, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or Protected Health Information that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment.

)ther Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release:

Disclosure of your Protected Health Information to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required:

Use and disclosure of your Protected Health Information is allowed without your authorization or any opportunity to agree or object under the following circumstances:

(1) When required by law.

(2) When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Protected Health Information may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

(3) When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's Protected Health Information.

(4) The Plan may disclose your Protected Health Information to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(5) The Plan may disclose your Protected Health Information when required for judicial or administrative proceedings. For example, your Protected Health Information may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(8) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(9) The Plan may use or disclose Protected Health Information for research, subject to certain conditions.

(10) When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(11) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

State laws may provide you with additional rights or protections.

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the following officer: Steve Harmon, Manager, Employee Benefits, Atmos Energy Corporation, 5430 LBJ Freeway, 1800 Three Lincoln Centre, Dallas, TX 75240-2601, (972) 855-4021.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the Protected Health Information in your designated record set. Requests for access to Protected Health Information should be made to the following office: Steve Harmon, Manager, Employee Benefits, Atmos Energy Corporation, 5430 LBJ Freeway, 1800 Three Lincoln Centre, Dallas, TX 75240-2601, (972) 855-4021.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend

You have the right to request the Plan to amend your Protected Health Information or a record about you in a designated record set for as long as the Protected Health Information is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that

:atement included with any future disclosures of your Protected Health Information.

Requests for amendment of Protected Health Information in a designated record set should be made to the following officer: Steve Harmon, Manager, Employee Benefits, Atmos Energy Corporation, 5430 LBJ Freeway, 1800 Three Lincoln Centre, Dallas, TX 75240-2601, (972) 855-4021.

You or your personal representative will be required to complete a form to request amendment of the Protected Health Information in your designated record set.

The Right to Receive an Accounting of Protected Health Information Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your Protected Health Information during the six years prior to the date of your request. However, such accounting need not include Protected Health Information disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own Protected Health Information; (3) pursuant to a valid authorization; (4) ncident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the following officer: Steve Harmon, Manager, Employee Benefits, Atmos Energy Corporation, 5430 LBJ Freeway, 1800 Three Lincoln Centre, Dallas, TX 75240-2601, (972) 855-4021.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your Protected Health Information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your Protected Health Information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

You have a right to request an amendment to your Protected Health Information; however the Plan may deny your request and you may appeal any denial.

You have the right to receive an accounting of any disclosures made of your Protected Health Information excluding those disclosures or uses for payment, treatment or health care operations.

You have a right to receive a copy of this notice in paper format. The Plan is required by law to maintain the privacy of Protected Health Information and provide individuals with notice of its legal duties and privacy practices with respect to the Protected Health Information.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all Protected Health Information the Plan maintains. Any Protected Health Information that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all Protected Health Information it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

GENERAL INFORMATION

Minimum Necessary Standard

When using or disclosing Protected Health Information or when requesting Protected Health Information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of Protected Health Information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for the Plan's compliance with legal regulations; and
- uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

In addition, the Plan may use or disclose a "Limited Data Set" which may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set. Disclosures of a Limited Data Set need not be included in any accounting of disclosures by the Plan.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with Phil Allbritten, at Atmos Energy Corporation, 5430 LBJ Freeway, 1800 Three Lincoln Centre, Dallas, TX 75240-2601, describing when you believe the violation occurred, and what you believe the violation was. You will not retaliated against for filing a complaint.

You may also file a complaint with the Office of Civil Rights of the Department of Health and Human Services at Richard Campanelli, Director, 200 Independence Avenue S.W., Room 515F, HHH Building, Washington, DC 20201, or at the appropriate regional office of the Office of Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. If you would like to receive further information, you should contact Steve Harmon, the privacy officer or Phil Allbritten, the privacy complaint officer, for the Plan. This notice will first be in effect on April 14, 2003, and shall remain in effect until you are notified of any changes, modifications or amendments

GENERAL INFORMATION

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 PLAN ADMINISTRATION INFORMATION

NAME OF THE PLAN:
Retiree Medical Plan for Retirees and Disabled Employees of Atmos Energy Corporation.

