# 2017 Vistra Energy
# Health and Welfare Benefit Plan
# Summary Plan Description

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# Overview

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# Your Health and Welfare Benefit Plan

As an employee of Vistra Operations Company LLC "Vistra Energy" or one of its subsidiaries, you have access to a broad range of valuable benefits that are designed to meet the needs of our diverse employee population. The company's philosophy is to provide a comprehensive and competitive benefits program that helps meet the needs of both employees and the Company's business.

A health and welfare benefits program has been established which allows you to choose among available benefit options that best meet your needs. Additionally, it also allows you to set up flexible spending accounts (FSAs) and contribute to a health savings account (HSA), if selected. With these accounts, you can use tax-free dollars to pay dependent care expenses and to help pay eligible health care expenses that are not covered by the Medical Plan options. This tax-free status gives you the full buying power of your benefit dollars and allows you to reduce your taxes.

The Vistra Energy Health and Welfare Benefit Program is designed to:

- Help provide protection for employees and their families against catastrophic health care expenses, disability, and death
- Provide benefit options so employees can choose benefits that best meet their personal needs
- Provide benefits that are simple and easy to use and understand
- Focus on the health and overall wellness of the participants

This handbook is a summary of the health and welfare benefits that is provided to active employees and to individuals receiving long-term disability (LTD) benefits. It serves as a summary plan description (SPD) under the Employee Retirement Income Security Act of 1974, as amended (ERISA). A different handbook describes the health and welfare benefits for retirees.

This handbook summarizes the primary provisions of the Health and Welfare Benefit Program (the "Plan") effective January 1, 2017. For complete details regarding the administration and operation of health and welfare benefits, your rights and your obligations under the Plan, you should refer to both this handbook and the Plan. **If there is any conflict between this handbook and the Plan, the Plan governs.**

Vistra Energy reserves the absolute right, in its sole discretion, to amend, modify, or terminate the Plans, in whole or in part, at any time and for any reason, including but not limited to the right to increase, reduce, or terminate benefits for all employees or for any group of employees; to change carriers, network administrators, or benefits; to increase employee required premiums or contributions, Deductibles, Coinsurance, or other payments; or any other changes.

Subject to your right to appeal denied claims for benefits, the Plan Administrator's decisions regarding the interpretation of the Plan documents and SPD are conclusive and binding on all persons. See the section entitled "Claim Review and Appeal Process" for a description of your benefit claims appeal rights. The Plan Administrator may, however, delegate some of its interpretation and decision-making authority to the insurers or Claims Administrators of the Plan. Benefits under this Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

When the Plan's benefits are changed, you will be notified by the Plan Administrator. If the Plan is terminated, in whole or in part, or terminated as to any employee group, benefits will be paid up to the date of the Plan's termination. No benefits will be paid after the date of the Plan's termination, and no charges incurred after the date of the Plan's termination will be covered by the Plan.

Certain words or phrases used in this handbook are capitalized. These words or phrases have specific meanings. Please refer to the Glossary at the back of this handbook for the definition of these defined terms.

# Plan Highlights

This section gives you a brief overview of the health and welfare benefits available to you as an employee. Each benefit option is described in greater detail in subsequent sections.

## Medical Plan Options

The primary purpose of medical coverage is to help you avoid the financial risk of significant expenses from a major injury or illness. A Medical Plan option is offered which also helps you with your day-to-day health care expenses, such as prescriptions and preventive care charges.

## Dental Plan Options

The dental coverage options cover a portion of charges for dental care and emphasizes preventive care.

## Vision Plan Option

The vision plan option provides coverage for eye exams, contacts (including disposable contacts), and eyeglass lenses and frames. It also offers discounts on special features such as laser eye surgery, UV coatings, tints for lenses, and more.

## Flexible Spending Accounts (FSAs) Options

The Health Care Flexible Spending Account option lets you set aside money for health care expenses that are not covered by other insurance. The Dependent Care Flexible Spending Account option lets you set aside money for dependent care expenses incurred so that you can work. One of the advantages of these options is the tax-free status of your contributions and reimbursements.

## Life Insurance Options

You can choose from various levels of group term life insurance coverage according to your personal needs. You can also choose coverage for your eligible dependents, if desired.

## Accidental Death and Dismemberment (AD&D) Insurance Options

The employee AD&D option is payable in the event of death or dismemberment from a covered accidental injury. You can also choose coverage for your eligible dependents.

## Long-Term Disability (LTD) Benefit Options

LTD works with other sources of disability income to replace 60% of your pre-disability base pay, either on a pre-tax basis or post-tax basis, while you are disabled.

# If You Have Questions About Your Benefits

Although this handbook will answer most of your questions about your Plan benefits, you may still have questions from time to time. The table below provides contact information for each of your benefit options under the Plan.

| Contact | Web Site | Member Services | Group ID |
|---|---|---|---|
| **Benefits Eligibility, Enrollment, Provider Search, and Year-Round Health Care Decision Support**<br><br>Benefits Service Center | HRHelp@vistraenergy.com | 1-844-469-9539 | N/A |
| **Medical**<br><br>Blue Cross Blue Shield of Texas (BCBSTX) plan option:<br><br>MyHealth HSA Option | www.bcbstx.com | 1-800-762-8532 | 121212 for MyHealth HSA |
| **Prescription Drugs**<br><br>CVS Caremark | www.caremark.com | 1-877-775-5642 | Vistra EnergyRX |
| **Mental Health and Chemical Dependency**<br><br>BCBSTX Behavioral Health Helpline | www.bcbstx.com | 1-800-528-7264 | Same as for medical plans |
| **Dental**<br><br>MetLife | www.metlife.com/mybenefits | 1-800-942-0854 | 138353 |
| **Vision**<br><br>UnitedHealthcare Vision | www.myuhcvision.com | 1-800-638-3120 | 4229 |

| Contact | Web Site | Member Services | Group ID |
|---|---|---|---|
| **Life and AD&D Insurance**<br><br>MetLife | HRHelp@vistraenergy.com | 844-469-9539 | 138353 |
| **Flexible Spending Accounts (FSAs)or Health Savings Account (HSA)**<br><br>WageWorks | www.wageworks.com | 1-877-WageWorks<br>(1-877-924-3967) | |
| **Disability**<br><br>Benefits Service Center | HRHelp@vistraenergy.com | 1-844-469-9539 | N/A |
| **EAP**<br><br>Magellan | www.magellanassist.com | 1-800-327-7850 | N/A |
| **Compass Health Services** | www.compassphs.com | 1-877-546-4146 | N/A |
| **Airrosti Rehab** | www.airrosti.com | 1-800-404-6050 | N/A |
| **Livongo** | www.Welcome.livongo.com/Vistra | 1-800-945-4355 | N/A |

# About This Handbook

The sections that follow will help you understand how your benefit options work. We encourage you to make the best use of them by taking time to review and become familiar with this handbook and to use it as a reference guide in the future.

There is a separate section for each benefit option. There is also a separate section for each of the following types of information:

- Plan participation (eligibility and enrollment)
- Plan administration
- Life events
- Glossary

# Plan Participation

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# Employee Eligibility

> **Participating Employers**
> Participating employers include Vistra Energy and its U.S.-based subsidiaries.

You are eligible to participate in the Plan if you are a regular employee of Vistra Energy or a Participating Employer (see sidebar). A regular employee is one who is regularly scheduled to work at least a 30-hour work week on an ongoing basis. Support Personnel Group employees (SPG's), Door-to-Door (D2D), eligible student employees, employees on an approved leave of absence, and part-time employees regularly scheduled to work at least 20 hours per week are eligible for all benefits. LTD participants are eligible for certain benefits in accordance with plan provisions.

## Who Is Not Eligible

You are not eligible for the benefits described in this handbook if you are:

- A leased or contract employee, consultant or independent contractor
- A nonresident alien
- An individual who is not paid directly by a Participating Employer through the company's normal employee payroll, or otherwise characterized in a Participating Employer's internal records as other than in one of the eligible classes described above, even if a court or administrative agency determines that such individual is a common-law employee, or even if Vistra Energy subsequently agrees to retroactively treat or reclassify such individual as an employee
- Temporary employees (including summer interns and co-op students)
- Part-time employees working less than 20 hours

# Dependent Eligibility

You can also enroll your eligible dependents for medical, dental, vision, life insurance, and AD&D insurance coverage. Your eligible dependents are your:

- Legal spouse for all lines of coverage
- For medical, vision, and dental coverage: Children up to age 26. Any provisions related to coverage of a handicapped child will start at age 26.
- For life and AD&D coverage: Your unmarried children up to age 26 and are not serving in the armed forces
- Unmarried children of any age who become physically or mentally disabled before reaching age 26 for life and AD&D, medical, vision, and dental programs. You must apply for continued coverage for a disabled child at least 31 days before coverage otherwise would end.

**Children**
Your children include:

- Your natural children
- Your legally adopted children (or children who have been placed with you for adoption)
- Your stepchildren living with you
- Children for whom you (the Vistra Energy employee) have Legal Custody and who live with you
- Children you are required to cover under a Qualified Medical Child Support Order

Please Note: **You may be required to verify the eligibility of any person(s) covered as your dependent or otherwise claiming coverage through you (e.g., as your spouse or your child). Requested information to verify your dependent's eligibility must be remitted timely in order to continue coverage under the Plan for that person. Failure to timely remit information required by Vistra Energy to verify eligibility of that person may result in his or her loss of coverage retroactive to the date they are deemed ineligible, to the extent permitted by applicable law. You may also be required to provide reimbursement for any claims paid for an ineligible dependent.**

**By submitting your requested benefit elections, you are certifying that all the information you have provided is accurate. In the event that you fraudulently misrepresent your relationship to another person in order to obtain coverage for such person, or otherwise make a material misrepresentation regarding a person's eligibility to participate in the Plan, you and all persons who claim coverage through you may lose coverage under the Plan. In addition, you may be subject to disciplinary action by your employer, up to and including termination of employment.**

## Eligibility Reviews

As plan sponsor of the Plan, Vistra Energy is responsible for enrollment and disenrollment of participants in the Plan. Accordingly, Vistra Energy may, from time to time, request

**Be Sure to Enroll New Dependents!**
If you want to cover a new dependent, you must enroll the new dependent within 31 days. However, you have 60 days to enroll new dependents after birth or adoption.

enrollment information from the Plan to determine a person's eligibility for Plan participation.

## If Two Family Members Work for Vistra Energy

If you and your spouse both work for Vistra Energy or a Participating Employer, only one of you can cover your dependents. You can choose one of the following two options:

- One spouse can carry all family members under his or her coverage (one spouse elects family coverage and the other spouse elects no coverage).
- Each spouse can be covered as an employee, but dependent children can be covered as dependents by only one spouse. One spouse should elect family coverage (you + children) and the other spouse should elect employee-only coverage.

If your dependent child works for Vistra Energy or a Participating Employer and is eligible for coverage as an employee, you cannot also cover that child as a dependent.

## Special Eligibility Rules for Vision

The vision plan option is subject to insurance laws in the state of Texas. These laws allow you to cover:

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

For more information, you should refer to documentation provided by the provider of these options.

# Enrolling for Coverage

| Vistra Energy Health and Welfare Plan Benefits |
|---|
| Medical Plan option |
| Dental Plan options |
| Vision Plan option |
| Life Insurance options |
| Accidental Death and Dismemberment (AD&D) Insurance options |
| Flexible Spending Accounts (FSAs) options |
| • Health Care Spending Account option |
| • Dependent Care Spending Account option |
| Long-Term Disability (LTD) Benefit options |
| Health Savings Accounts |

To receive coverage under certain benefit options, you have to enroll through the Plan's enrollment program each year.

## Enrolling in the Vistra Energy Health and Welfare Program

### New Hire Enrollment

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

Once you make your coverage decisions, log on to www.myworkday.energyfutureholdings.com and follow the prompts to enroll. Be sure to specify which dependents, if any, you want to enroll for each benefit option that allows dependent coverage. You can also call the Benefits Service Center at 1-844-469-9539. Representatives are available Monday through Friday from 8:00 a.m. to 5:00 p.m. Central time.

If you don't enroll within 31 days of your hire date, you will receive only company paid coverage for life insurance, accidental death & dismemberment, and long-term disability coverage until the next calendar year, unless you have a qualified status change.

**Open Enrollment Period**
During the annual enrollment period held each year in the fall, you decide whether you want to participate in some or all of the benefit program options during the next calendar year. In some cases, you also choose the level of coverage you want. These coverage choices go into effect on the next January 1 and remain in effect for one year (through December 31) or until you have a qualified status change (see sidebar). Some elections may be subject to carrier approval.

**Your Elections Are Effective for a Full Year**
You will not be able to change your elections until the next applicable enrollment period. However, you can change your elections if you have a qualified status change (see sidebar). To make a change:

- Log on to the MyWorkday within 31 days following the qualified status change or 60 days for birth, adoption or placement for adoption.
- Any changes that you make to your benefits must be consistent with the qualified status change.

For more information about making changes to your benefits, see "Changing Your Coverage" later in this section or see the "Life Events" section of this handbook.

**Qualified Status Changes**
- Your marriage, divorce, annulment or legal separation
- The birth, adoption, or placement for adoption of a child
- The death of your spouse or a covered dependent child
- Your gain or loss of Legal Custody of an eligible dependent
- A child's gain or loss of status as an eligible dependent
- A change in the employment status of you, your spouse, or an eligible dependent (e.g., from part-time to full-time or vice versa), resulting in gain or loss of coverage
- Your or your covered dependent's eligibility in Medicare or Medicaid
- A court order requiring a change in coverage (such as a qualified medical child support order)

**Coverage Categories**
When you enroll for medical, dental, and vision coverage, you also choose a coverage category. There are four categories to choose from:

- You only
- You and spouse
- You and child(ren)
- You and family (spouse and children)

You can choose different coverage categories for each benefit option. For example, you can choose "you and family" for medical coverage and "you only" for vision coverage.

**Automatic Enrollment in the HSA**
If you enroll in the MyHealth HSA Option, you are automatically enrolled in the Health Savings Account (HSA).

**Life Insurance Limits**
At each enrollment period, you can increase your Employee Life option coverage by one coverage level (for example, from one times pay to two times pay, or from times pay to four times pay)

without Evidence of Insurability. MetLife must approve your application before additional coverage can go into effect.

You will be required to answer medical questions if, during the initial enrollment period, you request a coverage amount that exceeds the plan's Medical Evidence of Insurability level of 1x, 2x or 3x pay or increase coverage amount by more than one coverage level at the time of enrollment or at the time of a Qualifying Life Event. All late entrants must also provide Medical Evidence of Insurability.

For more information, see the Life and Accidental Death and Dismemberment Insurance section in this handbook.

**Working Spouse Charge**
If your spouse is employed and is eligible for medical coverage through his or her employer, you and your spouse should give careful consideration to covering your spouse under that plan. If your spouse is eligible for his or her own employer-sponsored coverage and you still decide to cover your working spouse under the Medical Plan option, you will be charged an extra surcharge per month. The surcharge will not apply if the spouse also works for Vistra Energy or a participating employer in the Plan.

# Paying for Coverage

You and Vistra Energy share the cost of your benefits coverage.

Vistra Energy pays the full cost of many of your benefits. You and Vistra Energy share the cost of other coverage – including medical coverage for you and your family. You pay the full cost of optional employee and dependent life and accidental death and dismemberment (AD&D) insurance. Vistra Energy, in its sole discretion, determines the amount of required employee contributions for each of the benefit options under the Plan. Required employee contributions are subject to change from time to time as Vistra Energy determines.

## Pretax and After-Tax Contributions

For some benefits coverage, you pay your contributions on a pretax basis. This means your contributions are deducted from your pay before federal, state and Social Security taxes are withheld. You never pay any taxes on these contributions.

For other benefits, you pay your contribution on an after-tax basis. This means your contributions are deducted from your pay after taxes are withheld.

| Benefits Coverage | Paying for Coverage |
|---|---|
| Medical, dental, vision, and AD&D coverage | Your contributions for these benefits use pre-tax dollars. |
| Health Savings Account (HSA) | If you enroll in the MyHealth HSA option, the company may make an annual contribution to your HSA based on compliance of wellness activities. You also can make employee pretax contributions to your HSA. |
| Employee Life option | Vistra Energy provides a life insurance benefit equal to one times your annual base pay. If you elect additional life insurance coverage, you pay the premium with after-tax dollars. |
| Spouse Life option and Child Life option | You pay for these benefits with after-tax dollars. |
| Flexible Spending Accounts (FSAs) options<br>• Health Care Spending Account option<br>• Dependent Care Spending Account option | You can contribute pretax dollars to one or both options. |
| Long-Term Disability (LTD) Benefit options | Vistra Energy provides LTD benefits on a pretax basis. |

| Benefits Coverage | Paying for Coverage |
| --- | --- |
| | Any LTD benefits you receive will be considered taxable income.<br><br>You can choose to pay for coverage with after-tax dollars. If you pay for coverage with after-tax dollars, any LTD benefits you receive will not be taxed. |

## Insured and Self-Insured Options

Medical benefits, prescription drug benefits, and dental benefits are self-insured. This means the benefits are paid by Vistra Energy rather than through an insurance contract. Although insurance companies (such as BlueCross and BlueShield of Texas, CVS Caremark, and MetLife) provide administrative services (such as claims administration, utilization review, case management, and similar support services), all benefits are paid from Vistra Energy's general assets.

Life insurance, AD&D insurance, long-term disability and vision benefits are provided through contracts with insurance companies. For insured benefits, Vistra Energy pays a premium to the insurance company, and the insurance company pays all benefits. (However, if you were disabled before May 1, 2001, your LTD benefits may be self-insured.)

## Premiums Paid in Error

It is your responsibility to disenroll dependents when they are no longer eligible. If you fail to do so and you continue to pay premiums in error, you may be reimbursed for no more than three months' premiums.

# Naming a Beneficiary

When you enroll on MyWorkday, you are required to name a beneficiary for your life insurance options.

## Your Life Insurance Beneficiary

When you enroll for the Employee Life and Employee AD&D options, you will be asked to name a beneficiary – someone who will receive benefits if you die. If you wish, you can name more than one beneficiary. If you name two or more beneficiaries, you should indicate the respective percentages of benefits each beneficiary will receive. Your beneficiary designation will apply to your Employee Life and Employee AD&D options and to your Survivor's Benefit (a non-ERISA-covered benefit, which normally equals one month's base pay). For the Spouse Life, Child Life, and Dependent AD&D options, you are the named beneficiary.

Your beneficiary designations take effect on the day you complete your Beneficiary Designation.

### Changing Your Life Insurance Beneficiary

You can change your beneficiary designation at any time by updating it in MyWorkday or by calling the Vistra Energy Benefits Service Center. Because family situations change, you may want to review your beneficiary designation from time to time.

# When Coverage Begins

Subject to your enrolling within your first 31 days of employment, your coverage starts on the day you start work – except for Support Personnel Group (SPG) employees, whose coverage starts on the first day of the month following thirty (30) days of employment and D2D, whose coverage begins after 90 days. If you are not Actively at Work on your first day of employment, your participation starts on the day you are Actively at Work.