EMPLOYER/PLAN SPONSOR:
Atmos Energy Corporation
c/o Vice President, Human Resources
P.O. Box 650205
Dallas, Texas 75265-0205

EMPLOYER IDENTIFICATION NUMBER:
75-1743247

PLAN NUMBER:
512

TYPE OF PLAN:
Welfare Benefit Plan

TYPE OF PLAN ADMINISTRATION:
The Plan is administered on behalf of the Plan Administrator by the Claims Administrator. The benefits are paid from funds provided by the Employer on behalf of the Plan in accordance with a contract with Blue Cross and Blue Shield of Texas (called "the Claims Administrator").

PLAN ADMINISTRATOR:
Vice President, Human Resources
(972) 934-9227

TRUSTEES OF PLAN:
Qualified Retirement Plans and Trusts Committee

AGENT FOR SERVICE OF LEGAL PROCESS:
The Plan Sponsor

PLAN CONTRIBUTIONS AND FUNDING ARRANGEMENTS:
The Plan is funded by direct benefit payments from the general assets of the Employer. The employee's contribution toward the cost of this Plan is at a rate determined by the Employer.

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

CLAIMS ADMINISTRATORS/CLAIMS ADMINISTRATORS:
Blue Cross Blue Shield Texas

CLAIMS FILING PROCEDURES:
This information is explained in the section of this booklet entitled **"CLAIM FILING PROCEDURES."**

CLAIM REVIEW PROCEDURES:
This information is explained in the section of this booklet entitled **"CLAIM FILING PROCEDURES."**

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 78
Witness: Jim Cagle

Respondent: Pace McDonald

Data Request:

Refer to the response to the Staff First Request, Item 29.

a. Atmos was requested to provide a reconciliation of its book to taxable income for both the base and forecasted test periods utilizing the format provided in Schedule 9. Atmos did not provide the requested reconciliation. Provide the requested reconciliations using the format provided.

b. In the response, Atmos contends that its filing in Volume 9 of the Application, Tab 5 provides the proper calculation of income tax expense for rate-making purposes. A review of those calculations shows that Atmos used a Kentucky corporate income tax rate of 8.25 percent. The Kentucky corporate income tax rate in effect from January 1, 2005 through December 31, 2006 was 7.00 percent. The Kentucky corporate income tax rate in effect after January 1, 2007 is 6.00 percent. Recalculate Schedule E as shown in Tab 5 for both the base and forecasted test periods reflecting the appropriate Kentucky corporate income tax rates. In addition, correct and resubmit all schedules and workpapers affected by the correction of the Kentucky corporate income tax rate and the corresponding adjustment to the federal income taxes.

Response:

a. On March 9, 2007, in order to provide an adequate answer for this question, a conference call was arranged which included Staff, the office of the Attorney General and the Company. At that time, it was agreed that, given the complexity of the Company's tax calculations, the following information would appropriately respond to the question:

1. Atmos should provide a reconciliation of book to taxable income reflecting its last filed corporate income tax return.

   Please see attached. The 9/30/05 walk represents the last filed corporate income tax return. The 9/30/06 walk represents estimates as of that date. The corporate return will not be filed until June 2007.

2. Atmos should also show how much of the book income was attributable to Kentucky operations for the applicable period.

As Atmos does not compute or assign taxable income down to the KY operations. We calculate book income at that level which includes allocations of common costs. There are a myriad of adjustments made between book and taxable income and in order to arrive at taxable income for KY operations every single adjustment would have to be split between KY and non-KY operations. That process would require the use of extensive estimates and assumptions.

Please see attached.

3, An explanation of the differences between book income tax expense and the amounts it has included for the base and forecasted test periods.

The per book expense is an allocation. The expense included in the filing is a calculation based upon the revenues and expenses adjusted for ratemaking purposes, utilizes synchronized interest using the stated ratebase, interest rates, and capital structure in the filing. Additionally, the calculation is based on the statutory rates for federal and state taxes. As such, the process is not one whereby adjustments are made to book expense to arrive at the tax expense in the rate case. Rather the tax expense in the rate case is a new calculation made solely for the case. As the two are independent calculations, there is no schedule of adjustments that reconciles between the two numbers.

b. Please see the response to AG 1-1.

Preparer: Inguyen
DATE: 3/14/2007

ATMOS ENERGY CORPORATION
TAX INCOME TO PROVISION WALK
09/30/05

	FYE 09/30/05 Book-Tax Walk
BOOK INCOME/(LOSS)	108,550,667
FEDERAL INCOME TAXES	58,281,179
STATE INCOME TAX	6,298,845
TOTAL INCOME TAX PER BOOKS	64,580,024
>> PRE-TAX BOOK	**173,130,691**
PERMANENT DIFFERENCES:	
Merger & Integration Amortization	2,801,067
Club Dues	47,432
Meals & Entertainment	731,792
Penalties	34,260
Spousal Travel	40,168
Lobbying Expense	584,032
Cash Surrender Value Adjustment	(1,461,369)
Dividends Paid to RSGP	(398,349)
ESOP Dividends	(3,109,305)
SERP Premiums	769,470
State Income Tax Deduction	(6,965,231)
Capitalized Meals & Entertainment	472,609
RSGP - Permanent	(147,375)
TOTAL	(6,600,799)
TAXABLE INCOME BEFORE TEMPORARY DIFFERENCES	**166,529,892**
TEMPORARY DIFFERENCES:	
Accrued Environmental Asset	(1,824,036)
Vacation Accrual	-
Allowance for Doubtful Accounts	6,773,341
Clearing Account - Adjustment	113,741
Deferred Gas Costs	74,542,012
Unrecovered Gas Cost Adjustment	(38,095,613)
Directors Deferred Bonus	83,532
Directors Deferred Comp	5,988,236
Environmental Activities	(529,133)
FAS 106 Adjustment	12,020,247
Miscellaneous Accrued	(30,089)
Prepaid Dues	(56,962)
Prepaid Gas	26,379
Prepaid OSC/PUCA Assessment	(18,988)
Research and Development Expenses	(83,328)
Rate Case Accrual	6,267,670
SEBP Adjustment	6,559,662
Self Insurance - Adjustment	3,647,347
Worker's Comp Insurance Reserve	2,302,665
Regulatory Liability - MidTex	488,641
Regulatory Liability - GGC 109	(38,176)
Regulatory Asset - UCG 109	137,148
Regulatory Liability - UCGC Rate	(247,374)
Regulatory Asset - LGS Amortizatio	