## Delayed Life Insurance Coverage Date

If you are not Actively at Work on the date your Employer Paid Basic Employee Life coverage is due to start, coverage will not start until the day you are back Actively at Work. However, the Optional Contributory Life Insurance benefit will take effect on the eighth ($8^{th}$) calendar day following your return to Active Work, provided that you have been Actively at Work for at least 20 hours during the 7 calendar days preceding that date.

For the Spouse Life and Child Life options, your dependent must not be confined at home under a doctor's care, be receiving or applying to receive disability insurance from any source, or be hospitalized. In these situations, coverage will start when the dependent is no longer confined, hospitalized, or receiving or applying for disability insurance from any source.

## Limited LTD Coverage for Pre-existing Conditions

If you are disabled due to a pre-existing condition during the first 12 months you are covered under the LTD benefit option, LTD benefits are not paid for that pre-existing disability. A pre-existing condition is a disease or accidental injury for which, during the six-month period before you were eligible for coverage, you received medical treatment, consultation, care, services, or prescribed drugs or medicines.

## ID Cards

You receive identification cards after enrolling for coverage. Remember to carry your ID cards with you at all times. If a provider wants to verify your or your dependent's coverage, have the provider call the number listed on the ID card. This is not applicable to Dental, Vision, Life/AD&D or Disability coverages.

# Changing Your Coverage

## Changing Your Benefit Elections

Once you make your benefit elections during open enrollment, they are effective for the next calendar year. Because of tax advantages under the Plan, the IRS restricts the coverage changes you can make during the year. However, under certain circumstances, you can enroll for coverage or change your elections during the year. These circumstances include the following:

- You qualify for a special enrollment under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as described below
- You have a qualified status change that affects your, your spouse's, or your dependent's eligibility
- The Plan receives a court order, such as a Qualified Medical Child Support Order (QMCSO), obligating the Plan to cover one or more of your dependents
- You, your spouse, or your dependent enrolls in Medicare, Medicaid or CHIP

**Special Enrollment Rights**

If you decline enrollment in the Medical Plan option, Dental Plan options, Vision Plan option, or Health Care Spending Account options for yourself or your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if another employer stops contributing toward your or your dependents' other coverage).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment in this Plan within 31 days after your or your dependent's other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this Plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this Plan, you may request enrollment under this Plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

If you or your dependent currently has health plan coverage that is *not* COBRA continuation coverage and employer contributions toward that coverage or your dependent's coverage end, you may be able to enroll for coverage under this Plan.

If you or your dependent has COBRA continuation coverage and that coverage is exhausted, you may be able to enroll for coverage under this Plan. You have a special enrollment right at the end of your COBRA continuation coverage period if you have received continuation coverage for the maximum time period available to you.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependents. However, you must request enrollment within 31 days after the marriage and within 60 days after the birth, adoption, or placement for adoption.

To request special enrollment or to obtain more information, contact the Vistra Energy Benefits Service Center.

**Changes in Status**
You can change your elections during the year if you have an eligible qualified status change, as long as your change is consistent with the qualified status change. Changes can be made to your medical, dental, vision, and LTD coverage; to your Flexible Spending Accounts options (Health Care Spending Account option and Dependent Care Spending Account option); and to your life insurance and AD&D insurance coverage. Any change in life insurance benefits may require Evidence of Insurability.

Qualified status changes include the following:

- You marry, divorce, legally separate, or have your marriage annulled
- You have a baby, you adopt, you have a child placed with you for adoption, or your spouse or dependent dies
- You, your spouse, or your dependent starts or ends employment
- Your, your spouse's, or your dependent's work schedule changes (a switch from part-time to full-time employment and vice versa, a strike or lockout, or the start of or return from an unpaid leave of absence)
- Your dependent becomes eligible or ineligible for coverage (for example, he or she reaches the Plan's eligibility age limit)

You can change your coverage during the year due to a qualified status change *only if **both** the following apply*:

- The qualified status change causes you, your spouse, or your dependent to lose or gain eligibility for accident or health coverage under the Plan (or under a spouse's or dependent's accident or health plan)
- Your election change is consistent with the gain or loss of coverage

If you have an eligible qualified status change and need to change your coverage during the year, you must make the change within 31 days of the event that necessitates the change, or with respect to a change resulting from a birth, adoption, or placement for adoption, within 60 days. If you don't, you can't make a coverage change until the next open enrollment period, unless you once again meet one of the conditions for midyear election changes.

**Qualified Medical Child Support Order**

A Qualified Medical Child Support Order (QMCSO) or other domestic relations order could have an effect on your benefit coverage or elections. Please notify the Vistra Energy Benefits Service Center if you become aware of an order like this affecting you.

> **IMPORTANT NOTICE**
> Following a qualified status change, you must log on to the MyWorkday site or call the Vistra Energy Benefits Service Center within 31 days (or 60 days for a newborn) to make any changes in your benefit elections.

You or your beneficiary can write to the Vistra Energy Benefits Service Center to get a free copy of the Plan's procedures for determining whether a court order qualifies as a Qualified Medical Child Support Order. See the Glossary for an explanation of a Qualified Medical Child Support Order.

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# Medical Benefits

Most of us take reasonable precautions to guard our health and safety. Despite this, it is possible that each of us, at one time or another, may have an injury or illness that is serious enough to require hospitalization. That's when comprehensive medical coverage is most important. Protecting your finances against the high costs of a serious medical condition is the main purpose of our medical benefit option. In addition, the medical option covers treatment for minor illnesses and injuries, as well as many preventive care services that can help you stay healthy.

This section of the handbook describes how the medical option works.

## Medical Coverage Decisions

When you enroll for coverage each year, you choose a coverage category that best fits your situation. Beginning January 1, 2017, the MyHealth HSA option is the only medical option available to you.

### Your Coverage Category Choices

Each year during annual enrollment, you will be asked to make a decision about the coverage category you want. The coverage categories are:

- You only
- You and spouse
- You and child(ren)
- You and family (spouse and children)

If your spouse is eligible for medical coverage through his or her employer and you choose to cover your spouse using Vistra Energy benefits, you pay an additional surcharge per month in payroll deductions to cover your spouse.

However, the charge does not apply if your spouse:

- Is employed by Vistra Energy
- Is not employed
- Is employed, but not eligible for benefits with his or her employer

## Medical Plan Option

The Company offers a high deductible health plan option that includes prescription drug and mental health coverage.

| Medical Option: | Has these features: | And comes with these programs: | | |
|---|---|---|---|---|
| | | Prescription Drug | Mental Health | Health Reimbursement Account or Health Savings Account |
| MyHealth HSA Option | The MyHealth HSA Option provides basic, high-Deductible medical coverage with a Health Savings Account to help you pay for your share of medical expenses. This option also utilizes the BlueChoice PPO Plan network. | CVS Caremark Pharmacy Management | BCBSTX Mental Health/Chemical Dependency | Health Savings Account (HSA) administered by WageWorks |

## About the Network

The Plan's medical option utilizes the BCBSTX BlueChoice PPO Plan network. A network is a group of doctors, hospitals, and other facilities that contract with medical plan administrators (like BCBSTX) to offer specially negotiated rates to their participants.

Providers can leave or join a network at any time, so be sure there are several doctors and hospitals that you are comfortable using in the network you choose.

### Under the BCBSTX Option

You have more freedom to choose any provider for your medical care. When you choose in-network providers, the Plan usually pays a higher portion of costs, and you pay a smaller amount. When you choose providers outside the network, the Plan usually pays a lower portion of costs, and you pay a higher amount.

If care is not available from network providers as determined by the Claims Administrator, and the Claims Administrator approves your visit to an out-of-network provider **prior to the visit**, in-network benefits may be paid; otherwise, out-of-network benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

When traveling out of your local Plan service area, you can use the BCBS BlueCard PPO network. To find a nearby doctor or hospital when traveling, refer to the customer service number on your member ID card or call BlueCard Access at 800-810-BLUE (2583). You can also visit the BlueCard Doctor and Hospital Finder at www.bcbs.com. Your BCBS member ID card is recognized throughout the United States. You should not have to pay up front for medical services, except for the usual out-of-pocket expenses (non-covered services, Deductibles, Copayment or Coinsurance). Your local BCBS Plan will provide an Explanation of Benefits (EOB).

In addition to in-network providers, when you consult an out-of-network Provider, you should inquire if he or she participates in the Claims Administrator's ParPlan; a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the ParPlan, he or she agrees to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and

- Not bill you for services over the Allowable Amount determination

You will receive out-of-network benefits and be responsible for:

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

## About the Health Savings Account (HSA) and the Health Care Spending Account Option (an FSA)

In addition to the benefits you receive from your medical option, you may be eligible for reimbursement of expenses from:

- A Health Savings Account if you have available funds remaining in your account, and incur eligible expenses
- A Health Care Spending Account option (see below), if you enroll and make contributions to this account option, have available funds remaining in your account, and incur eligible expenses

**Health Care Flexible Spending Account Option (an FSA)**
You can use your Health Care Flexible Spending Account option to pay certain medical expenses that are not paid by:

- Your Medical Plan option
- Other health care coverage (for example, dental and vision coverage, or coverage you or your dependents might have through your spouse's employer)

This includes Deductibles, Copayments, expenses that exceed option limits, and expenses that are not covered by the option. For more information, see the "Flexible Spending Accounts" section.

***Note that if you enroll in the HSA option, your participation in the Health Care Flexible Spending Account (FSA) option is limited to reimbursement of eligible dental and vision expenses only unless and until you reach the applicable deductible under the HSA medical option.***

# MyHealth HSA Option

The MyHealth HSA option provides basic, high-Deductible medical coverage with a Health Savings Account (HSA) to help you pay for your share of medical expenses.

The HSA may be funded in part through direct contributions to your account from Vistra Energy. You can also make tax-free contributions through payroll deductions, or you can make after-tax contributions by writing a check to the account up to a specific maximum amount. You can invest and earn interest on your account, and you can take your HSA balance with you if you leave Vistra Energy. This option allows you to pay for health care expenses today and save for tomorrow.

## How the MyHealth HSA Option Works

1. The MyHealth HSA offers funding by Vistra Energy based on the wellness activities you (and your spouse, if applicable) complete.

2. An HSA is set up in your name to help you pay your health care expenses (for example, Deductibles, Coinsurance, and Copayments). Vistra Energy may make contributions to this account based on the wellness activities you (and your spouse, if applicable) complete, and you can make contributions too. (For contribution amounts, see the Fact Sheet.) From time to time, Vistra Energy may also make additional contributions as an incentive for you to try or use different benefit features. Note: HSA accounts require certain bank requirements be met in order to properly open and maintain your account. The Company cannot make contributions if this account fails to open or remain open.

3. Each year, you must meet a Deductible before the medical option starts to pay benefits. If you choose individual coverage, you must meet the individual Deductible. If you choose any other coverage level such as you + spouse, you + children, or you + family, you must meet the family Deductible. (For Deductible amounts, see the Fact Sheet.)

4. You can use your HSA to pay Deductible expenses and other health care expenses.

5. After you meet the Deductible, the option's Coinsurance is 80% for most in-network expenses and 60% for most out-of-network expenses. Your Coinsurance is the remaining 20% or 40% of charges. There are no medical Copayments under this option (only prescription Co-pays).

6. When you use in-network providers for eligible preventive care expenses, there is no Deductible, and the option pays 100%.

7. If you reach the out-of-pocket maximum during the year, the option pays 100% of most Eligible Charges for the rest of the year.

8. With this option, you receive prescription drug coverage through CVS Caremark. You receive mental health and chemical dependency coverage through BlueCross BlueShield of Texas Behavioral Health.

9. Since an HSA is a personal savings account, you need to designate a beneficiary with the custodian. Beneficiary forms are available on the accounts website through www.wageworks.com and should be sent directly to the custodian.

## About the Deductible

The Deductible is the amount of covered medical expenses you and your family pay each year before the option starts to pay medical, mental health, or prescription drug benefits.

If you have individual coverage (the "you only" coverage category), you must meet the individual Deductible each year before the option starts paying benefits. If you have family coverage (the "you and spouse," "you and child(ren)" or "you and family" coverage category), you must meet the family Deductible each year before the option starts paying benefits. The family Deductible is met when combined expenses from one or all covered family members reach the family Deductible amount.

All eligible medical, prescription drug, and mental health and chemical dependency expenses (including those that you pay through your HSA) count toward the annual medical Deductible. However, the following charges do *not* count toward the Deductible:

- Any charges that are not covered by the option or that exceed the Allowable Amount or other option limits

- The $250 penalty for failure to precertify an out-of-network Hospital, mental health, chemical dependency, or maternity admission

Please note that there are separate Deductibles for In-Network and Out-of-Network Services.

## About Coinsurance

You share in the cost of medical services through Coinsurance. There are no medical Copayments (only prescription Co-pays) under the MyHealth HSA option.

Coinsurance is the portion of charges that you and the option each pay for covered services. Your Coinsurance is the percentage of charges shown on the Fact Sheet– usually 20% for In-Network Services and 40% for Out-of-Network Services. The Plan's Coinsurance is the remaining portion of charges.

## Allowable Amount

Under the BCBSTX options, when you choose to receive services, supplies, or care from a provider that does not contract with BCBSTX (a non-contracting provider), you receive out-of-network benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount. The non-contracted provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies, and procedures limited

or not covered under the Plan and any applicable Deductibles, Coinsurance, and Copayment amounts.

**Benefits Based on Allowable Amounts**
Under the MyHealth HSA option, your Coinsurance (usually 20% when you receive services from in-network providers and 40% when you receive services from out-of-network providers) is based on the Allowable Amounts that have been negotiated with network providers, *whether or not you use network providers.* It works like this:

- When you receive care from in-network providers, the provider bills the option at the provider's regular rate. Then the option reduces the bill to the Allowable Amount. (The provider has agreed to accept the Allowable Amount as payment.) The option then pays 80% of the Allowable Amount, and you pay the other 20% of the Allowable Amount.

- When you receive care from out-of-network providers, the provider bills the option at the provider's regular rate. The option calculates what the Allowable Amount would be and pays 60% of that amount. Since the providers have not agreed to accept the Allowable Amount as payment, you are responsible for paying the entire remaining amount (which usually will be greater than 40% of the bill).

Here's an example: Say you have health care charges of $1,000. Under the network, the Allowable Amount is $700. Assuming you've met any Deductible requirements and the option pays 80% in-network and 60% out-of-network, payments would be:

| | **In-Network** | **Out-of-Network** |
|---|---|---|
| Full charge | $1,000 | $1,000 |
| Allowable Amount | $700 | $1,000 (no negotiated rate) |
| Option pays percentage of network Allowable Amount | 80% of $700 = $560 | 60% of $700 = $420 |
| You pay remainder | $700 − $560 = $140 | $1,000 − $420 = $580 |

In this example, you pay $140 if you receive services from in-network providers, or you pay $580 if you receive services from out-of-network providers. Please note that this is a very simple example to show how the concept works. The actual negotiated network Allowable Amounts may vary depending on the physician's billing practices and the geographic area. The percentage the option pays also may vary depending on the type of expense.

## About the HSA Annual Out-of-Pocket Maximums

The MyHealth HSA option places a maximum on the amount of money you have to pay out-of-pocket each year for your share of covered medical expenses (that is, your Coinsurance). This is called the out-of-pocket maximum. The out-of-pocket maximum provides protection against high Coinsurance expenses during a calendar year.

If you have individual coverage (the "you only" coverage category), the MyHealth HSA option pays 100% of most covered charges after you meet the individual out-of-pocket maximum each year. If you have family coverage (the "you and spouse," "you and child(ren)" or "you and family" coverage

category), the option pays 100% of most covered charges after combined expenses from all covered family members reach the family out-of-pocket maximum. In the MyHealth HSA option, your deductible will count toward your out-of-pocket maximum. If you sign up for family coverage, each individual will be responsible for the individual out-of-pocket maximum, until the family reaches the out-of-pocket maximum.

The following charges do not count toward the annual out-of-pocket maximum:

- Any charges that are not covered by the option or that exceed the Allowable Amount or other option limits

- The $250 penalty for failure to precertify an out-of-network Hospital, mental health, chemical dependency, or maternity admission under the MyHealth HSA option

## About Covered Charges

The MyHealth HSA option pays benefits for services and supplies that are specifically covered by the option. Covered charges are shown on the Fact Sheet. To be covered, a medical service must be Medically Necessary.

## About the Health Savings Account (HSA)

Vistra Energy may partially fund the HSA to help offset your out-of-pocket expenses.

When you choose this option, a Health Savings Account is set up in your name. The HSA is your personal savings account. It is not part of the Medical Plan option and it is not sponsored by Vistra Energy. However, Vistra Energy helps you pay expenses by crediting your HSA. If you don’t use the balance in your HSA, it will roll over to the next year. Dollars in your HSA are yours to keep, even if you leave Vistra Energy. The annual Vistra Energy credit to your HSA depends on your coverage category and completion of wellness activity requirements, as shown on the Fact Sheet.

You can also contribute tax-free dollars to your HSA through payroll deductions, or you can contribute after-tax dollars by writing a check to your account. The maximum amount you can contribute is set by the IRS and is based on the coverage category you choose. Once you enroll in Medicare, you are no longer eligible to make or receive HSA contributions.

When you enroll, you’ll be asked to designate your annual contribution amount. The IRS limits the amount you and Vistra Energy can contribute to your HSA during the year, and there may be penalties if you exceed these limits. You can still write a check to your account, even if you do not designate your annual contribution during annual enrollment. If you are between ages 55 and 65, you can also contribute additional “catch-up” contributions.

**Vistra Energy contributions to the MyHealth HSA**

Vistra Energy won’t make any automatic funding contributions to your MyHealth HSA. The amount Vistra Energy contributes to your MyHealth HSA depends on the coverage level you choose and the program activities you complete:

| MyHealth Activities … | | Employee Only | Employee + Children | Employee + Spouse | Employee + Family |
|---|---|---|---|---|---|
| **Annual Physical** | Employee | $900 | $1,800 | $900 | $900 |
| | Spouse | N/A | N/A | $900 | $900 |
| **Age and Gender Screenings** | Employee | $500 | $500 | $500 | $500 |
| | Spouse | N/A | N/A | $500 | $500 |
| ***GetConnected!* Registration *1 time only** | Employee | $125 | $125 | $125 | $125 |
| | Spouse | N/A | N/A | $125 | $125 |
| **Potential Funding Total (2017)** | | $1,525 | $2,425 | $3,050 | $3,050 |

Vistra Energy will make contributions to your MyHealth HSA as you complete the MyHealth wellness activities listed above. You must complete and have received funding for your wellness activities prior to termination. No funding will be made after termination. If you rehire in the same year, you are not eligible for additional contributions for activities previously completed and paid. See the annual Guide to Benefits for more information about the timing of Vistra Energy contributions.

**Covered Expenses**
You can use your HSA to pay for eligible health care expenses, including medical, prescription drug, dental, and vision Deductibles and Coinsurance, as well as other health care expenses not covered by our programs.

In general, you can use the HSA to pay the same health care expenses that would be payable through the Health Care Spending Account option (see "Eligible Health Care Expenses" in the "Flexible Spending Accounts" section) if you have met your Deductible. As long as an expense qualifies as an itemized medical deduction on your federal income tax return, it is eligible for reimbursement through the HSA.

The money that goes in and out of your HSA is *not* considered taxable income to you. However, when you pay expenses through your HSA, you give up the right to deduct those same expenses on your tax return. For more information, see the "Flexible Spending Accounts" section.

**How to Pay Expenses Through Your HSA**
When you enroll in the MyHealthHSA Medical Plan option, you will receive information about how to open the required HSA custodial account in order to manage your HSA dollars. Remember that even though the health coverage is part of your Vistra Energy benefit program, the HSA custodial account is not a benefit sponsored by Vistra Energy, but is a personal savings account maintained by the custodian. You'll need to abide by all laws and regulations regarding the HSA.

Once your account is established, a Visa account will be set up in your name, and you'll receive a WageWorks card that you can use to pay for your expenses from the HSA. If you don't use all of the money in your HSA, it will roll over to the next year.

When you visit an in-network provider, you typically do not pay at the time of service. However, some providers may require payment at the time of service. The claim is sent to the BCBSTX administrator to make sure you are charged the negotiated rate. You then receive an Explanation of Benefits (EOB) statement outlining your final cost. Your provider receives the same statement and bills you for the final amount.

You may be able to then pay with a convenient HSA card issued by WageWorks, assuming your provider accepts Visa. Typically, your provider's bill will list the accepted forms of payment.

**If you have the Health Care Flexible Spending Account option (an FSA), your FSA will be a limited-use FSA. You can use your FSA only for dental and vision expenses. You cannot use it for medical expenses (unless you have already met the full Deductible, at which time the FSA is no longer "limited use"). When you meet your deductible, you must contact WageWorks to request for your FSA to no longer be marked as limited-use.**

With WageWorks, there are no fees for additional or replacement HSA cards. Also note that since there will be no PIN associated with your HSA card, you will not be able to check your balance at an ATM.

When you order prescription drugs, you can pay with the WageWorks HSA card when you pick up your prescription (as long as your pharmacist accepts Visa). You can also use your HSA card for the mail-order service.

**Tips on Using Your HSA Card**
Here are some tips for making the best use of your WageWorks HSA card:

- **Press the Credit button when you swipe your card (even though it isn't a credit card)**
- **Use your card only for eligible health care expenses.** Separate health care items from any other items that you're purchasing (such as food, cosmetics, and magazines). Pay the health care expenses with your HSA card and pay the charge for other items separately.
- **Save your itemized receipts.** Receipts must show the date, the name of the item purchased, and the cost. An Explanation of Benefits (EOB) statement is also valid documentation. As required by the IRS, this documentation substantiates your purchase – meaning it shows that your purchase is eligible to be paid from your HSA.

### Medical Care Away From Home

If you or a dependent needs medical care while away from home, you can use the BCBS BlueCard PPO/EPO network. To find a nearby doctor or hospital when away from your local BCBS plan, refer to the customer service number on your member ID card or call BlueCard Access at 800-810-BLUE (2583). You can also visit the BlueCard Doctor and Hospital Finder at www.bcbs.com. Your BCBS member ID card is recognized throughout the United States. You should not have to pay up front for medical services, except for the usual out-of-pocket expenses (non-covered services, Deductibles, Copayment or Coinsurance). Your local BCBS Plan will provide an Explanation of Benefits (EOB).

If you need Emergency care while away from home, you do not need to contact BCBSTX before getting the treatment you need. But you should call BCBSTX as soon as possible after you receive Emergency treatment. If the Plan determines that the care was an Emergency, benefits are paid at the in-network rates; otherwise, they are paid at out-of-network rates (if applicable).

| Fact Sheet – MyHealth Savings Account (HSA) Plans | | |
|---|---|---|
| | **In-Network you pay:** | **Out-of-Network you pay:** |
| **BlueChoice Provider Network** | You can go to any doctor you choose, but your benefits will be higher when you use in-network providers. Utilizes the BlueChoice PPO Plan Network. | |
| **Deductible (Family Deductible must be met before option begins paying benefits.)** | $1,800 individual/ $3,600 family | $3,600 individual/ $7,200 family |
| **Out-of-Pocket Maximum** (including Deductible) | $4,800 individual/ $9,600 family | $9,600 individual/ $19,200 family |
| **Physician's Services** | | |
| Doctor's office visits for illness or injury | 20% after Deductible | 40% after Deductible |
| Specialist's office visits for illness or injury | 20% after Deductible | 40% after Deductible |
| Consultation services of a physician or other professional provider | 20% after Deductible | 40% after Deductible |
| **Adult Preventive Care** | | |
| Annual physical exam | 0% (no Deductible) | 0% (no Deductible) |
| Cardiovascular screening | 0% (no Deductible) | 0% (no Deductible) |
| Colorectal cancer screening after age 50, including annual fecal occult blood testing, 5-year sigmoidoscopy, and 5-year colonoscopy. 1 colonoscopy or sigmoidoscopy is covered every 5 years when billed as routine/preventive. Sigmoidoscopy and colonoscopy services billed as diagnostic will be subject to Deductible and Coinsurance. | 0% (no Deductible) | 0% (no Deductible) |
| Prostate cancer screening after age 40, including digital rectal exam and PSA – one per year | 0% (no Deductible) | 0% (no Deductible) |
| Well-woman exam – one exam per year (includes one Pap test each year) | 0% (no Deductible) | 0% (no Deductible) |
| Mammogram – one per year | 0% (no Deductible) | 0% (no Deductible) |
| Immunizations (includes immunizations for travel) | 0% (no Deductible) | 0% (no Deductible) |
| **Well-Baby/Well-Child Preventive Care** | | |
| Pediatric exams | 0% (no Deductible) | 0% (no Deductible) |
| Immunizations, including:<br>• Immunizations for travel<br>• Routine immunizations: diphtheria, Hemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization that is legally required for the child | 0% (no Deductible) | 0% (no Deductible) |
| Screening test for hearing during the first 31 days following birth, and necessary diagnostic follow-up care related to the screening test until the child reaches age 2 | 0% (no Deductible) | 0% (no Deductible) |

| Fact Sheet – MyHealth Savings Account (HSA) Plans | | |
|---|---|---|
| | **In-Network you pay:** | **Out-of-Network you pay:** |
| **Inpatient Hospital Care** | | |
| Hospital room and board up to the semiprivate room rate (preauthorization required) | 20% after Deductible | 40% after Deductible, $250 penalty for no preauthorization |
| Intensive care unit | 20% after Deductible | 40% after Deductible |
| Services and supplies provided by the hospital during confinement, such as medicines, lab tests, use of operating rooms and special equipment, and anesthetics and their administration | 20% after Deductible | 40% after Deductible |
| Inpatient physician's and surgeon's services | 20% after Deductible | 40% after Deductible |
| Consultations | 20% after Deductible | 40% after Deductible |
| Physical therapy, anesthesia, blood transfusions (if not replaced), and treatment of pulmonary tuberculosis | 20% after Deductible | 40% after Deductible |
| Renal dialysis | 20% after Deductible | Not covered |
| Private duty nursing (up to 70 8-hour shifts per calendar year) | 20% after Deductible | 20% after Deductible |
| Organ transplants | 20% after Deductible | 40% after Deductible |
| Cosmetic, reconstructive, or plastic surgery:<br>• To correct an injury that occurs while the patient is enrolled in the option<br>• Following cancer surgery<br>• To treat or correct a congenital defect for a newborn child<br>• To treat or correct a congenital defect (other than conditions of the breast) for a dependent child<br>• To correct craniofacial abnormalities, improve functioning, or create a normal appearance from a congenital defect, trauma, tumor, infection, or disease for a dependent child under age 19<br>• Following mastectomy<br>• Morbid obesity surgery | 20% after Deductible | 40% after Deductible |
| Reduction Mammoplasty | 20% after Deductible | 40% after Deductible |
| **Outpatient Care** | | |
| Outpatient surgery | 20% after Deductible | 40% after Deductible |
| Services and supplies provided for outpatient treatment at a hospital, ambulatory surgical facility, or radiation therapy center | 20% after Deductible | 40% after Deductible |
| Second surgical opinions when you want to confirm the need for surgery | 20% after Deductible | 40% after Deductible |
| Laboratory, x-ray, and other diagnostic procedures | 20% after Deductible | 40% after Deductible |
| Anesthetics and their administration, when administered by someone other than the operating physician | 20% after Deductible | 40% after Deductible |
| Services of a certified registered nurse-anesthetist (CRNA) | 20% after Deductible | 40% after Deductible |
| Radiation therapy (Radiation/Dialysis/Chemotherapy) | 20% after Deductible | 40% after Deductible |

| Fact Sheet – MyHealth Savings Account (HSA) Plans | | |
|---|---|---|
| | **In-Network you pay:** | **Out-of-Network you pay:** |
| Oxygen and its administration, provided the oxygen actually is used | 20% after Deductible | 40% after Deductible |
| Blood, blood plasma, and blood plasma expanders, when not replaced by or for the patient | 20% after Deductible | 40% after Deductible |
| Injectable drugs administered by or under the direction of a physician or other professional provider | 20% after Deductible | 40% after Deductible |
| Emergency room. If possible, to determine if emergency care is needed, contact your in-network physician before going to the ER. | 20% after Deductible | 40% after Deductible |
| Professional local ground or air ambulance service to the nearest hospital appropriately equipped for treatment of the patient's condition | 20% after Deductible | 20% after Deductible |
| Urgent care clinic visit | 20% after Deductible | 40% after Deductible |
| Physical therapy, speech and hearing therapy, occupational therapy, respiratory and other physical medicine services such as hot and cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training | 20% after Deductible for up to 60 visits per calendar year (60 visits each for physical, speech, and occupational therapy, 60 visit limitation combined for in- and out-of-network and only applies to outpatient) | 40% after Deductible for up to 60 visits per calendar year (60 visits each for physical, speech, and occupational therapy, 60 visit limitation combined for in- and out-of-network and only applies to outpatient) |
| **Care in Other Settings** | | |
| Home health care for chronically ill or disabled patients. Services must be provided by a qualified nurse or fully licensed therapist. Services provided by relatives or persons living with you are not covered. You must preauthorize home health care before services begin. Custodial care is not covered. 120 visit maximum per calendar year. | 20% after Deductible | 40% after Deductible |
| Skilled nursing facility expenses, including:<br>• Room and board, equipment, routine services and supplies, and usual nursing services (nursing services must be provided by RNs, LPNs, or APNs)<br>• Physical, occupational, speech, and respiratory therapy by licensed therapists<br>Admission requires preauthorization. Custodial care is not covered. 120 day maximum per calendar year. | 20% after Deductible | 40% after Deductible |
| Hospice care (preauthorization required) unlimited | 0% after Deductible | 40% after Deductible |
| Home infusion therapy (preauthorization required) | 20% after Deductible | 40% after Deductible |
| Private duty nursing (up to 70 8-hour shifts per calendar year in home setting) | 20% after Deductible | 20% after Deductible |
| **Family Planning/Maternity Care** | | |
| Office visits (prenatal and postnatal) | 20% after Deductible | 40% after Deductible |
| In-hospital delivery services (preauthorization required)<br>**Note:** The option does not limit childbirth-related hospital stays to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section. In addition, the option does not require a provider | 20% after Deductible | 40% after Deductible, $250 penalty for no preauthorization |

| Fact Sheet – MyHealth Savings Account (HSA) Plans | | |
|---|---|---|
| | **In-Network you pay:** | **Out-of-Network you pay:** |
| to receive authorization for any length of stay that is less than the above period. | | |
| Newborn nursery services, including initial exam | 20% after Deductible | 40% after Deductible |
| Services and supplies provided by a birthing center when low-risk pregnancy | 20% after Deductible | 40% after Deductible |
| Midwife services (must be licensed and certified) | 20% after Deductible | 40% after Deductible |
| Infertility services (diagnosis and testing only) | 20% after Deductible | 40% after Deductible |
| Outpatient contraceptive services and devices | 20% after Deductible | 40% after Deductible |
| Sterilization services (tubal ligation and vasectomy) | 20% after Deductible | 40% after Deductible |
| Maternity coverage for dependent children | | |
| • Normal pregnancy | No coverage except for complications of pregnancy | No coverage except for complications of pregnancy |
| • Complications of pregnancy | 20% after Deductible | 40% after Deductible |
| **Other Services and Supplies** | | |
| Electrical and hospital grade breast pumps (covered preventive services) | 0%, no deductible | |
| Chiropractic services. Note that lab and x-ray charges related to chiropractic treatment are covered under "Outpatient Care." | 20% after Deductible, for up to 25 visits per year (combined in-network and out-of-network) | 40% after Deductible, for up to 25 visits per year (combined in-network and out-of-network) |
| Airrosti office visit | $25 copay after Deductible is met, combined with Chiropractic 25 visits per year | |
| Surgical treatment of temporomandibular joint (TMJ) disorder (nonsurgical treatments are not covered) | 20% after Deductible | 40% after Deductible |
| Foot care and orthotics | 20% after Deductible | |
| Allergy tests and treatments | 20% after Deductible | 40% after Deductible |
| Treatment of acquired brain injury, including neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing, treatment, and remediation | 20% after Deductible | 40% after Deductible |
| Bariatric Surgery | 20% after Deductible | Not covered |
| Treatment of diabetes, including:<br>• Equipment (blood glucose monitors; external and implantable insulin pumps; associated accessories such as batteries, skin preparation items, insulin cartridges, infusion sets, infusion devices, and disposable devices and supplies) and equipment repairs<br>• Podiatric appliances to prevent complications of diabetes<br>• Supplies, including test strips for blood glucose monitors; needles and syringes; visual reading and urine test strips and tablets for glucose, ketones, and protein; injection aids; biohazard disposable containers; oral agents for controlling blood sugar levels; and | 20% after Deductible | 40% after Deductible |

| Fact Sheet – MyHealth Savings Account (HSA) Plans | | |
|---|---|---|
| | **In-Network you pay:** | **Out-of-Network you pay:** |
| glucagon emergency kits<br>• Diabetic management services and diabetes self-management training when ordered by your physician<br>**Note:** insulin is covered under the prescription drug program | | |
| Rental of durable medical equipment (such as wheelchairs and hospital beds). In some cases, the option may require the purchase of equipment. The option does not cover equipment primarily designed to alleviate pain or relieve discomfort; home air fluidized bed therapy; or such things as air conditioners, air purifiers, humidifiers, physical fitness equipment, or whirlpool bath equipment | 20% after Deductible | 40% after Deductible |
| Orthopedic braces and crutches, casts, and special surgical and back corsets | 20% after Deductible | 40% after Deductible |
| Wigs, when needed for baldness resulting from chemotherapy, alopecia, radiation therapy, or surgery | 20% after Deductible, up to $500 per calendar year, combined in- and out-of-network costs) | 40% after Deductible, up to $500 per calendar year, combined in- and out-of-network costs) |
| Dressings, bandages, trusses, and splints that are custom designed to assist joint function (when prescribed, directed, or applied by a physician) | 20% after Deductible | 40% after Deductible |
| Prosthetic appliances, including replacements needed because of a patient's growth to maturity | 20% after Deductible | 40% after Deductible |
| Dietary formulas for treatment of phenylketonuria (PKU) or other heritable diseases | 20% after Deductible | 40% after Deductible |
| **Hearing Care** | | |
| Routine hearing exam – 1 covered per calendar year | 0% (no Deductible) | 0% (no Deductible) |
| Hearing therapy | 20% after Deductible | 40% after Deductible |
| Hearing aids | 20% after Deductible: 1 pair every 36 months | 40% after Deductible: 1 pair every 36 months |
| **Dental Care** | | |
| Treatment of accidental injury to healthy, unrestored natural teeth and supporting tissues. Treatment must be completed within 24 months following the initial treatment. Injuries due to biting or chewing are not covered. | 20% after Deductible | 40% after Deductible |
| Surgical removal of tumors, cysts, and fully bony impacted teeth when Medically Necessary | 20% after Deductible | 40% after Deductible |
| Services to treat or correct a congenital defect for a newborn child | 20% after Deductible | 40% after Deductible |
| **Routine Vision Care** | | |
| Routine vision exam – 1 covered per calendar year | 0% (no Deductible) | 0% (no Deductible) |
| Vision hardware, eyeglass lenses and frames, and contact lenses | Not covered | Not covered |
| **Mental Health and Chemical Dependency** | | |

| Fact Sheet – MyHealth Savings Account (HSA) Plans | | |
|---|---|---|
| | **In-Network you pay:** | **Out-of-Network you pay:** |
| **(BCBSTX Behavioral Health)** | | |
| Mental Health | | |
| • Outpatient (preauthorization required for certain outpatient treatments) | 20% after Deductible | 40% after Deductible |
| • Inpatient (preauthorization required) | 20% after Deductible | 40% after Deductible, $250 penalty if no preauthorization |
| Chemical Dependency | | |
| • Outpatient (preauthorization required for certain outpatient treatments) | 20% after Deductible | 40% after Deductible |
| • Inpatient (preauthorization required) | 20% after Deductible | 40% after Deductible, $250 penalty if no preauthorization |
| **Prescription Drugs (CVS Caremark)** | **Medical Deductible Applies** | **Medical Deductible Applies** |
| Retail (up to 30-day supply) | | |
| • Value (preventive) generic | $0 if on preventive drug list, otherwise $5 Co-pay (no Deductible) | Not covered |
| • Generic | 20% after Deductible | Not covered |
| • Preferred brand (if a generic is available, you pay the generic Co-pay, plus the difference between the price of the generic and brand-name drugs)<br>Note: Iron and Fluoride Rx's, you incur the brand Co-pay plus the cost difference | 20% after Deductible | Not covered |
| • Non-preferred brand (if a generic is available, you pay the generic Co-pay, plus the difference between the price of the generic and brand-name drugs)<br>Note: Iron and Fluoride Rx's, you incur the brand Co-pay plus the cost difference | 20% after Deductible | Not covered |
| Mail order (up to 90-day supply) | | |
| • Value (preventive) generic | $0 if on preventive drug list, otherwise $10 Co-pay (no Deductible) | Not covered |
| • Generic | 20% after Deductible | Not covered |
| • Preferred brand (if a generic is available, you pay the generic Co-pay, plus the difference between the price of the generic and brand-name drugs)<br>Note: Iron and Fluoride Rx's, you incur the brand Co-pay plus the cost difference | 20% after Deductible | Not covered |
| • Non-preferred brand (if a generic is available, you pay the generic Co-pay, plus the difference between the price of the generic and brand-name drugs)<br>Note: Iron and Fluoride Rx's, you incur the brand Co-pay plus the cost difference | 20% after Deductible | Not covered |

## Charges That Are Not Covered Under MyHealth HSA Option

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

- Acupuncture, acupressure and acupuncture therapy
- Allergy and specific non-standard allergy services and supplies including but not limited to skin titration, cytotoxicity testing treatment of non-specific candida sensitivity, and urine autoinjections
- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this booklet
- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain prescription drugs or supplies
- Any services or supplies not specifically defined as eligible expenses in this Plan
- Artificial organs including any device intended to perform the function of a body organ
- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to the provision of blood, other than blood derived clotting factors
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the option
- Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license
- Cosmetic services and plastic surgery, including treatment, surgery, service or supplies to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons
- Costs for services resulting from the covered person's commission of or attempt to commit a felony
- Counseling services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counseling
- Court-ordered services, including those required as a condition of parole or release
- Custodial care
- Dental services, including any treatment, services or supplies related to the care, filling, removal or replacement of teeth and treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth (unless services or treatment is medical in nature)
- Disposable outpatient supplies or devices including sheaths, bags, elastic garments, support hose, bandages, bedpans, blood or urine testing supplies (except Glucometers), and other

home test kits (except diabetic supplies); splints, neck braces, compresses, and other devices not intended for reuse by another patient