BOOK - TO - TAX PROVISION WALK

Regulatory Asset - Mid-Tex	-
Capitalized Selling Expense	71,881
Amortization - LGS Acq. 1860.14155	(31,338)
Amortization - LGS Acq. 1810.13523	186,324
RAR 91/93 Bond Cost Amortized	3,935
RAR 86/90 Lease Expense Amortiz.	(14,726)
Monarch - Non Compete	(26,667)
Palmyra - Non Compete	(19,363)
RAR CFWE 1990-1985	(2,906)
Merger and Integration Amortiz.	(1,118,498)
LGS Goodwill Amortization	(2,725,034)
Regulatory Asset Amortization	(63,887)
TXU Goodwill Amortization	(31,844,334)
ComfurT Goodwill Amortization	(79,868)
Excess Capital Losses over Capital Gains	(321,658)
Aid in Construction Adjustment	13,084,182
Capitalized Interest Adjustment	(1,125,358)
Capitalized Overhead Adjustment	(19,614,320)
Software Capitalized per Books	(17,881,852)
Customer Advances	1,778,504
Customer Forfeiture	511,608
DIG on Fixed Assets	192,551
Deferred Projects - ANG Acq.	-
Deferred Projects - One Oak Purcha	198,953
Deferred Projects - LGS Acq.	-
Deferred Projects - TXU Acquisitio	1,787,184
Deferred Projects - MVG Acq.	3,292,745
Deferred Expense Projects	2,300,939
Tax Deprection Adjustment	(205,752,631)
Book Deprection Adjustment	175,004,205
Gain/Loss on Sale of FA - BOOK	-
Gain/Loss on Sale of FA - TAX	(13,311,253)
Pension Expense	1,478,522
Rabbi Trust MVG	(73,787)
Rabbi Trust	12,196
RSGP - Temporary	3,043,220
Subs Gain/Loss on Vehicle Sales	(2,903)
UNICAP Section 263A Costs	4,112,776
481(a) UNICAP	2,953,539
Accrued Severence	-
Ad Valorum Taxes	(290,554)
Prepayments	344,625
Capitalized Book Depreciation	(1,485,618)
Charitable Contribution Deduction	(1,110,003)
SUBTOTAL - TEMP ITEMS	(8,511,747)
OTHER TAXABLE INCOME ADJUSTMENTS	
Nonqualified Stock Option Income	(3,458,593)
TAXABLE INCOME BEFORE NOL & SPECIAL DEDUCTION	**154,559,552**
Dividends Received Deduction	(628,842)
TAXABLE INCOME AFTER NOL & SPECIAL DEDUCTION	**153,930,710**

BOOK - TO - TAX PROVISION WALK

ATMOS ENERGY CORPORATION & SUBSIDIARIES
CONSOLIDATED TAX PROVISION
September 30, 2006

	UTILITY 75-1743247
BOOK INCOME/(LOSS)	67,115,540
FEDERAL INCOME TAXES	53,457,169
STATE INCOME TAX	4,745,711
PRE-TAX BOOK	125,318,420
PERMANENT DIFFERENCES:	
Dividends Paid to RSGP	(600,339)
ESOP Dividends	(3,370,717)
Bolivar Lease Adjustment	-
Restricted Stock Grant Plan	(647,365)
SEBP Adjustment - Amended Item	(2,140,690)
Excess Capital Loss ovr Capital Ga	-
Excess 162(m) Exec Comp	304,341
Other - Partnership Income	-
Club Dues	58,348
Capitalized Meals & Entertainment	440,904
Cash Surrender Value Adjustment	(2,211,878)
Lobbying Expense	747,756
Meals & Entertainment	998,844
Penalties	104,717
SERP Premiums	758,558
Spousal Travel	15,897
State Income Tax Deduction	-
TOTAL PERMANENT DIFFERENCES	(5,541,624)
TAXABLE INCOME BEFORE TEMPORARY DIFFERENCES	119,776,796
TEMPORARY DIFFERENCES:	
Environmental Activities	(31,075)
Ad Valorum Taxes	(98,823)
Directors Deferred Bonus	108,529
Directors Deferred Comp	(2,337,090)
Accrued Environmental Asset	123,256
Miscellaneous Accrued	(8,223,634)
Self Insurance - Adjustment	(3,929,193)
Vacation Accrual	114,503
Worker's Comp Insurance Reserve	3,942,042
Accrued SUT Audit	800,000
Customer Advances	(1,390,432)
Amortization - LGS Acq. 1810.13523	186,326
Deferred Expense Projects	4,227,318
Amortization - LGS Acq. 1860.14155	(31,338)
Deferred Projects - TXU Acquisitio	(71,443)
Amortization	-
RAR 91/93 Bond Cost Amortized	3,935
Lease Income - Bolivar	-
DIG on Fixed Assets	192,595
Investment in Heritage	-
RAR 86/90 Lease Expense Amortiz.	(14,726)
Pine Pipeline Partnership	-
Lease Income - Staley	-
Amortization - ComfurT Goodwill	(79,868)
Depreciation Adjustment	(47,927,572)
BOOK Gain/Loss on Sale of FA	318
TAX Gain/Loss on Sale of FA	(48,184,379)
Subs Gain/Loss on Vehicle Sales	(2,903)