- Drugs, medications, supplies and, services covered under the CVS Caremark Pharmacy Plan are not covered under the medical plan

- Educational services and supplies related to training or retraining services or testing, including evaluation or treatment of learning disabilities and other developmental, learning, and communication disorders, behavioral disorders, training or cognitive rehabilitation

- Elective abortions

- Examinations and treatments required to obtain employment, required by any law of a government, required for securing insurance or school admissions, required for professional or other licenses, required to travel, or required to attend a school, camp or sporting event or participate in a sport or other recreational activity

- Experimental or investigational drugs, devices, treatments or procedures

- Facility charges for care, services or supplies provided in rest homes, assisted-living facilities or similar institutions, health resorts, spas, sanitariums, or infirmaries at schools, colleges or camps

- Food items such as infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition

- Growth aids including any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones

- Hearing services or supplies that do not meet professionally accepted standards, hearing exams given during a stay in a hospital or other facility, or any tests, appliances, and devices for the improvement of hearing, including hearing amplifiers

- Home, workplace or any other environment or vehicle alterations including bathroom equipment, exercise equipment, air purifiers, air conditioners, water purifiers, waterbeds, pools, whirlpool pumps, sauna baths, equipment or supplies to aid sleeping, transportation devices, including stair-climbing wheelchairs or personal transporters or any vehicle or other transportation device

- Home birth services and supplies relating to childbirth occurring in the home or in a place not licensed to perform deliveries

- Home uterine activity monitoring

- Infertility services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception

- In-vitro fertilization is not covered

- Medicare or payment for that portion of the charge for which Medicare or another party is the primary payer

- Miscellaneous charges, such as charges to be in a physician's practice or to have preferred access to physician services, charges for canceled or missed appointments, or charges the recipient has no legal obligation to pay

- Non-Medically Necessary services, including but not limited to those treatments, services, prescription drugs, and supplies that are not Medically Necessary, as determined by BCBSTX, CVS Caremark or other applicable vendor for the diagnosis and treatment of illness, injury, restoration of physiological functions or covered preventive services (even if prescribed, recommended or approved by your physician)

- Nursing or home health aide services provided outside the home (such as in conjunction with school, vacation, work or recreational activities)

- Over-the-counter contraceptive supplies, including but not limited to condoms, contraceptive foams, jellies, and ointments

- Personal comfort and convenience items and services, including telephones, televisions, barber or beauty services, housekeeping, cooking, cleaning, shopping, or security or other home services

- Private duty nursing during your stay in a hospital and outpatient private duty nursing services except as specifically described elsewhere in this booklet

- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member

- Services of a resident physician or intern rendered in that capacity

- Services provided where there is no evidence of pathology, dysfunction or disease except as specifically provided in connection with covered routine care and cancer screenings

- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage under the option, unless coverage is continued under COBRA

- Services and supplies provided in connection with treatment or care that is not covered under the option

- Services, devices, and supplies to enhance strength, physical condition, endurance or physical performance

- Sexual dysfunction or sexual enhancement treatments, drugs, services or supplies, including surgery, drugs, implants or preparations to correct or enhance erectile function, enhance

sensitivity, or alter the shape or appearance of a sex organ; sex therapy, sex counseling, marriage counseling or other counseling or advisory services

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate)

- Transportation costs for routine transportation to receive outpatient or inpatient services

- Unauthorized services, including any service obtained by or on behalf of a covered person without precertification by BCBSTX when required. This exclusion does not apply in a medical emergency or in an urgent care situation.

- Vision-related services and supplies are not covered under the Medical Plan options

- Weight loss treatments, drugs, or supplies intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity (except bariatric surgery when Medically Necessary)

- Work-related illness or injuries related to employment or self-employment, including any injuries that arise out of any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law.

# Prescription Drug Coverage

When you enroll in the Medical Plan option, you also receive prescription drug coverage, as follows:

| Medical Plan Option | Prescription Drug Coverage |
|---|---|
| MyHealth HSA Option | CVS Caremark |

## CVS Caremark Pharmacy Benefits

The prescription drug program covers charges for outpatient prescription drugs for the treatment of an illness or injury, subject to certain limitations and exclusions. Prescriptions must be written by a prescriber licensed to prescribe federal legend prescription drugs.

Your prescription drug benefit coverage is based on CVS Caremark's Preferred Drug List. The Preferred Drug List includes both brand-name prescription drugs and generic prescription drugs. Your out-of-pocket expenses may be higher if your physician prescribes a covered prescription drug not appearing on the preferred drug guide. Generic prescription drugs may be substituted by your pharmacist for brand-name prescription drugs. You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available.

Coverage of prescription drugs may, in CVS Caremark's sole discretion, be subject to requirements or limitations. Prescription drugs covered by this program are subject to drug utilization review by CVS Caremark and/or your provider and/or your network pharmacy.

Generally, the program covers prescription drugs and medicine that require a prescription and can be obtained only through a licensed pharmacy. The program does not cover medical supplies or most over-the-counter medications, such as aspirin, cough syrup, or cold remedies, even if your doctor prescribes them.

The prescription drug program has contracted with network providers to fill Vistra Energy employees' prescriptions at lower rates. To receive the highest benefits, it's important that you use in-network providers. The only exception is if you or your covered dependent needs an emergency prescription and a participating pharmacy is not available.

Drugs and medicines that you receive during a hospital admission are covered under your Medical Plan option instead of the prescription drug program.

If you have a job-related medical condition, your prescriptions should be considered for coverage under workers' compensation instead of the prescription drug program.

## Retail Pharmacy Benefits

Prescriptions are typically limited to a maximum 30-day supply when filled at a network retail pharmacy. You have a choice of getting long-term maintenance medications either through CVS Caremark mail services pharmacy or directly from any CVS/Pharmacy retail store. Reference the Maintenance Choice details for more information.

To see a list of CVS Caremark's network pharmacies:

- Go to www.caremark.com or call CVS Caremark Customer Care at 1-877-775-5642.

To purchase a short-term prescription at a network retail pharmacy:

- Present your CVS Caremark ID card when you pick up your prescription.
- Pay any Deductibles, Copayments or Coinsurance requiredwhether you purchase a value (preventive) generic, preferred brand, or non-preferred brand drug. You can use your WageWorks HSA card or your personal checks to pay for your prescriptions, or pay from your pocket if you want to save your HSA dollars.

**Tips on Using Your HSA Card**

Here are some tips for making the best use of your WageWorks HSA card:

- **Press the Credit button when you swipe your card (even though it isn't a credit card).**
- **Use your card only for eligible health care expenses.** Separate health care items from any other items that you're purchasing (such as food, cosmetics, and magazines). Pay the health care expenses with your HSA card and pay the charge for other items separately.
- **Save your itemized receipts.** Receipts must show the date, the name of the item purchased, and the cost. An Explanation of Benefits (EOB) statement is also valid documentation. As required by the IRS, this documentation substantiates your purchase – meaning it shows that your purchase is eligible to be paid from your HSA.
- **Alternatively, you can pay for the item out-**of-pocket and use Pay Me Back to submit your claim and prescription to WageWorks for reimbursement. Pay Me Back claims can be submitted online, or with your smartphone or mobile device.

## Mail-Order Pharmacy Benefits

Each prescription is limited to a maximum 90-day supply when filled at a network mail-order pharmacy. You can use the mail-order service if you take long-term maintenance medication for ongoing conditions like diabetes or high blood pressure. When your doctor prescribes a new long-term medicine for you, have two prescriptions written: one for a 30-day supply that you can have filled right away at a retail pharmacy, and one for up to a 90-day supply (plus up to three refills, when needed) to send with your mail service order form. You may also have your doctor call CVS Health toll-free at 1-800-378-5697.

- Complete the mail-order form.
- Include a check or your debit or credit card information for your payment (the amount you pay is based on whether you purchase a generic, preferred brand, or non-preferred brand drug). For more information, see the Fact Sheet for your Medical Plan option.

- Mail your completed order form (along with your prescription and payment). Use the special mail-order envelope contained in your prescription drug package. The address also is listed on the order form. You may also download a mail order form from www.caremark.com.

- Your prescription will be mailed to your home. (It usually takes about 7 to 10 days to receive your prescription.)

## Maintenance Choice

The Maintenance Choice program gives you and your family the option of getting long-term maintenance medications either through CVS Caremark Mail Service Pharmacy or directly from any CVS/pharmacy retail store. Either way, your copay will be the same.

## About Generic, Preferred Brand, and Non-Preferred Brand Drugs

Your prescription drug coverage includes special coverage for generic drugs and drugs listed on the formulary for both the retail and mail-order programs.

- A generic drug is a chemical copy of a brand-name prescription drug. It must contain the same active ingredients and be equivalent in strength and dosage to its brand-name counterpart. It is subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength, and purity as its brand-name counterpart. Generally, generic drugs cost 30% to 60% less than their brand-name counterparts because manufacturers of generic drugs don't have to pay for research and development or marketing and advertising.

- A formulary is a list of frequently prescribed preferred brand medications for which the program has negotiated preferred pricing. As a result, prescriptions for preferred brand medications are more cost-effective for you and the program. Physicians and pharmacists develop and evaluate the formulary list.

If your doctor wants your prescription to be filled only with a brand-name drug, he or she must indicate that by writing "Dispense as Written" (DAW) on the prescription slip. If your doctor has not written DAW on the prescription slip, but you choose the brand-name drug when a generic is available, you will pay the cost difference between the generic and brand, plus any applicable Deductible, Copayment or Coinsurance amount. The amount you must pay is limited by a maximum Copayment.

## Generic Step Therapy

If you have an ongoing health condition such as arthritis or high blood pressure, the generic step therapy program requires you to try a generic alternative medication that is safe and equally effective before a brand name medication is paid through your prescription insurance benefits. Be sure to advise your doctor that our plan uses step therapy.

## Free Value Preventive Drugs

If you have a condition that requires preventive generics like certain statins or maintenance prescriptions, and they are listed on the preventive drug list, then you will not pay any deductible, copayment or coinsurance.

## Accessing Network Pharmacies

You can select a network pharmacy from the CVS Caremark Network Pharmacy Directory or by logging on to CVS Caremark's Web site at www.caremark.com. If you cannot locate a network pharmacy in your area, you should call CVS Caremark Customer Care at 1-877-775-5642.

To be eligible for network benefits, you must present your CVS Caremark ID card to the network pharmacy every time you get a prescription filled. The network pharmacy will calculate your claim online. You will pay any Deductible, Copayment or Coinsurance directly to the network pharmacy.

CVS Caremark will pay the network pharmacy the plan payment percentage for a covered expense, less any cost sharing required by you. You do not have to complete or submit claim forms. The network pharmacy will take care of claim submission.

## Covered Charges – Prescription Drug Program

The prescription drug program covers the following drugs and medications that are Medically Necessary and prescribed by a physician. For information about how the program pays prescription drug benefits, see the Fact Sheet for your Medical Plan option.

- Legend drugs, with the exception of those that are specifically excluded from coverage
- Insulin
- Tretinoin, all dosage forms (e.g., Retin-A) for individuals through age 35
- Compounded medication of which at least one ingredient is a legend drug
- Any other drug that, under state law, may be dispensed only with a written prescription from a physician or other lawful prescriber
- Legend oral contraceptives

Please note that you or your doctor may need to call CVS Caremark and receive prior authorization before you fill a prescription for arthritis treatments, Xolair®, and migraine agents. CVS Caremark also has quantity limitations on certain medications, such as erectile dysfunction and migraine agents.

For proton pump inhibitors (PPI – prescribed to reduce gastric acid), a step therapy program requires you to try a lower cost generic drug first and progress to other more costly brand-name drugs only if necessary.

## What the Prescription Drug Benefits Do Not Cover

Although prescription drug benefits can help you pay many of your prescription drug expenses, certain types of expenses are not covered. Here are some examples of specific types of prescription drug expenses the program does not cover:

- Over-the-counter contraceptive supplies, including but not limited to condoms, foams, jellies, and ointments and services associated with the prescribing, monitoring, and administration of contraceptives

- Food items including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods, and other nutritional items
- Mifeprex®
- Immune/gamma globulins
- Dental fluoride products
- Homeopathics
- Needles and syringes (these are covered under the Vistra Energy Medical Plan option rather than the prescription drug program)
- Inhaler spacers
- Ostomy supplies (covered under the Vistra Energy Medical Plan option)
- Immunizations (covered under the Vistra Energy Medical Plan option)
- Infertility medications
- Levonorgestrol (Norplant®)
- Minoxidil (Rogaine®) for treatment of alopecia, or any drugs whose sole purpose is to promote or stimulate hair growth or is for cosmetic purposes only
- Nonlegend drugs other than insulin
- Tretinoin, all dosage forms (e.g., Retin-A) for individuals age 36 and older
- Therapeutic devices or appliances, support garments, and other nonmedicinal substances, regardless of their intended use
- Charges for the administration or injection of any drug (may be covered under the Vistra Energy Medical Plan option)
- Prescriptions that an eligible person is entitled to receive without charge, including but not limited to those paid under workers' compensation laws
- A drug labeled "Caution – limited by Federal law to investigational use" or an experimental drug, even though a charge is made to the individual
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals

- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order

- Drugs used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants, and other medications

- Prescription drugs, medications, injectables or supplies provided through a third party vendor contract with the contract holder

- Replacement of lost or stolen prescriptions

- Drugs, services, and supplies provided in connection with treatment of an occupational injury or occupational illness

- Strength and performance drugs, preparations, devices, and supplies to enhance strength, physical condition, endurance or physical performance, including performance-enhancing steroids

- Sex change drugs or supplies related to changing sex or sexual characteristics, including hormones and hormone therapy

- Sexual dysfunction supplies or supplies to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

  - Implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ

- Biological sera, blood, blood plasma, blood products or substitutes or any other blood products

- Embryo transfer procedures

- Drugs used for the treatment of obesity

- All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a prescription drug

- Durable medical equipment, monitors, and other equipment

- Experimental or Investigational drugs or devices; this exclusion will not apply with respect to drugs that:

  - Have been granted treatment investigational new drug (IND) or group/treatment IND status; or

  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and

- CVS Caremark determines, based on available scientific evidence, that the drugs are effective or show promise of being effective for the illness

## If You Have Questions

Contact CVS Caremark if you need to find a participating retail pharmacy, if you lose your ID card, if you want to check whether a drug is a preferred brand drug, or if you have any other questions about the program. For contact information, see the chart in the “Overview” section.

The estimated cost of a particular drug can be obtained by accessing www.caremark.com/vistraenergy.

# Mental Health and Chemical Dependency Coverage

When you enroll in the Medical Plan option, you automatically receive the mental health and chemical dependency benefits associated with that option.

| Medical Plan Option | Mental Health and Chemical Dependency Coverage |
|---|---|
| MyHealthHSA | BCBSTX Behavioral Health |

Benefits vary depending on whether you receive mental health or chemical dependency treatment, whether you receive treatment as an inpatient or outpatient, and whether you use in-network or out-of-network providers. For information about your mental health benefits, see the Fact Sheet for your Medical Plan option.

## Accessing Mental Health Care

To receive in-network benefits, you should first contact your mental health program administrator for an assessment and referral to an in-network provider each time you need mental health or chemical dependency treatment.

## If You Are Hospitalized

If you are hospitalized for mental health or chemical dependency treatment, you must have the admission preauthorized before going into the hospital. In the event of an emergency admission, you must call the mental health program administrator within 48 hours of admission – even if you are discharged within that 48-hour period.

# Special Medical Benefit Features

## Reconstructive Surgery After a Mastectomy

**Participants in the Medical Plan Option**

If you or your dependent receives medical benefits for a mastectomy, coverage will include reconstructive surgery after the mastectomy, as follows:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema

The Claims Administrator for your Medical Plan option determines the appropriate services for this provision. Deductibles, Coinsurance, and Copayments are the same as those for other medical and surgical benefits under your Medical Plan option.

## Health and Wellness Programs

Through the Medical Plan option, you will have access to health and wellness programs, such as:

- Tobacco cessation program, which helps you quit using tobacco – for good.
- Weight management program, which gives you tips and resources to maintain a healthy weight.
- Information about additional programs available through BCBS can be accessed online at www.bcbstx.com

## Home Health Care

**Participants in the Medical Plan Option**

Home health care is care you receive at home, usually following a hospitalization. The Medical Plan option covers home health care expenses if all of the following requirements are met:

- Charges are made by a home health care agency
- Care is provided according to a home health care treatment plan
- Care is provided to a covered patient in his or her home

Home health care charges include the following services and supplies:

- Part-time or intermittent care by an RN, or by an LPN if an RN is not available

- Part-time or intermittent home health aide services for patient care
- Physical, occupational, respiratory, and speech therapy
- Medical supplies, drugs, and medicine provided by a physician, and lab services provided by the home health care agency (note that these services and supplies are covered only if they would have been covered by the option during inpatient hospital or convalescent facility confinement)

Home health care benefits do not cover services or supplies that are not part of the home health care treatment plan. They also do not cover services provided by family members, persons who usually live with the patient, social workers, or homemakers. Transportation expenses also are not covered. Note that other medical services and supplies used during home health care (for example, durable medical equipment) may be covered under the provisions in other parts of the Medical Plan option. There is a 120 visit maximum per calendar year.

## Hospice Care

**Participants in the Medical Plan option**

Hospice care is intended for patients whose life expectancy is six months or less. It is directed at providing comfort and relief (not treatment or a cure) for a terminal illness.

Hospice care may be provided in a patient's home or in a special hospice facility. However, it must be provided through a licensed hospice care agency under a formal program prescribed by a physician. Covered services include patient comfort, psychological counseling for patients and their families, and medication administration.

You must precertify hospice care before services begin.

Services and supplies typically billed through a hospice include the following:

- Inpatient care
- Nutritional counseling and special meals
- Part-time nursing
- Homemaker services
- Bereavement counseling for immediate family members during the six-month period following the patient's death (immediate family members include husband, wife, and children)

These options cover the following hospice services provided at home:

- Part-time or intermittent nursing care by an RN, APN or LVN
- Part-time or intermittent home health aide services
- Physical, speech or respiratory therapy by licensed therapists

- Homemaker and counseling services routinely provided by the hospice agency, including bereavement counseling

These options cover the following hospice services provided by a hospice care facility:

- Room and board, equipment, routine services and supplies, and usual nursing care by RNs, APNs and LVNs
- Physical, speech and respiratory therapy by licensed therapists

## Organ Transplants

The Medical Plan option pays benefits for human organ transplants listed in the sidebar.

**What's Covered**
Bone marrow
Bone marrow/stem cell
Heart
Heart/lung
Kidney
Kidney/pancreas
Liver
Lung
Pancreas

**Under the Medical Plan option**, benefits include evaluation and surgical removal of the donated organ from a living or nonliving donor. If a living donor is not covered by your option, the option covers remaining charges after any benefits are paid from the donor's group or individual insurance. Covered expenses include the following:

- Organ or tissue procurement from a cadaver, consisting of removing, preserving, and transporting the donated part
- Services and supplies furnished by a facility provider
- Treatment and surgery by a professional provider
- Drug therapy treatment to prevent rejection of the transplanted organ or tissue
- Donor search and acceptability testing of potential live donors

**What's Not Covered**
The Medical Plan option does not cover:

- Experimental or investigational treatments
- Expenses related to maintaining the life of a donor for purposes of organ or tissue donation
- Organs obtained from other species
- Acquisition costs of organs

**When bone marrow transplants are covered**, the Medical Plan option pays benefits for the following services related to the bone marrow transplant, provided the services are performed to treat a covered condition and there is the right match of genetic markers:

- Services to transplant the bone marrow of another person into the patient or to transplant the patient's own bone marrow and/or peripheral blood stem cells
- Blood tests for family members who are approved by your Medical Plan option to evaluate potential donors (provided the donor's plan does not cover the tests)
- The harvesting of marrow and/or blood stem cells

**You must *precertify* an organ or tissue transplant before you start treatment.**

When transportation and lodging expenses are paid, the option will reimburse the costs of travel and lodging for the patient and one companion, as shown in the chart below.

| Travel and Lodging Benefits | BCBSTX |
|---|---|
| • Required distance from transplant facility | No requirements/limitations |
| • Number of companions | One |
| • Maximum daily lodging benefit per person | $50 (lodging only) |
| • Maximum travel benefits per surgery | $10,000 |

Covered expenses include the following:

- Transportation for the patient and one companion traveling on the same day(s) to or from the site of the transplant for the evaluation, transplant procedure, or necessary post-discharge follow-up

- Reasonable and necessary expenses for lodging for the patient (while not hospitalized) and one companion, as shown in the chart above

- Travel and lodging benefit for organ transplants is $10,000 maximum per surgery with a $50 daily maximum for lodging expenses per person, one companion is covered

## MyHealth On-Site Health Care Clinics and Mobile Doc

All employees of Vistra Energy, their Spouses, and dependents over the age of 6 who participate in the Medical Plan option, will have access to the MyHealth on-site clinics or the Mobile Doc ("Mobile Doc" or "MyHealth Clinics").

The services available through Mobile Doc or the MyHealth Clinics include preventive medicine (e.g., common immunizations, flu shots, periodic health exams), episodic urgent care (e.g., colds, influenza, sinus infections, sprains and strains, ear infections, minor injuries), and primary care and care management (e.g., asthma, diabetes, high blood pressure, high cholesterol).

You are not required to pay a premium or contribution for access to the Clinic; however, you may be required to pay your Deductible, Copayment or Coinsurance, as applicable, in the same manner as would apply if you received such services from your primary care physician. For these purposes, the services that you receive at the Clinic are treated as In-Network Services. In some instances, the cost of these services will be provided at a discount to the amounts normally charged by your primary care physician.

Your coverage under the Clinic is subject to the generally applicable terms and conditions of your Medical option as described in this document. For example, your claims for benefits under the Clinic will be processed in accordance with the claims procedures for the Medical options and will be subject to the same coordination of benefits and subrogation provisions. However, certain provisions that may be applicable to the Medical options will not be applicable to the Clinic. For example, the Clinic is not subject to the mandates applicable to the Medical options under the Patient Protection and Affordable Care Act. As a result, the Clinic does not offer pediatric services.

# Managing Medical Costs

The Medical Plan option has a number of features that help manage medical costs.

## Mandatory Preadmission Review of Hospital Stays and Other Treatment

Before you or a covered dependent receives certain types of treatment (such as an overnight hospital admission), you may be required to have the treatment reviewed in advance by the Claims Administrator.

You must pre-certify the following:

- All inpatient hospital stays
- All inpatient and certain outpatient mental health and chemical dependency hospital stays (you should preauthorize these stays through the mental health/chemical dependency administrator – BCBSTX)
- All skilled nursing facility stays
- Hospice care
- Home health care
- Home infusion therapy
- All organ and tissue transplants
- Weight reduction (Bariatric) surgery
- Outpatient surgery or procedures

**Terminology**
The precertification process may be referred to as preauthorization, preadmission review, precertification, or pre-service claims.

**Claims Review Process**
To ensure that you receive the care you need on a timely basis, preadmission reviews and concurrent reviews have special timing requirements under the claims review procedures, as described in the "Plan Administration" section. Claims subject to precertification are also called "pre-service claims."

## How to Preauthorize

To preauthorize, you must call the Claims Administrator for your network. If you do not preauthorize a hospital stay or other stay or treatment when required, your benefits may be reduced or denied, as shown in the chart below:

## How Precertification Affects Your Benefits

| | **BCBSTX Medical Plans**<br>***(BCBSTX provider is required to preauthorize)*** |
|---|---|
| **If you call and the Claims Administrator determines that treatment is Medically Necessary** | Option pays benefits at regular rates |
| **If you call and the Claims Administrator determines that treatment is not Medically Necessary** | No benefits are paid without additional information from your physician that supports a determination of medical necessity |
| **If you do not call and the Claims Administrator determines that treatment is Medically Necessary** | Option pays benefits at regular rates |
| **If you do not call and the Claims Administrator determines that treatment is not Medically Necessary** | No benefits are paid without additional information from your physician that supports a determination of medical necessity |

### Emergency Hospitalization – All Participants

In order to receive full benefits for emergency admissions, you must contact the Claims Administrator as soon as possible following the emergency admission. Preauthorization for an emergency admission is not required. Note that you also don't need to preauthorize a hospital stay following the birth of a newborn, as long as the stay does not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section.

### Concurrent Review – All Participants

If a stay needs to be extended beyond the number of days originally certified, the additional days must be approved before your hospital stay that was originally certified ends. This is called concurrent review. When you use in-network providers, your doctor is responsible for making sure that a concurrent review occurs. When you use out-of-network providers, you are responsible for precertification of services.

Preadmission review and concurrent review are intended to help you make informed decisions about health care costs and treatment alternatives. These services also can help you understand how to use your medical benefits to your best advantage and monitor the quality of care being provided. Here's how they work:

- When your doctor recommends hospitalization, you or the doctor should call the toll-free number on your medical ID card for preadmission review. In an emergency, it is your responsibility to contact your doctor or the Claims Administrator as soon as possible following your admission.

- The Claims Administrator compares information about your admission with nationally accepted medical standards, including the treatment and expected length of stay. If there is any question, a physician from the Claims Administrator's office will review your admission and either approve it for benefit payment purposes or discuss it further with your doctor, perhaps suggesting an alternative such as outpatient treatment or a shorter stay. Whatever the outcome, you, your doctor, and the hospital will be notified.

- On the day before you are expected to leave the hospital, the Claims Administrator will call your doctor or hospital to ask about discharge plans. If your doctor wants to lengthen your

stay, the nurse will ask for medical information to support the request. If the nurse reviewer cannot approve an extended stay, a physician from the Claims Administrator's office will talk with your doctor. You, your doctor, and the hospital will be told whether the extra days are eligible for reimbursement from the option.

## Second Surgical Opinion

### Participants in the Medical Plan option

A second surgical opinion helps ensure that surgery is best for you. It also helps to control the expense of unnecessary surgery. Second surgical opinions for elective (nonemergency) surgery are paid according to the Fact Sheet for your Medical Plan option. The second opinion must be from a surgeon who specializes in your injury or illness and is not in practice with the first surgeon.

Following is a list of surgeries for which a second opinion is commonly recommended:

| | | |
|---|---|---|
| • Back (disc surgery)<br>• Breast<br>• Bunion<br>• Cataract<br>• Dilation and curettage (except elective abortion) | • Heart bypass<br>• Hemorrhoid<br>• Hysterectomy<br>• Intestine<br>• Knee<br>• Nose | • Pacemaker insertion<br>• Prostate<br>• Thyroid<br>• Tonsil/adenoid<br>• Varicose vein |

If the second opinion conflicts with the first, you can obtain a third opinion. This third opinion will be covered in the same way as the second opinion.

# Applying for Benefits

## When You Use In-Network Providers

You don't need to file a claim when you use in-network providers. In most cases, the providers will file the claim for you. After the Claims Administrator has processed your claim, you will receive an Explanation of Benefits (EOB) statement that shows the amounts paid and any amounts you owe.

## If You Use Providers Outside the Networks

If you use out-of-network providers, you will usually need to file a claim to receive benefits. To file a claim, follow these instructions:

**Save your bills.** Save all health care bills for you and your covered family members. Each bill should include the following:

- The full name of the person being treated
- The diagnosis of the illness or injury
- The date and type of service received
- Any itemized charges
- The name, address, and tax ID number of the provider performing the service

**Reimbursement from WageWorks HAS**
Certain expenses that are not covered by the Medical Plan option, or that are not fully reimbursed, may be Eligible Charges under the HSA. These charges might include Deductibles, Copayments, charges that are over and above option limits, and charges not covered by the Medical Plan.

**Keep a record of expenses.** Keep separate records of your expenses and those of each of your dependents, because benefits, Deductibles, and maximum payments apply separately to each of you.

It's important that you keep a record of expenses and save your bills or EOBs for tax purposes.

**Obtain claim forms.** To get claim forms, call the Claims Administrator or print out the form from the Claims Administrator's Web site. Claim forms need to be filed separately with the appropriate Claims Administrator.

**Determine the type of claim.** There are four types of health care claims, and the claim process varies with each type. The four types of claims are:

- *Concurrent care claim.* A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim for a course of treatment involving urgent care. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

- *Preservice care claim.* A preservice care claim is a claim for a benefit for which the Medical Plan option requires approval before you receive the medical services or treatment (for example, preadmission review or precertification).

- *Post-service care claim.* A post-service care claim is a claim for a benefit that is made after you receive health care services.

- *Urgent care claim.* An urgent care claim is any claim for health care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of you or your covered dependent. The determination of the claim as an urgent care claim is made at the discretion of the Claims Administrator or may be characterized as such by the treating physician. This type of claim generally includes emergency care claims.

  If you have an urgent care claim, you can initiate the claim yourself if you are able to do so, or your physician can file for you. An urgent care claim can be made orally, but you will be responsible for completing a written claim form in support of your claim, as required by the Claims Administrator.

**Make copies of your claim forms and bills.** The Claims Administrator cannot return original claims to you.

> **Important**
> Be sure to file your claims within 90 days after you incur health care expenses. The Medical Plan won't pay benefits if you don't submit your claims within 12 months of the date of service.

**Submit the claim.** Submit the claim to the Claims Administrator. Make sure you are submitting bills for which benefits are payable. If a Deductible has to be met, you are encouraged to accumulate enough expenses to satisfy the Deductible before submitting the claim. Before submitting the claim, make sure that the claim form is complete and has an original signature, and that all bills are attached. Benefits for services received by an in-network provider are generally paid directly to the provider. However, in other circumstances, benefit payments are paid to you, and you are responsible for paying the provider. To have benefits paid directly to the provider, complete the assignment of benefits statement on your claim form.

## Prescription Drug Claims

You pay for your prescriptions when you pick them up from a retail pharmacy or send in your order to the mail-order program, so you don't need to file claims for prescription drug benefits unless you need to use an out-of-network pharmacy. In this case, you can get a claim form from CVS Caremark, the prescription drug administrator. Complete the form and return it to CVS Caremark. Benefits will be paid directly to you.

## HSA Claims

You do not need to submit verification  for the HSA. The account holder is responsible for determining if withdrawals are for qualified medical expenses. If the IRS questions any withdrawals, it is the sole responsibility of the employee to prove those expenditures were for qualified medical expenses.

You can choose to purchase eligible HSA products or services using out of pocket dollars and be reimbursed from your HSA. This reimbursement process is addressed via an on-line claim submission process via the WageWorks employee site, by using your smartphone to file claims or

you can print and fax/e-mail paper claim forms. Each process will allow reimbursements to be directed via check to your home address or direct deposited to your bank account.

For IRS purposes, be sure to save your receipts as documentation of expenses.

## If a Claim Is Denied

There is a procedure to follow to obtain a full and fair review if a claim is denied and you believe it should be paid. See "Claim Review and Appeal Process" in the "Plan Administration" section.

## Coordination of Benefits

Your Medical Plan option benefits are coordinated with benefits from other group health care plans that cover you or your dependents. When benefits are coordinated, the benefits from all plans cannot be greater than your allowable health care expenses. For information about how coordination works, see "Coordination of Benefits" in the "Plan Administration" section.

## Subrogation Rights

Subrogation rights apply when another party is responsible for your injury or illness or your enrolled spouse's or child's injury or illness (for example, in the case of an automobile accident) and the Vistra Energy Plan pays benefits relating to that illness or injury. By participating in the Plan, you agree that if you or your enrolled spouse or child are injured by a third party, the Plan will be subrogated to your rights against the third party, and/or the third party's insurance carrier, and will be entitled to full reimbursement for any benefits paid by the Plan that are related to the injury. The Plan has the right to recover benefit amounts from funds that you or your spouse or child receive from the responsible third party, whether through a judgment, settlement, or otherwise (including but not limited to an uninsured motorist award or settlement from your own or another's insurance) whether or not you have been fully compensated for your losses, and without offset for any costs of recovery. This means that the Plan may sue the third party and/or its insurance carrier and recover any and all amounts paid by the Plan from the third party or its insurance carrier, up to the total amount that the Plan paid, or may pay, for expenses related to the injury. The Plan's right of recovery is without any reduction for attorney fees or court costs, and without regard to whether (i) you and/or your enrolled spouse or child would be fully compensated or made whole by the amount recovered, (ii) the third party admits causing the injury, or (iii) the amount recovered is awarded specifically for medical expenses. The Plan will have a lien on any and all amounts you recover up to the full amount paid by the Plan.

If the Plan advances payment for any benefits, such payment may be advanced on the condition that you (or the injured person) execute a subrogation agreement that requires you to acknowledge, among other things, (i) the conditional nature of the Plan's payment, (ii) the Plan's right to subrogation and full reimbursement, and (iii) your obligation to cooperate in protecting the Plan's rights. The subrogation agreement may contain additional terms and conditions determined by the Plan Administrator to be necessary or appropriate. Additionally, you and/or your enrolled spouse or child must, as a condition to receiving Plan benefits, assist with the Plan's recovery. In this connection, you must provide the Plan Administrator with information about the facts surrounding your injury, your future medical needs, and any claim you may have against a third party. The Plan has the right to withhold benefits that you or your enrolled spouse or child may be entitled to receive under the Plan unless (and until) you fully comply with all the obligations explained, including executing a subrogation and reimbursement agreement. Regardless of whether you sign a subrogation

and reimbursement agreement, the subrogation provisions described herein will apply. The Plan also has the right to reduce future payments payable to or on behalf of you and/or your enrolled spouse or child by the amount that the Plan is entitled to reimbursement until the time that the entire amount has been recouped in full, including any costs of collection.

You and/or your enrolled spouse or child must contact the Plan Administrator and obtain the Plan Administrator's consent before settling any claim against a third party. You and/or your enrolled spouse or child and your attorney will hold any amounts recovered from a third party in constructive trust to satisfy the Plan's lien.

The Plan's subrogation and reimbursement rights do not limit your right or your spouse's or child's right to take legal action against the person who caused your (or your enrolled spouse's or child's) injury. You can pursue legal action to recover medical expenses and other damages. Again, however, you must obtain the Plan Administrator's consent before you settle any claim or release any third party from liability. The Plan will not be responsible for attorney fees or court costs that you and/or your spouse or child incur and will not reduce the amount of the required reimbursement by the amount of your attorney fees or court costs.

## Coordination With Medicare

If you are actively employed, you and your spouse (if age 65 or older) have primary coverage under the Vistra Energy Medical Plan option. Medicare coverage may be secondary for you or your spouse.

Coordination of benefits rules, which prohibit you from receiving a "double payment" of benefits for the same illness or injury, apply while you are covered by both the Vistra Energy Medical Plan option and Medicare. You can contact the Benefits Service Center for more information about Medicare, your eligibility, and how your benefits will be affected by Medicare.

# Situations Affecting Your Medical Plan Benefits

The Medical Plan option is designed to provide you with covered medical benefits. But some situations could affect your benefits. Those situations are summarized below:

- You do not qualify as an eligible employee under the Plan
- You have exceeded the Plan's limits on services (for example, the visit limit on chiropractic services)
- You fail to file a claim for out-of-network benefits within 12 months of the date of service
- You fail to respond within a reasonable period of time to a request for additional information regarding the processing of a claim
- You fail to pre-certify a medical service with the Claims Administrator when required
- You fail to arrange for mental health or alcohol or substance abuse treatment through BCBSTX
- Payment for your benefits is being coordinated with another group health plan
- You may be required to repay the Plan for benefits paid if you recover monetary damages for an illness or injury caused by a third party
- The Plan may recover against future plan benefits any benefits that have been overpaid;
- The Plan is amended to eliminate specific benefits (although the Plan will, in general, provide coverage for any such benefit services rendered prior to the date of the amendment).

# Dental/Vision

# Dental/Vision Contents

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# Dental Benefits

Although most of us don't look forward to dental appointments, we know that getting regular dental care is an important part of taking care of our health. Since dental care can be costly, Vistra Energy offers Dental Plan options to help offset some of your expenses. The options encourage regular checkups and treatment by paying a higher percentage of preventive and diagnostic expenses.

If you are eligible for the Vistra Energy Health and Welfare Program, you can elect dental coverage. This section of your handbook describes how the Dental Plan options work.

## Dental Coverage Decisions

When you enroll for coverage each year, you choose a coverage category and a Dental Plan option that best fit your situation. All employees have the same coverage category and Dental Plan option choices.

### Your Coverage Category Choices

Each year during annual enrollment, you will be asked to make a decision about the coverage category you want. The coverage categories are:

- You only
- You and spouse
- You and child(ren)
- You and family (spouse and children)

### Your Dental Plan Options

If you are eligible for the Plan, you can enroll in one of two Dental Plan options:

- Dental Plan A (enhanced coverage)
- Dental Plan B (comprehensive coverage)

The Dental A option provides a higher level of benefits than the Dental B option. Both options are administered by MetLife.

## About the Networks

The Vistra Energy Dental Plan options operate through a network. A network is a group of dentists and dental care providers who contract with the Dental Plan options' Claims Administrator (MetLife) to offer negotiated rates to their participants.

When you need dental care, you have the freedom to choose any dentist you want. However, in-network dentists have agreed to provide services to Vistra Energy employees at negotiated rates. This can result in significant cost savings for you.

# How the Dental Plan Options Work

For most dental expenses, the options work like this:

1. Each year, you must meet a Deductible before the option starts to pay benefits. However, a Deductible is not required for preventive/diagnostic care or orthodontia services.

2. Once you meet the Deductible, the option's Coinsurance is a percentage of charges. The percentage the option pays is based on the option you choose and the type of dental expense (see below). Your Coinsurance is the remaining charges.

3. Each year, you and each dependent can receive dental benefits up to an annual maximum. If you or a dependent reaches the maximum during the year, no further benefits are paid for that person for the rest of that calendar year.

4. There is a lifetime maximum for orthodontia benefits.

The Dental Plan option you choose determines the Deductible you pay, the option's Coinsurance, the annual maximum, and the orthodontia maximum. For more information, see the Dental Plan Options Fact Sheet.