Software Capitalized per Books	(9,649,183)
Aid in Construction Adjustment	18,239,092
Customer Forfeiture	3,700,823
Capitalized Interest Adjustment	(1,654,136)
Capitalized Overhead Adjustment	(25,246,951)
Capitalized Book Depreciation	(1,441,016)
Deferred Gas Costs	(1,971,853)
Hedging 481(a)	(92,228,399)
Unrecovered Gas Cost Adj	59,709,728
SEBP Adjustment - Amended Item	2,140,690
SEBP Adjustment	(1,844,042)
Rabbi Trust MVG	(73,787)
Restricted Stock Grant Plan	3,200,355
Rabbi Trust	12,196
Excess Capital Loss ovr Capital Ga	-
Capitalized Selling Expense	71,880
Industrial Contracts	-
Other - Partnership Investment	-
Linder - Partnership Investment	-
UNICAP Section 263A Costs	2,763,357
481(a) UNICAP	2,953,539
Allowance for Doubtful Accounts	(2,782,992)
Clearing Account - Adjustment	(658,325)
RAR CFWE 1990-1985	-
Contributed Contracts	-
LGS - Goodwill Acquisition	(2,979,224)
Legendary - Partnership Investment	-
Book Inc Recognized for MTM Acctg	-
Monarch - Non Compete	(26,667)
Palmyra - Non Compete	(19,363)
Prepaid OSC/PUCA Assessment	(55,259)
Duke - Purchased Contracts	-
Prepaid Dues	17,352
Prepaid Gas	152,278
Prepaid Software Maintenance	1,127,673
Rate Case Accrual	(6,808,369)
Research and Development Expenses	(51,354)
Partnership Investment-Unitary	-
LGS - Purchased Contracts	-
IGS - Purchased Contracts	-
TXU - Goodwill Amortization	(32,212,799)
Stock Option Expense	815,993
Pension Expense	14,537,333
FAS 106 Adjustment	13,945,704
Regulatory Asset - LGS Amortizatio	(63,887)
Regulatory Liability - Mid-Tex	(488,641)
Regulatory Liability - GGC 109	(37,029)
Regulatory Liability - UCGC 109	137,148
Regulatory Liability - UCGC Rate	(247,374)
TOTAL TEMPORARY DIFFERENCES	(159,639,163)
TAXABLE INCOME BEFORE NOL AND SPECIAL DEDUCT	(39,862,367)
Nonqualified Stock Option Income	(210,368)
TAXABLE INCOME BEFORE NOL & SPECIAL DEDUCTIO	(40,072,735)
Dividend Received Deduction	(628,842)
TAXABLE INCOME AFTER NOL & SPECIAL DEDUCTION	(40,701,577)

ATMOS energy

Income Statement

Kentucky Division - 009DIV

	Fiscal 2006 September
Operating Revenue	
Total Gas Revenue	5,810,069
Transportation Revenue	759,558
Forfeited Discounts	47,641
Other Operating Revenue	68,153
Realized Gas Trading Margin	0
Unrealized Gas Trading Margin	0
Intersegment Revenue Elimination	0
Total Operating Revenues	**6,685,420**
Purchased Gas Cost	3,821,600
Intersegment Gas Cost Elimination	0
Total Purchased Gas Costs	**3,821,600**
Gross Profit	**2,863,820**
Operating Expenses	
Total Operation & Maintenance Exp - Excl Bad Debt	1,422,841
Bad Debt Expense	90,350
Depreciation and Amortization	1,057,043
Taxes-Other Than Income Taxes	
Payroll Taxes	24,662
Ad Valorem	216,804
Franchise Taxes	0
State Gross Receipts	0
Others	848,336
Total Taxes - Other Than Income Taxes	**1,089,802**
Total Operating Expenses	**3,660,036**
Operating (Income) Loss	**(796,216)**
Other Non-Operating Income/Expense	
Interest Income	41,794
PBR	46,146
Others Income	61,450
Total Non-Operating Income	**149,389**
Long Term Interest Expenses	473,730
Short Term Interest Expenses	122,431
Donations	126,619
Other Non-Operating Expense	43,380
Total Non-Operating Expense	**766,160**
Equity in Earnings	0
Total Other Non-Operating Income/Expense	**616,770**
Income / Loss, Before Income Taxes	**(1,412,986)**
Provision (Benefit) for Income Taxes	
Current Federal Income Tax	71,236
Current State Income Tax	713,787
Deferred Federal Income Tax	(592,640)
Deferred State Income Tax	(904,267)
Investment Tax Credits	0
Total Provision (Benefit) for Inc Tax	**(711,884)**
Income / Loss, Before Cumulative Effect	**(701,102)**
Cumulative Effect of Acct Change, Net of Tax	0
Income Statement - Net (Income) Loss	**(701,102)**