## Types of Expenses

Dental expenses are generally divided into the following four categories. The option pays different benefits for each category of expenses.

- Diagnostic and preventive services
- Basic services
- Major services
- Orthodontia services

## Deductible

The Deductible is the amount of covered basic and major dental expenses you pay each year before the option starts to pay benefits. You don't need to meet the Deductible before preventive and diagnostic expenses or orthodontia expenses are paid.

Each covered person must meet the annual Deductible each year before the option starts paying these benefits. The option also has a family maximum Deductible. The maximum family Deductible is three times the individual Deductible (once three people in your family meet the individual Deductible, no further Deductibles will be required from your family for the rest of the year).

All eligible dental charges count toward the Deductible, with these exceptions:

- Preventive care expenses
- Orthodontia expenses
- Any charges that are not covered by the option or that exceed reasonable and customary charges or other option limits

## Coinsurance

You share in the cost of dental services through Coinsurance. There are no Copayments under either Dental Plan option.

Coinsurance is the portion of charges that you and the option each pay for covered services. The option's Coinsurance is the percentage of charges shown on the Fact Sheet for your Dental Plan option. Your Coinsurance is the remaining portion of charges.

**In-Network Benefits Based on Negotiated Rates**

The Coinsurance is based on the rates that have been negotiated with in-network providers. It works like this:

- When you receive care from in-network providers, the provider bills the option at the provider's regular rate. Then the Claims Administrator reduces the bill to the negotiated rate. (The provider has agreed to accept the negotiated rate as payment.) The option then pays its Coinsurance (for example, 80%) based on the negotiated rate for that type of dental expense, and you pay the remaining Coinsurance (for example, 20%) based on the negotiated rate.

**Out-of-Network Benefits Based on Recognized Charges**

- When you receive care from out-of-network providers, the provider bills the option at the provider's regular rate. The Claims Administrator calculates what the recognized charge would be in-network and pays its Coinsurance based on the recognized charge. You are responsible for paying the entire remaining amount of the provider's regular rate.

Here's an example: Say you and your family have dental care charges of $1,000 during the year. The negotiated rate for those expenses is $700. Assuming you've met any Deductible requirements and that the option pays 80% of charges for those expenses, payments would be:

| | **In-Network** | **Out-of-Network** |
|---|---|---|
| Full charge | $1,000 | $1,000 |
| Negotiated rate | $700 | $1,000 (no negotiated rate) |
| Recognized Charge | $700 | $700 |
| Option pays percentage of network negotiated rate | 80% of $700 = $560 | 80% of $700 = $560 |
| You pay remainder | $700 − $560 = $140 | $1,000 − $560 = $440 |

In this example, you pay $140 if you receive services from in-network providers, or you pay $440 if you receive services from out-of-network providers. Please note that this is a very simple example to show how the concept works. The actual negotiated network rates may vary depending on the network, the physician's billing practices, and the geographic area. The percentage the option pays also may vary, depending on the type of expense and on the network you choose.

## Benefit Maximums

The annual maximum for basic and major services applies to each covered person during each calendar year. Benefit payments for preventive and diagnostic services do not count against this annual maximum.

A separate, lifetime maximum applies to orthodontia services for each covered person.

# Dental Plan Options Fact Sheet

| | **Dental A Option (enhanced coverage) you pay:** | **Dental B Option (comprehensive coverage) you pay:** |
|---|---|---|
| **Deductible for Basic and Major Services** | $25 individual/$75 family | $50 individual/$150 family |
| **Individual Annual Maximum Benefit for Basic and Major Services** | $2,500 per individual | $1,500 per individual |
| **Diagnostic and Preventive Care**<br>Routine dental exams<br>Prophylaxis (teeth cleaning – twice each year)<br>Bitewing x-rays (one set per calendar year)<br>Full-mouth x-rays (one set every rolling 3 years)<br>Periapical x-rays<br>Diagnostic tests and laboratory work<br>Periodontal cleaning (active perio therapy is a prerequisite)<br>Fluoride treatments (twice each year)<br>Space maintainers<br>Emergency treatment to relieve pain (charges count toward the annual maximum)<br>Sealants<br>Consultations (charges count toward the annual maximum) | 0% (no Deductible) Charges do not count toward annual maximum unless specifically noted | 0% (no Deductible) Charges do not count toward annual maximum unless specifically noted |
| Appliances to correct harmful habits (charges count toward orthodontia lifetime maximum) | 0% (no Deductible) Charges do not count toward annual maximum unless specifically noted | 20% (no Deductible) Charges do not count toward annual maximum unless specifically noted |
| **Basic Services**<br>Fillings (amalgam and resin composites only)<br>Pulp capping<br>Endodontic treatment, including root canal therapy (except for molar root canal therapy)<br>Periodontal treatment, including surgery and scaling of teeth<br>Rebasing and relining of dentures<br>Tooth extractions<br>Treatment of bruxism (grinding of the teeth) | 20% after Deductible, up to annual maximum | 40% after Deductible, up to annual maximum |

| | Dental A Option (enhanced coverage) you pay: | Dental B Option (comprehensive coverage) you pay: |
|---|---|---|
| Oral surgery (except those procedures covered by a Medical Plan option)<br><br>Osseous surgery<br><br>Occlusal guards<br><br>Partial/full bony impactions<br><br>Disease of the gums<br><br>Anesthetics in connection with covered surgery or other dental treatments<br><br>Accidental injury to sound natural teeth (when not covered under Medical Plan option) | | |
| **Major Services**<br><br>Inlays and onlays<br><br>Crowns (once each 60 months)<br><br>Certain other restorative services<br><br>Molar root canal therapy<br><br>Initial installation of complete and partial removable dentures<br><br>Initial installation of fixed bridgework, including removable dentures and inlays and crowns as abutments. The options also cover adjustments following installation.<br><br>Repairing and recementing crowns, inlays, bridgework, and dentures<br><br>Replacement of existing dentures and bridgework when they:<br>• Are needed to replace natural teeth extracted while you are covered by a Dental Plan option<br>• Are needed to replace congenitally missing teeth<br>• Are at least 60 months old and cannot be made serviceable<br>• Are damaged because of an accident occurring while the patient is covered by a Dental Plan option<br><br>Dental implants<br><br>Treatment and appliances for temporomandibular joint disorder, other than surgery (surgery is covered under the Medical Plan options) | 50% after Deductible, up to annual maximum | 50% after Deductible, up to annual maximum |
| **Orthodontia** | | |
| Initial workup | 20% (no Deductible), up to lifetime orthodontia maximum | 20% (no Deductible), up to lifetime orthodontia maximum |
| Orthodontia treatment. The Dental Plan options pay an initial benefit equal to 20% of the estimated treatment cost at the 50% rate after the first appliance is installed. Remaining payments are prorated and paid monthly over the expected | 50% (no Deductible), up to lifetime orthodontia maximum | 50% (no Deductible), up to lifetime orthodontia maximum |

| | **Dental A Option (enhanced coverage) you pay:** | **Dental B Option (comprehensive coverage) you pay:** |
|---|---|---|
| length of treatment.<br>Lifetime orthodontia maximum | <br>$2,000 | <br>$1,000 |

# More About Orthodontia Services

Orthodontia coverage provides benefits for teeth straightening. Benefits are 50% of reasonable and customary charges, with no Deductible requirement.

Orthodontia expenses do not count toward the per-person annual benefit maximum for other dental services, but are limited to the lifetime orthodontia maximum for the Dental Plan option you choose.

Before treatment begins, you must file an orthodontia treatment plan with the Claims Administrator. The orthodontia treatment plan is a report that describes what treatment is needed, the length of treatment, and the cost. You are not required to submit any further claims for benefits for your orthodontia treatment. After you submit your orthodontia treatment plan, the Claims Administrator calculates your benefits for the entire treatment and pays benefits directly to your orthodontist under an assignment of benefits.

## How the Payment Plan Works

Regular, fully banded orthodontia is paid over the entire length of time services are received. When the appliances are first installed, the Dental Plan options pay an initial benefit of 20% of the total cost at the 50% benefit rate. As treatment continues, the options pay 50% of the remaining expenses, up to the lifetime maximum. Payments are made monthly. Here is an example of how orthodontia payments work.

| | |
|---|---|
| **Total fee** | $ 2,500.00 |
| | × 20% |
| | $ 500.00 |
| | × 50% |
| **Initial payment** | $ 250.00 |

| | |
|---|---|
| **Remaining balance** | $ 2,000.00 |
| **Payable over 2 years (24 monthly installments)** | ÷ 24 |
| | $ 83.33 |
| | × 50% |
| **Monthly payment amount** | $ 41.66* |

Benefits for fixed or removable appliance therapy (interceptive orthodontia) are not paid under the payment plan procedure, but are paid as services are rendered.

* Subject to the lifetime maximum benefit for orthodontia services.

## Orthodontia Expenses Not Covered

The Dental Plan options do not cover charges for orthodontia procedures under a treatment plan that began before the date you or your eligible dependent is covered by a Dental Plan option.

The plan does not cover the following orthodontic services and supplies:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners")

The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan.

# Special Dental Benefit Features

## Predetermination of Benefits

If you expect charges for planned dental work to be $250 or more, a predetermination of benefits (pretreatment estimate) should be filed with the Claims Administrator before treatment begins, unless emergency care is necessary. Your dentist should submit a completed claim form that itemizes the services to be performed and their costs.

Predetermination works like this: Your dentist decides what treatment is needed and describes it on the claim form along with an estimate of treatment charges. Your dentist also should attach x-rays and other supporting records with the form.

The Claims Administrator will review the claim to make sure the charges are reasonable and customary and the proposed services are within the option's guidelines. You and your dentist will be notified of what portion of the charges will be paid by your option.

## Benefits Based on Professionally Acceptable Treatments

Please be aware that many dental problems can be treated in more than one way. The Dental Plan options cover the least expensive procedure that is effective in providing a professionally satisfactory result.

For example, if you have a cavity in a tooth and you have the tooth crowned for the sake of appearance instead of simply having the cavity filled, your benefit will be based on the cost of the filling. If, however, because of the condition of the tooth, a crown is necessary to provide a professionally satisfactory result, your benefit will be based on the cost of the crown.

## Accidents to Teeth

If you injure your teeth as a result of an accident, all necessary dental treatments will be covered as follows:

- Claims for injury to natural teeth need to be submitted to your medical plan first. If the claims are not covered by medical, dental will consider the service based on whichever category the service falls under.

- All services would count toward the annual maximum, not just to one type of tooth. Coverage would not be based on sound or unsound teeth.

## In Case of a Dental Emergency

The Plan pays a benefit at the network level of coverage even if the services and supplies were not provided by a network provider up to the dental emergency maximum. The care provided must be a covered service or supply. You must submit a claim to MetLife describing the care given. Additional dental care to treat your dental emergency will be covered at the appropriate Coinsurance level.

## Dental Medical Integration (DMI)

The following additional dental expenses will be considered covered expenses for you and your covered dependent if you have medical coverage and have at least one of the following conditions:

- Pregnancy;
- Coronary artery disease/Cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes

**Additional Covered Dental Expenses**

- Scaling and root planning, (4 or more teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year); and
- Localized delivery of antimicrobial agents (not covered for pregnancy)

**Payment of Benefits**

The Plan Coinsurance applied to the other covered dental expenses above will be 100%. These additional benefits will not be subject to any frequency limits except as shown above or any calendar year maximum.

MetLife will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement of covered expenses.

# What the Dental Benefits Do Not Cover

Although the Dental Plan options cover you and your dependents against many dental care expenses, certain services are not covered. You and your dentist should consult the following list when you are planning a course of treatment.

The Dental Plan options do not cover:

- Crowns, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Orthognathic surgery
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply
- Orthodontic treatment except as covered in the Fact Sheet and "More About Orthodontia Services" section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium)
- Prescribed drugs, pre-medication or analgesia
- Replacement of a device or appliance that is lost, missing, or stolen, or for the replacement of appliances that have been damaged due to abuse, misuse, or neglect or for an extra set of dentures
- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
- Services and supplies provided for your personal comfort or convenience, or for the convenience of any other person, including a provider
- Services and supplies provided in connection with treatment or care that is not covered under the option
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth

- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by someone other than a dentist; however, the option will cover some services such as scaling and cleaning of teeth provided by a licensed dental hygienist under the supervision and guidance of a dentist
- Charges incurred before coverage begins or after coverage ends
- Services not Medically Necessary or usually provided for dental care
- Any work not done by a dentist, except x-rays ordered by a dentist and services by a dental hygienist performed under the dentist's supervision
- The cost of a more expensive or elaborate course of treatment in excess of a less expensive procedure that would have produced a professionally satisfactory result
- Drugs or medicines
- Charges over the reasonable and customary charge amount
- Dentures, bridgework or implants if the work involves existing dentures, bridgework or implants that were installed in the last 60 months
- Dentures, bridgework or implants if the work involves natural teeth extracted within six months before a person's effective date, unless the denture or bridgework also includes a natural tooth extracted while the person is covered by a Dental Plan option
- A crown, gold restoration, or bridge if the tooth was prepared before the patient was covered by a Dental Plan option
- Root canal therapy if the pulp chamber was opened before the patient was covered by a Dental Plan option
- Appliances or modification of an appliance if an impression was made before the patient was covered by a Dental Plan option
- Services for cosmetic purposes, unless it is cosmetic dentistry made necessary by an accident that happened while the patient was covered by a Dental Plan option. Facings on molar pontics are always considered cosmetic.
- Appliances or restorations for the purpose of crowns or splinting, to change vertical dimension, or to restore occlusion
- Services or supplies furnished or payable by any government or governmental agency, or any governmental program or law under which you could be covered, unless payment is legally required

- Services or supplies for any illness or accidental injury in connection with any employment for wage or profit
- Replacement of lost or stolen appliances
- Charges that you are not legally obligated to pay
- Services or supplies received as a result of war or an act of war, declared or undeclared, including resistance to armed aggression

# Vision Benefits

The Vision Plan option covers expenses for routine eye exams, eyeglasses, and contact lenses, and provides discounts on laser eye surgery. Benefits are provided through an insurance contract issued by UnitedHealthcare Vision℠, the insurance carrier.

## How the Vision Plan Option Works

If you elect vision coverage, the option covers costs of eye exams and contacts (including up to four boxes, or 12 pairs, of certain disposable contacts), or eyeglass lenses and frames instead of contacts. There are also discounts on lens options such as progressives, anti-reflective coating and photochromic lenses.

When you need eye care services, you choose whether or not to use an in-network provider that has contracted with the insurance carrier. Similar to the Medical Plan options, you receive a higher benefit when you use the services of an in-network provider. You can get a list of participating providers on the insurance carrier's Web site at www.myuhcvision.com, or by calling UnitedHealthcare Vision at 1-800-638-3120.

If you use an out-of-network provider, you pay the full costs at the time you receive care, and you must submit your receipts to the insurance carrier to receive the appropriate reimbursement.

Coverage includes benefits for an eye exam once every calendar year and either lenses and frames or contact lenses once every calendar year.  Members are eligible to receive an additional exam each year.

## Eye Exams

### In-Network Providers

If you use in-network providers, you pay a $10 Copayment for an eye exam and the option pays the remaining costs.  If you use in-network providers, you pay a $10 Copayment for retinal screening photography and the option pays the remaining costs.

### Out-of-Network Providers

If you use out-of-network providers, the option reimburses  up to $40.

## Eyeglass Lenses and Frames

### In-Network Providers

After you pay the eye exam Copayment, there is no additional fee for standard, clear, single-vision lenses, lined bifocals or trifocals, or lenticular lenses. A standard scratch-resistant coating also is covered in full.

You can purchase elective eye care materials, such as progressive lenses and antireflective coatings at a preferred discounted price.  If you purchase elective eye materials, you pay the discounted cost offered by in-network providers for lenses and frames.

Frames are covered once per calendar year ($130 allowance).

Vision benefits include 100% coverage for a wide variety of selected frames.

- If you use a private-practice provider or retailer, you receive an allowance of $130. You are only responsible for paying the difference between $130 and the cost of the frame.

**Out-of-Network Providers**
If you use out-of-network providers, the Vision Plan option reimburses up to the following amount for lenses and frames:

| | Out-of-Network Benefit |
|---|---|
| **Lenses** | |
| • Single Vision | Up to $40 |
| • Bifocal | Up to $60 |
| • Trifocal | Up to $80 |
| • Lenticular | Up to $80 |
| **Frames** | Up to $45 |

## Contact Lenses

### In-Network Providers

You can choose contact lenses instead of eyeglasses if you wish. However, if you purchase contact lenses, you will not be able to purchase eyeglasses under the Vision Plan option until the next calendar year.

When you use in-network providers, the option covers the full cost of many different types of contact lenses (including up to four boxes, or 12 pairs, of disposable contact lenses). Many popular brands are covered, such as Alcon, CooperVision, and Vistakon ACUVUE. The option also covers the full costs for fitting, evaluation, and two follow-up visits with in-network providers.

If you choose contacts that are not covered-in-full, such as toric or bifocal contacts, you pay the difference between the benefit of $105 and the cost of the fitting and contacts. Be sure to ask your provider which contacts are covered in full.

### Out-of-Network Providers

If you use out-of-network providers, the option covers up to $105 toward the cost of contacts.

### Necessary Contact Lenses

If your provider determines that contact lenses are necessary, the Vision Plan option pays the full cost if you use in-network providers. It pays up to $210 toward the contacts if you use out-of-network providers. Situations where contacts may be necessary include cataract surgery without intraocular lens implant, to correct extreme vision problems that cannot be corrected with eyeglasses alone, certain conditions of anisometropia, and keratoconus. Before you purchase the contacts, you should have your provider contact UnitedHealthcare Vision to be sure these benefits are payable.

## Laser Eye Care Surgery

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

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

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

- 15% off standard or reasonable and customary prices
- 5% off any promotional price

Not only are members given a meaningful discount, but that discount is also applied to prices that are often below the national average.

Call 1-888-563-4497 or access www.uhclasik.com to learn more about this benefit.

# Applying for Dental and Vision Benefits

## When You Use In-Network Providers

You typically don't need to file a claim when you use in-network dental or vision providers. In most cases, the providers will file the claim for you.

## If You Use Providers Outside the Networks

If you use out-of-network providers, you will usually need to file a claim to receive benefits. To file a claim, follow these instructions:

**Save your bills.** Save all dental and vision bills for you and your covered family members. Each bill should include:

- The full name of the person being treated
- The diagnosis
- The date and type of service received
- Any itemized charges
- The name, address, and tax ID number of the provider performing the service

> **Reimbursement From One of Your Flexible Spending Accounts (FSAs) Options**
> Expenses that are not covered by the Dental Plan options or Vision Plan option, or that are not fully reimbursed, may be eligible for reimbursement under your Health Care Spending Account option (an FSA).

**Keep a record of expenses.** Keep separate records of your vision and dental expenses for yourself and your dependents, because benefits, Deductibles, and maximum payments apply separately to each of you.

**Obtain claim forms.** To get claim forms, call the Claims Administrator or print out the form from the Claims Administrator's Web site. Claim forms need to be filed separately with the appropriate Claims Administrator.

**Determine the type of claim.** There are two types of claims under the Dental Plan options and the Vision Plan option:

- *Post-service care claim.* A post-service care claim is a claim for a benefit that is made after you receive care services.
- *Urgent care claim.* An urgent care claim is any claim for care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of you or your covered dependent. The determination of the claim as an urgent care claim is made at the discretion of the Claims Administrator or may be characterized as such by the treating dentist or physician. This type of claim generally includes emergency care claims.

If you have an urgent care claim, you can initiate the claim yourself, or your dentist or physician can file for you. An urgent care claim can be made orally, but you will be responsible for completing a written claim form in support of your claim, as required by the Claims Administrator.

**Make copies of your claim forms and bills.** The Claims Administrator cannot return original claims to you.

**Submit the claim.** Submit the claim to the dental Claims Administrator or to the vision insurance carrier. Make sure you are submitting bills for which benefits are payable. If a Deductible has to be met, you are encouraged to accumulate enough expenses to satisfy the Deductible before submitting the claim. Before submitting the claim, make sure that the claim form is complete and has an original signature, and that all bills are attached. Benefits for services received by an in-network provider are generally paid directly to the provider. However, in other circumstances, benefit payments are paid to you, and you are responsible for paying the provider. To have benefits paid directly to the provider, complete the assignment of benefits statement on your claim form.

Be sure to file your claims within 90 days after you incur the expenses. If through no fault of your own you are not able to meet the 90-day deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 12 months after the date of service.

## If a Claim Is Denied

There is a procedure to follow to obtain a full and fair review if a claim is denied and you believe it should be paid. See "Claim Review and Appeal Process" in the "Plan Administration" section.

## Coordination of Benefits

Your Dental Plan options benefits are coordinated with benefits from other group health care plans that cover you or your dependents. When benefits are coordinated, the benefits from all plans cannot be greater than your allowable health care expenses. For information about how coordination of benefits works, see the "Plan Administration" section.

## Subrogation Rights

Subrogation rights apply when another party is responsible for your injury or illness or your enrolled spouse's or child's injury or illness (for example, in the case of an automobile accident) and the Vistra Energy Plan pays benefits relating to that illness or injury. By participating in the Plan, you agree that if you or your enrolled spouse or child are injured by a third party, the Plan will be subrogated to your rights against the third party, and/or the third party's insurance carrier, and will be entitled to full reimbursement for any benefits paid by the Plan that are related to the injury. The Plan has the right to recover benefit amounts from funds that you or your spouse or child receive from the responsible third party, whether through a judgment, settlement, or otherwise (including but not limited to an uninsured motorist award or settlement from your own or another's insurance) whether or not you have been fully compensated for your losses, and without offset for any costs of recovery. This means that the Plan may sue the third party and/or its insurance carrier and recover any and all amounts paid by the Plan from the third party or its insurance carrier, up to the total amount that the Plan paid, or may pay, for expenses related to the injury. The Plan's right of recovery is without any reduction for attorney fees or court costs, and without regard to whether (i) you and/or your enrolled spouse or child would be fully compensated or made whole by the amount recovered, (ii) the third party admits causing the injury, or (iii) the amount recovered is awarded specifically for medical

expenses. The Plan will have a lien on any and all amounts you recover up to the full amount paid by the Plan.

If the Plan advances payment for any benefits, such payment may be advanced on the condition that you (or the injured person) execute a subrogation agreement that requires you to acknowledge, among other things, (i) the conditional nature of the Plan's payment, (ii) the Plan's right to subrogation and full reimbursement, and (iii) your obligation to cooperate in protecting the Plan's rights. The subrogation agreement may contain additional terms and conditions determined by the Plan Administrator to be necessary or appropriate. Additionally, you and/or your enrolled spouse or child must, as a condition to receiving Plan benefits, assist with the Plan's recovery. In this connection, you must provide the Plan Administrator with information about the facts surrounding your injury, your future medical needs, and any claim you may have against a third party. The Plan has the right to withhold benefits that you or your enrolled spouse or child may be entitled to receive under the Plan unless (and until) you fully comply with all the obligations explained, including executing a subrogation and reimbursement agreement. Regardless of whether you sign a subrogation and reimbursement agreement, the subrogation provisions described herein will apply. The Plan also has the right to reduce future payments payable to or on behalf of you and/or your enrolled spouse or child by the amount that the Plan is entitled to reimbursement until the time that the entire amount has been recouped in full, including any costs of collection.

You and/or your enrolled spouse or child must contact the Plan Administrator and obtain the Plan Administrator's consent before settling any claim against a third party. You and/or your enrolled spouse or child and your attorney will hold any amounts recovered from a third party in constructive trust to satisfy the Plan's lien.

The Plan's subrogation and reimbursement rights do not limit your right or your spouse's or child's right to take legal action against the person who caused your (or your enrolled spouse's or child's) injury. You can pursue legal action to recover medical expenses and other damages. Again, however, you must obtain the Plan Administrator's consent before you settle any claim or release any third party from liability. The Plan will not be responsible for attorney fees or court costs that you and/or your spouse or child incur and will not reduce the amount of the required reimbursement by the amount of your attorney fees or court costs.

# Situations Affecting Your Dental/Vision Benefits

Your benefits under the dental and vision options may be affected under certain circumstances. Some of the reasonably foreseeable situations are summarized below:

- You do not qualify as an eligible employee under the Plan
- You have exceeded the Plan's limits on services (for example, the dollar limit on dental benefits)
- You fail to respond within a reasonable period of time to a request for additional information regarding the processing of a claim
- You fail to pre-certify a dental service with the Claims Administrator when required
- You may be required to repay the Plan for benefits paid if you recover monetary damages for an illness or injury caused by a third party
- The Plan may recover against future plan benefits any benefits that have been overpaid;
- The Plan is amended to eliminate specific benefits (although the Plan will, in general, provide coverage for any such benefit services rendered prior to the date of the amendment).

# Flexible Spending Accounts & Health Savings Account (HSA)

# Flexible Spending Accounts Contents

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# How the Flexible Spending Accounts (FSAs) Options Work

The Flexible Spending Account (FSA) options allow you to set money aside on a tax-free basis to pay health care and dependent care expenses. By paying expenses through your FSA options, you save money by lowering your federal income and Social Security taxes. You get the full buying power of every dollar you spend for these expenses, because taxes are not deducted from the money you contribute to these accounts.

> This section provides a summary of Vistra Energy's Flexible Spending Account options. Vistra Energy has contracted with WageWorks to provide certain administrative services for the FSAs. If you have any questions about the FSAs, please contact WageWorks by calling 1-877-924-3967 or by visiting their web site at www.wageworks.com.

Here's how it works:

- There are two FSA options: the Health Care Spending Account option and the Dependent Care Spending Account option.
- Every year, you decide how much you want to contribute to each FSA option. You can make pretax contributions from your paycheck.
- When you make pretax contributions, you authorize Vistra Energy to reduce your pay by the amount of your contributions. Since your pay is lower, you pay lower federal income taxes, lower Social Security taxes and, in most areas, lower state and local taxes.
- If you are enrolled in the Medical Option and have available funds in your health care FSA, your FSA will pay first, when you have eligible health care expenses incurred for a dental or vision provider. Once you have met your deductible you may use your FSA funds for medical and prescription drug expenses.
- When you have eligible dependent care expenses, you pay the expenses and file a claim for reimbursement from your Dependent Care Spending Account option. You are reimbursed with tax-free dollars.
- In exchange for the significant tax advantages that your FSA options can provide, the IRS requires that you forfeit any money that remains in your accounts at year-end. However, you have until March 31 of the next year to turn in claims for expenses you incurred through December 31 of the previous year. Because of this rule, it's important that you estimate your eligible expenses carefully and don't contribute any more than you expect to use during the year.

## WageWorks for Flexible Spending Account Participants

WageWorks' web site at www.wageworks.com is an online resource for FSA and other information. WageWorks FSA participants can take full advantage of an interactive web site to complete a variety of self-service transactions online.

You can access the site 24 hours a day, seven days a week from wherever you have Internet access. You can:

- Check the status of your Flexible Spending Accounts
- Review your FSA account balances
- Obtain details for claim submissions and payments
- Look up claim submission deadlines
- Receive automatic alerts whenever there is a new Explanation of Payment (EOP) statement to view online
- Request online-only delivery of your Explanation of Payment statements (if you have direct deposit) to eliminate EOPs by mail
- Print out WageWorks standard forms
- Contact WageWorks Member Services
- View a list of eligible expenses

# Making Contributions to Your FSA Options

## Contribution Amount

When you enroll, you decide how much you want to contribute to your Health Care Spending Account option and your Dependent Care Spending Account option. There are minimum and maximum contributions for each option.

| Flexible Spending Account Options | Minimum Contribution | 2017 Maximum Contribution* |
|---|---|---|
| Health Care Spending Account option | $120 each Plan Year<br>($10 a month) | $2,500 each Plan Year<br>($208.33 a month) |
| Dependent Care Spending Account option | $120 each Plan Year<br>($10 a month) | $5,000 each Plan Year<br>($416 a month)<br><br>Married taxpayers filing separate returns:<br>$2,500 each Plan Year<br>($208 a month) |

*These amounts are based on federal regulations and subject to change each year. Please contact the Benefits Service Center to confirm the maximum allowable contribution for a specific calendar year.

## Avoiding Forfeitures

The Internal Revenue Service (IRS) requires you to forfeit any unused balances in your Health Care Spending Account option or Dependent Care Spending Account option at the end of each year. To avoid forfeitures, it's important to carefully estimate the expenses you expect to have during the year. WageWorks has helpful online tools that you can use to estimate your expenses.

## Additional Considerations for Dependent Care Contributions

- If your spouse also makes deposits into a dependent care flexible spending account where he or she works, your combined dependent care deposits cannot be more than the annual maximum contribution limit.

- You cannot contribute more than your earned income. If you're married, you cannot contribute more than your own earned income or your spouse's earned income – whichever is less. For example, if you earn $25,000 per year and your spouse earns $4,000 per year, the maximum amount you can contribute is $4,000.

- If your spouse does not work because he or she is disabled, or if your spouse is a Full-Time Student for at least five months during the year, you can contribute up to the following amounts, even if your spouse's income is less than these amounts:

  – Up to $200 for each month your spouse doesn't work, if you pay for day care for one qualified dependent

– Up to $400 for each month your spouse doesn't work, if you pay for day care for two or more qualified dependents

## Coordinating Contributions With Tax Credits and Deductions

When you use pretax dollars from the FSA options, you cannot also take a tax deduction or credit on your federal income tax return for the same expenses. Whether you would be better off using the FSA options or taking deductions and credits on your federal income tax return depends on your personal situation. Following are some general guidelines to keep in mind as you make your decisions.

### Health Care Expenses

Under current tax law, only out-of-pocket health care expenses over 7½% of your adjusted gross income are tax-Deductible on your federal income tax return. In addition, you must itemize all your deductions in order to be eligible for this deduction.

In contrast, the Health Care FSA gives you a tax break beginning with your first $1 of expense, but only up to the maximum contribution. You do not have to report the expenses or the reimbursements on your income tax returns. So, if your medical, dental, and vision expenses are less than the minimum allowable income tax deduction for medical expenses, you will probably be better off using the Health Care FSA.

### Dependent Care Expenses

By using the Dependent Care FSA, a tax break is available to any taxpayer with qualifying dependent care expenses. You can claim reimbursement of up to the annual maximum of eligible expenses (total) for any number of eligible dependents. For 2012, the contribution limit is $5,000.

A tax credit for dependent care expenses is available to taxpayers when filing annual federal income tax returns. The maximum tax credit is 30% of eligible expenses for families with adjusted gross income of $10,000 or less. As adjusted gross income increases, the tax credit percentage decreases to a minimum of 20% of eligible expenses for taxpayers whose adjusted gross income is more than $28,000. You may be able to use a combination of the child care tax credit and the Dependent Care Spending Account option. For example, assume you contribute $3,000 to the Dependent Care Spending Account option for two or more dependents, but your eligible expenses are $3,500. You may be able to take a tax credit on the remaining $500 of child care expenses when you file your income tax return.

Each dollar you contribute to your Dependent Care Spending Account option reduces the maximum child care expenses available for the tax credit by a corresponding dollar. So, if you contribute $5,000 to the Dependent Care Spending Account option, but your eligible expenses are actually $5,500 for two or more dependents, you would not be able to count the remaining $500 in expenses toward the tax credit.

Also, you cannot claim a dependent care tax credit for any expenses that were reimbursed to you through the Dependent Care Spending Account option.

You may want to talk to a tax advisor to determine which option is best for you.

## Planning Contributions to Your Flexible Spending Accounts

Go to www.wageworks.com for help in estimating your health care and dependent care expenses and deciding how much to contribute to each option.

**Avoiding Forfeitures**
Careful planning is the key to making the most of your Flexible Spending Accounts options and reducing the risk of forfeiture.

As you plan, keep in mind that:

- The funds in each option must remain separate.
- You cannot shift money from one option to the other.
- Expenses you incur before your participation starts or after December 31 of each Plan Year are not eligible for reimbursement.

Generally, you will want to estimate how much you expect to spend on the following expenses and any other costs you anticipate.

| Health Care FSA Option | Dependent Care FSA Option |
|---|---|
| • Estimate out-of-pocket expenses for doctor and hospital bills, prescription drugs, dentistry, and orthodontia and vision care, including the Deductibles and Coinsurance you pay, as well as expenses (other than over-the-counter drugs and medications that have not been prescribed by your physician) that may not be covered by your health care plans.<br>• Remember to include expenses for everyone who is an eligible dependent.<br>• Remember that if you participate in the MyHealth HSA option, your reimbursements are limited to eligible dental and vision expenses until you meet the MyHealth HSA option annual deductible. | • "Day care" expenses usually are predictable. Estimate the weekly charge for your eligible dependents and multiply it by the number of weeks that each dependent will receive care.<br>• Be sure to exclude vacations, holidays, and other periods when you will not be charged for day care.<br>• Remember that this option cannot be used for child care expenses after your child reaches age 13. |

# Eligible Health Care Expenses

You can use your Health Care FSA for medical (**once you meet meet your Deductible if enrolled in the MyHealth HSA option**), dental, vision, and hearing expenses that are not covered by the Plan or by other plans in which you or your dependents participate.

## Eligible Dependents for Your Health Care Flexible Spending Account

For your Health Care FSA, your eligible dependents include any person who qualifies as your dependent for income tax purposes. This generally includes anyone who depends on you for at least half of his or her financial support. (In other words, a dependent does not have to meet the requirements for dependent coverage under the Plan in order to qualify under the Health Care Spending Account option.)

In addition, eligible dependents include all children through the year they attain age 26. Any restrictions in the definition of Dependent in your plan document which require a child to be unmarried, a student, financially dependent on the employee, etc. no longer apply. If the definition of Dependent in the plan document provides coverage for a child beyond age 26, the provision and all restrictions will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child will start at age 26.

## Eligible Health Care Expenses

Eligible health care expenses include your medical and dental Deductibles (except if enrolled in the MyHealth HSAoption), your share of other expenses covered by the health care option, as well as certain additional medical, prescription drug, vision, and dental expenses that are not covered or fully reimbursed by any employer-provided plans.

In general, expenses that qualify as itemized deductions on your federal income tax return are eligible for reimbursement through the Health Care FSA option (which includes an amount paid for medicine or a drug only if such medicine or drug is prescribed – without regard to whether such medicine or drug is available without a prescription – or is insulin). Contact WageWorks directly or go to www.wageworks.com for a complete and up-to-date list of eligible expenses. Listed below are a few examples of eligible expenses:

- Any Deductibles and Copayments you pay for medical (once you meet your medical Deductible), dental or vision coverage through Vistra Energy or other health care plans in which you or your dependents participate

- Your Coinsurance – that is, the portion of medical, dental or vision expenses you pay under your health care plans

  – If enrolled in the HSA medical option, eligible expenses are limited to certain dental and vision expenses until you have met the full plan Deductible. After the Deductible is met, the Health Care FSA is no longer "limited scope".

- Medical, dental, and vision expenses that exceed your health care plans' maximums – for example, charges that exceed reasonable and customary limits, and charges that exceed annual, lifetime or treatment limits

- Expenses that are not covered by health care plans, such as private hospital room charges eye exams, eyeglasses, special features for eyeglasses, contact lenses and supplies, and laser eye surgery to the extent these charges are not covered by other medical or vision plans

- Insulin

- Fertility enhancement

- Psychiatric care, psychoanalysis, and psychologist's fees that are not covered or that exceed Medical Plan option limits

- Stop-smoking programs and medications, if prescribed by a physician

- Weight loss programs for the treatment of an existing disease, including weight loss medications, if prescribed by a physician

- Special education or learning disability fees for the treatment of a specific medical condition

- Transportation expenses for medical care, and cost of meals and lodging at a hospital or similar institution

- Nursing-home care and long-term care to the extent charges do not constitute "qualified long-term care services" under Section 7702B of the Internal Revenue Code

- Fees for special homes for the mentally handicapped if recommended by a psychiatrist

- Capital expenses for special medical equipment installed in your home or for certain improvements made to your home to accommodate your or your dependents' disabled condition

- Lead-based paint removal to prevent a child who has (or has had) lead poisoning from ingesting paint

- Special equipment for disabled persons, such as special hand controls and other equipment installed in a car in order for a disabled person to operate a car

- Hearing aids, the cost and repair of special telephone equipment for the hearing-impaired, and the cost of equipment that displays the audio part of television programs for the hearing-impaired

- Guide dogs and Braille books and magazines

## Ineligible Expenses

Listed below are examples of expenses that are not eligible for reimbursement from your Health Care FSA. Contact WageWorks directly or go to www.wageworks.com for a complete list of ineligible expenses.

- Marriage or family counseling
- Custodial care in an institution or a nursing home
- Cosmetic treatments or surgery (including face-lifts, liposuction, electrolysis, and hair transplants), unless for correction of disfigurement due to an accident or a birth defect
- Expenses for general well-being, such as health club dues, YMCA dues, exercise classes, swimming lessons, dancing lessons, steam baths, vitamins (unless prescribed by a physician for a specific health problem), nutritional supplements, and personal use items. Items such as these are covered only when you submit with your claim a letter of medical necessity from the prescribing physician.
- Costs associated with weight loss or stop-smoking programs, unless prescribed by a physician for a specific health problem. These costs are covered only when you submit with your claim a letter of medical necessity from the prescribing physician.
- Over-the-counter medicines or drugs for which you have not received a prescription

# Eligible Dependent Care Expenses

You can use your Dependent Care Spending Account option for child care expenses for your children under age 13 or for day care expenses for a disabled spouse or other dependent who is incapable of self-care.

## Eligible Dependents for Your Dependent Care Spending Account Option

The purpose of the Dependent Care FSA is to reimburse you for day care that is needed to allow you, and your spouse if you are married, to work. You also can be reimbursed for day care while your spouse is attending school as a Full-Time Student or if your spouse is incapable of self-care due to a mental or physical condition.

For this option, a qualifying dependent is either of the following:

- A dependent child who is under age 13 years at the time the care is provided and for whom you can claim an exemption on your federal income tax return

- A mentally or physically disabled child or adult, if he or she lives with you, depends on you for at least half of his or her financial support, and is incapable of caring for himself or herself

**Information About Your Day Care Provider**
You'll need your day care provider's name and address as documentation when you file a claim for dependent care expenses. You'll also need your provider's tax ID number when you file your taxes each year. (Note that a tax ID number is not required for a tax-exempt church day care provider.)