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 79
Witness: Dan Meziere

Data Request:

Refer to the response to the Staff First Request, Item 31. Provide the following information relating to the adoption of Statement of Financial Accounting Standards ("SFAS") Nos. 106, 109, 112, and 143 for both the base and forecasted test period for Atmos's Kentucky operations:

a. The unamortized balance of regulatory assets or regulatory liabilities related to the adoption of the referenced SFAS. Include account numbers and account titles utilized.

b. The annual amortization of regulatory assets or regulatory liabilities related to the adoption of the referenced SFAS. Include account numbers and account titles utilized.

Response:

Please see attachment Case 2006-00464 KPSC DR2-79 ATT

Atmos Energy Corporation
Kentucky Data Requests
Response to AG's First DR # 79
Amounts in Thousands

	Balance Sheet Account	Account Title	Unamortized balance in base	Unamortized balance in test period	Income Statement Account	Account Title	Amortization in base	Amortization in test period
FAS 106 (1)	2530-27706	FAS 106/OPEB	3,481,771	3,481,771	9260-0120/1	A&G - Employee pensions and benefits - benefits load/variance	355,000	355,000
FAS 109 (2)	NA	NA	NA	NA	NA	NA	NA	NA
FAS 112 (3)	NA	NA	NA	NA	NA	NA	NA	NA
FAS 143 (4)	NA	NA	NA	NA	NA	NA	NA	NA

(1) - The transition obligation is recorded as a component of the net FAS 106 liability on Atmos Energy's general ledger. The amount provided represents the total net FAS 106 liability for Kentucky as of September 30, 200€ Further, the amount of the amortization reflected in this table represents the total expense per the independent actuary report, BEFORE the application of any labor capitalization rate.

(2) - The adoption of FAS 109 had no impact on Atmos' Kentucky operations. Therefore, there is no associated regulatory asset or liability related to the adoption of SFAS 109 for Atmos Energy's Kentucky operations.

(3) - As discussed in the response to Staff First Request Item 31, the adoption of SFAS 112 was not material. Further, we do not separately track our SFAS 112 costs in our general ledger as these costs are de minimis. Thus, this information has not been provided.

(4) - As discussed in response to Staff First Request Item 31 and the AG's First DR # 157, the adoption of FAS 143 had no impact to Atmos Energy. Therefore, no accounting entries have been recorded to account for the effects of the adoption of this standard.

Atmos Energy Corporation, Kentucky
Case No. 2006-00464
KPSC 2nd Data Request Dated February 23, 2007
DR Item 80
Witness: Greg Waller

Data Request:

Refer to the response to the Staff First Request, Item 33(c). Provide the O&M services expense associated with WKG Storage and UCG Storage applicable to the base period and forecasted test period. Identify the adjustments to those periods that removed the O&M expense from the rate case.

Response:

Included in the O&M services expense, associated with WKG Storage and UCG Storage, are items such as labor, benefits and associated employee costs such as vehicle, telecom, etc. However, to clarify the initial response in Item 33(c), none of these costs are included in the base or forecasted test period. These costs are budgeted below-the-line and therefore there is no need for an adjustment to remove them from the base or forecasted periods.