If you're divorced or legally separated and have custody of your children, but your former spouse claims them as dependents for income tax purposes, you can be reimbursed for their dependent care expenses if you have custody of them for more than six months during the year.

A dependent does not need to meet the definition of qualified dependent under other company plans to qualify as a dependent under the Dependent Care FSA.

## Eligible Dependent Care Expenses

Generally, any expense that qualifies for inclusion under the "Credit for Child and Dependent Care Expenses" section on your federal income tax return also qualifies for reimbursement from the Dependent Care Spending Account option. For a complete and up-to-date list of eligible expenses, go to www.wageworks.com. Listed below are a few examples of eligible expenses:

- Care provided in your home by a babysitter or nurse (if a nurse is providing medical services, those expenses do not qualify under the Dependent Care Spending Account option, but may qualify under the Health Care Spending Account option)

- Care provided in your home (such as bathing and preparing meals) for a disabled person or an elderly dependent living with you

- Day care given outside your home by a Qualified Child Care Provider
- Before-school and after-school care
- School tuition, up to and including pre-kindergarten
- Dependent day care expenses incurred while your spouse either is disabled or is a Full-Time Student – even though your spouse does not work

## Ineligible Dependent Care Expenses

Below are examples of dependent care expenses that are *not* eligible for reimbursement. For a complete list of ineligible expenses, go to www.wageworks.com**.**

- Services provided for a child who is age 13 or older
- Any expenses reimbursable through any other benefit plans, including your spouse's employer-provided plans, a separate individual insurance policy, and coverage under any government programs
- School tuition for kindergarten through twelfth grades
- Fees charged by an overnight camp
- Any expenses that are claimed as a deduction on your income tax return
- Services provided by your child under age 19 (even if you do not claim that person as a dependent on your income tax return)
- Services provided by your spouse or a person you claim as a dependent on your tax return (such as a relative who lives with you)
- Any expenses that could not be claimed as a deduction on your federal income tax return
- Charges for nursing-home care

# How to Receive FSA Benefits

The benefit of your FSA options is to pay your health care and dependent care expenses with tax-free dollars. During the Plan Year, as you incur eligible expenses, you can receive benefits:

- By having eligible expenses automatically drawn from the Health Care FSA (by using your WageWorks FSA card) for any medical, prescription drug, dental, or vision provider
- By paying for eligible expenses yourself and submitting paper claims for reimbursement

**For More Information**
Go to WageWorks (www.wageworks.com) to:
- Get a list of providers and merchants who accept the card
- Find out about card transaction limits for various services and provider categories
- Get more information about your card and how to use it
- Print forms for filing paper claims

## Grace Period

Be sure to submit claims for all expenses incurred while you are a participant in the FSA options. If you participate in an FSA this year, you must submit your claims for expenses incurred this year before the claim submission deadline of March 31 of next year. Any amounts remaining in your account after March 31 will be forfeited.

## Having Eligible Expenses Paid Automatically

You can use the Health Care FSA to pay your Copayments or Coinsurance at your pharmacy, hospital, and doctor's or dentist's office. HSA and FSA participants can use the FSA to pay automatically for eligible dental and vision expenses (see sidebar).

**Participants in the HSA Option**
You will receive a WageWorks HSA/FSA card to use for your Health Savings Account (HSA) and also your FSA. Remember, if you have the MyHelath HSA option, your Health Care Spending Account can only be used to reimburse eligible dental and vision expenses until you meet your Deductible.

**Participants in Other Medical Plan Options**
You will receive a WageWorks card that you can use for reimbursements from your Health Care FSA.

## Paying Eligible Expenses Yourself and Submitting Claims for Reimbursement

You have the option of paying for some eligible expenses yourself and then filing your claims for reimbursement by fax or by mail.

### Fax or Mail

You can obtain a paper claim form by calling WageWorks directly or visiting www.wageworks.com. Once you've completed and signed the claim form, you'll need to include itemized receipts or other required documentation of your expenses with your form when you fax or mail it to WageWorks for processing.

## Where Do I Send My Claim Form?

| **Fax your claim to:** | 1-877-353-9236 |
|---|---|
| **Mail your claim to:** | WageWorks - Claims Administrator<br>P.O. Box 14053<br>Lexington, KY 40512 |

## Save All Bills, Receipts, and Other Documentation

Whether you pay expenses with your Wage Works card or you submit a claim for reimbursement by fax or mail, you must get itemized receipts or other required documentation for products purchased or services rendered. You'll need to turn in these receipts when you file a claim, and you may need to provide this documentation for validation purposes when using your card. If you don't provide this supporting documentation, your claim will not be processed, you won't be reimbursed, and your account may become suspended.

### Documents You'll Need to Provide for Claim Processing

You must provide proper supporting documentation to WageWorks so that your claim can be approved. This includes itemized receipts or other documentation, such as an Explanation of Benefits (EOB) statement from your health plan if you do not have a BCBSTX health care option.

## Your Receipts Should Include This Information

| Health Care Claims | Dependent Care Claims |
|---|---|
| An itemized receipt must include the following:<br>• Date of service<br>• Name of service provider<br>• Name of patient (not required for over-the-counter drugs)<br>• Name of drug, product or type of service provided<br>• Amount paid | If you use a care provider or day care service, your receipt must contain the following:<br>• Dates of service<br>• Name of service provider<br>• Name of dependent receiving services<br>• Amount paid |

If the receipt is handwritten, it must include the service provider's signature. For prescription drugs, submit the receipt that the pharmacist attaches to the prescription – don't submit the cash register receipt.

If you have medical insurance, proof (such as an EOB) of any amount paid by other coverage is required.

If you've lost a receipt, contact your doctor or pharmacy to request a copy, or call your health plan for an EOB. If you don't provide the necessary information, the processing of your claim may be delayed. Visit WageWorks at www.wageworks.com for more documentation requirements concerning medical necessity, orthodontia, and other services.

### Information Required for Dependent Care Providers

Federal tax rules require you to report the care provider's name and address for any dependent care expense claims. This applies both to expenses reimbursed from your Dependent Care Spending Account option and to expenses you claim as a tax credit on your federal income tax return. If you do not include this information when filing your federal income tax return, any Dependent Care

Spending Account option reimbursements that you received for payment of that provider's services may become taxable income to you.

## Payment of Flexible Spending Account Reimbursements

Your mailed claim will be processed as soon as administratively possible – usually within 10 days after WageWorks receives your paperwork. For faster processing, submit your claims online or via mobile app. You may also fax your signed and completed claim form and supporting documentation to WageWorks.

If you participate in direct deposit with your bank, reimbursements are deposited directly to your bank account; otherwise, a check is mailed to your home.

## How Much You Can Receive

### Health Care Flexible Spending Account

At any time during the Plan Year, you can be reimbursed for up to the total amount of your Health Care Flexible Spending Account election. Your ongoing contributions will fund the deficit in your account for the remainder of the year.

### Dependent Care Flexible Spending Account

If the balance in your account is enough to reimburse your entire claim, you will be reimbursed for the full amount of eligible expenses. If the claim is for more than your current balance, you will be reimbursed for the amount of your current balance. The remaining claim will automatically be recorded and paid to you as additional contributions are made.

## Account Balance Information

You can visit WageWorks online or call WageWorks Member Services at any time to verify the amount of your annual contribution elections, obtain a summary of account transactions, and confirm current account balance(s) for each Flexible Spending Account option in which you are participating.

## If a Claim Is Denied

There is a procedure to follow to obtain a full and fair review if a claim is denied and you believe it should be paid. See "Claim Review and Appeal Process" in the "Plan Administration" section.

# Situations Affecting Your FSA Participation

Participation in the FSA options stops automatically if your paycheck stops for any reason (for example, when you leave the company or take an unpaid leave of absence).

Participation also stops every December 31. If you want to participate in an FSA option during the next calendar year, you need to enroll during the open enrollment period. Claims for the current year will be accepted through the claims deadline that ends March 31 of the following year.

## Health Care Flexible Spending Account

If your contributions to this account stop during the year for any reason, only expenses you have incurred up to the date of the last deduction are eligible for reimbursement. Any remaining balance is forfeited. Claims for expenses in the current year incurred on or before the date of the last deduction will be accepted through the claims deadline that ends March 31 of the following year. Your participation may continue under COBRA, as described in the "Life Events" section.

## Dependent Care Flexible Spending Account

If your contributions to this account stop during the year for any reason, you can continue to submit claims for expenses incurred before your participation ended, up to the remaining balance. Claims for the current year will be accepted through the claims deadline that ends March 31 of the following year.

## Protection From Court Order

To the extent permitted by law, any money in your FSA options cannot be attached or garnisheed to pay for your debts and liabilities.

# Life and Accidental Death and Dismemberment (AD&D) Insurance

# Life and Accidental Death and Dismemberment (AD&D) Insurance Contents

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# Life Insurance and AD&D Insurance Options

You and your family depend upon your income to meet living expenses. Those income needs don't stop if you die or are seriously injured. That's why the company offers Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance options.

If you are eligible for the Plan, you have several types of life and AD&D insurance coverage available to you:

- The Employee Life option pays a benefit to your beneficiary if you die.
- The Spouse Life and Child Life options pay a benefit to you if your spouse or child dies.
- The Employee AD&D option pays a benefit to you if you have certain serious injuries, or it pays a benefit to your beneficiary if you die in an accident. You can also elect coverage for your spouse and children.

If you were employed prior to January 1, 1991, you had, at that time, the option to keep your coverage under the frozen former life insurance program (called Program A) or change coverage to that offered under the new flexible benefits program. If you chose to keep your Program A coverage, your coverage is different from that offered under the current option.

**Program A**
If you chose to remain in Program A, you can elect the Plan Life Insurance options during any annual enrollment period or when you have a qualified status change. However, you cannot transfer back to Program A at a later date.

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

This section provides a summary of the life and AD&D insurance coverage available to eligible employees and their dependents. If you have any questions about the information in this section, log on to MyWorkday or call the Benefits Service Center at 1-844-469-9539.

Coverage for eligible part-time employees is based on 20 hours of work each week. So your annual base pay is calculated by multiplying your hourly rate of earnings by 1,040 hours.

## Group Term Life Insurance

All of the life and AD&D insurance currently offered is group term insurance. There is no cash accumulation for term life insurance. However, when you retire or leave Vistra Energy, the Employee Life, Spouse Life, and Child Life options may be portable. AD&D insurance is not portable.

# Your Life Insurance and AD&D Insurance Fact Sheet

You have the following Life Insurance and AD&D Insurance options available to you when you make your Plan elections each year.*

| Type of Coverage | Coverage Amount |
|---|---|
| **Basic Life (company paid)** | 1 × pay |
| **Optional Basic Life** | 1, 2, 3, 4, 5 or 6 × pay |
| **Spouse Life** | .25, .50, 1, 2, 3, 4, 5 or 6 × pay |
| **Child Life** | $10,000, $15,000 or $20,000 |
| **Basic AD&D (company paid)** | 1 × pay |
| **Optional Employee AD&D** | |
| • Employee coverage | 1, 2, 3, 4, 5 or 6 × pay |
| • Family coverage | 1, 2, 3, 4, 5 or 6 × pay |

Note – Spouse coverage cannot exceed the amount of coverage the employee has. Dependent life cannot be elected unless Employee Option Life is elected.

* If you are an employee who chose to continue life insurance under Program A, see the "Program A" section for a description of coverage. If you are an LTD employee and eligible for coverage under Program B, see the "Program B" section for a description of coverage.

# Employee Life Option

## Employee Life Insurance Coverage Choices

The company provides a benefit of one times your annual pay.

You can choose employee-paid coverage of one, two, three, four, five, or six times your annual pay. If the resulting coverage amount is not an even multiple of $1,000, it is rounded to the next higher $1,000 (see example below).

**Employee Life Option Coverage Choices**
1 × pay
2 × pay
3 × pay
4 × pay
5 × pay
6 × pay

Your "annual pay" means your adjusted annual salary or wages as of October 1st immediately preceding the start of the benefit year. For example, your employee life insurance coverage for 2017 will be based on your adjusted annual salary or wages as of October 1, 2016. It does not include overtime or other extra pay. If your annual pay changes during the year (for example, when you get a raise), neither your costs for life insurance nor the amount of your life insurance benefit will change until the next open enrollment period.

At each enrollment period, you can increase your Employee Life option coverage by one coverage level (for example, from one times pay to two times pay, or from two times pay to three times pay) without providing Evidence of Insurability (EOI). However, if you do not currently have optional employee life coverage and select coverage during an enrollment period, or if you choose to increase your optional employee life coverage by more than one times annual base pay at open enrollment, or you choose coverage of four, five or six times annual base pay, you will be required to provide EOI. The maximum Employee Life option coverage available is $2,000,000 (two million).

For more information about making your Plan elections, see the "Plan Participation" section.

**Premiums Based on Smoker Status**
Your premiums for the Employee Optional Life option and the Spouse Life option are based on whether or not you use tobacco products. You are considered to "use tobacco products" if, in the previous year, you smoked cigarettes, pipes or cigars; used snuff; or chewed tobacco. Rates are announced each year during the open enrollment period.

### An Example

Here's an example of how coverage is calculated for the Employee Life option. Assume your annual base pay is $42,500 and you elect coverage of three times pay. Since the result – $127,500 – is not an even multiple of $1,000, it is rounded up to $128,000.

### Beneficiary

Benefits are paid to the beneficiary you name (see the "Plan Participation" section).

### Accelerated Benefits Option

If you have a terminal illness with a life expectancy of 24 months or less, you can elect to receive a portion of your life insurance benefit before your death.

You can receive up to 80% of the face value of your insurance coverage. The minimum payout is $20,000. The maximum payout is $500,000.

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

All claims for this option must be certified by a licensed physician and approved by the insurance carrier. You may be asked to have a physical exam by a doctor chosen by the insurance carrier.

You cannot choose this option if you assign your life insurance coverage.

## When Benefits Are Not Paid

Benefits are not paid for suicide committed within two years after coverage starts. After that, benefits for any coverage increase are not paid for suicide committed within two years after the coverage increase goes into effect.

## When Employee Life Insurance Coverage Ends

In addition to other situations, the Employee Life option ends when you retire or leave the company. In some cases, you can continue coverage under the portability or conversion feature. For a complete list of events that may result in the end of coverage, please refer to the Certificate of Insurance for this benefit.

If you retire from Vistra Energy, your coverage ends.

# Spouse Life Option

## Eligibility

You can enroll for the Spouse Optional Life option if you are enrolled for the Employee Optional Life option.

For more information about making your Plan elections, see the “Plan Participation” section.

## Eligible Spouse

For this option, your spouse is eligible for coverage if you are legally married and if your spouse lives in the United States or Canada and is not serving in the armed forces.

If you and your spouse both work for a Participating Employer and your spouse is eligible for coverage as an employee, you cannot enroll for the Spouse Life option. In addition, only one of you can elect the Child Life option.

## Spouse Life Option Coverage Choices

You can choose any of the Spouse Life coverage choices available through the Plan (see sidebar). The coverage choices are based on your annual pay. If the result is not an even multiple of $1,000, it is rounded up to the next higher $1,000.

You cannot choose Spouse Life coverage that is greater than your Employee Life coverage, and there is a maximum coverage limit of $250,000 for the Spouse Life option.

**Spouse Life Option Coverage Choices**

.25 × pay
.50 × pay
1 × pay
2 × pay
3 × pay
4 × pay
5 × pay
6 × pay

At each enrollment period, you can increase your Spouse Optional Life coverage by one coverage level (for example, from one times pay to two times pay, or from two times pay to three times pay) without providing Evidence of Insurability (EOI). However, if you do not currently have Spouse Optional Life coverage and select coverage during an enrollment period, or if you choose to increase your Spouse Optional Life by more than one coverage level, or you choose coverage of four, five or six times annual base pay, your spouse will be required to provide EOI. EOI is provided by answering medical questions online. MetLife must approve your application before coverage can go into effect.

## Beneficiary

You are automatically the beneficiary for the Spouse Life option, and any benefits are paid to you.

## Accelerated Benefits Option

If your spouse has a terminal illness with a life expectancy of 24 months or less, you can elect to receive a portion of the Spouse Life option benefit before your spouse’s death.

You can receive up to 80% of the face value of your spouse's coverage. The minimum payout is $20,000. The maximum payout is $200,000.

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

All claims for this option must be certified by a licensed physician and approved by the insurance carrier. Your spouse may be asked to have a physical exam by a doctor chosen by the insurance carrier.

You cannot choose this option if you assign your Spouse Life option.

## When Benefits Are Not Paid

Benefits are not paid for suicide committed within two years after coverage starts. After that, benefits for any coverage increase are not paid for suicide committed within two years after the coverage increase goes into effect.

## When the Spouse Life Option Ends

In addition to other situations, the Spouse Life option ends when your employment ends, you retire, or your spouse no longer meets the eligibility requirements for coverage. However, coverage is portable and can be continued when you leave the company or when your spouse becomes ineligible. Otherwise, a conversion privilege may apply. For a complete list of events that may result in the end of coverage, please refer to the Certificate of Insurance for this benefit.

# Child Life Option

## Eligibility

You can enroll your children for the Child Life option if you are enrolled for the Employee Optional Life option.

For more information about making your Plan elections, see the “Plan Participation” section.

## Eligible Children

For the Child Life option, your eligible children include the following:

- Your natural child, adopted child, or stepchild, who is under age 26, unmarried, and not serving in the Armed Forces
- Your unmarried child of any age who becomes physically or mentally disabled before reaching age 26. You must apply to continue the Child Life option and you must provide proof of disability at least 31 days before the child reaches this age limit. Coverage will continue as long as your child (1) has a disability that prevents him or her from engaging in self-sustaining employment, and (2) otherwise meets all the qualifications of a child (that is, unmarried, supported by you, and not employed full-time)
- Your grandchild(ren) resididing with you and able to be claimed by you as a dependent for Federal Income Tax purposes at the time you applied for Life Insurance who is under age 26 and unmarried

A child will be considered your adopted child during the period you are party to a suit in which you are seeking the adoption of the child.

**The term does not include** any person who:

- Is in the military of any country or subdivision of any country; or
- Is insured under the Group Policy as an employee

If your eligible child works for a Participating Employer and is eligible for coverage as an employee, that eligible child is not eligible for the Child Life option. If you and your spouse both work for a Participating Employer, only one of you can elect the Child Life option.

## Child Life Coverage Choices

You can choose any of the Child Life option coverage choices available through the Plan (see sidebar).

| Child Life Coverage Choices |
|---|
| $10,000 |
| $15,000 |
| $20,000 |

When you elect the Child Life option, all of your eligible dependent

children must be enrolled. The cost of the coverage is the same, regardless of the number of eligible children you have.

## Beneficiary

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

## When Benefits Are Not Paid

Benefits are not paid for suicide committed within two years after coverage starts. After that, benefits for any coverage increase are not paid for suicide committed within two years after the coverage increase goes into effect.

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

## When the Child Life Option Ends

In addition to other situations, the Child Life option ends when your employment ends, you retire, or your child no longer meets the eligibility requirements for coverage. However, you or your spouse can elect to convert the Child Life option coverage. For a complete list of events that may result in the end of coverage, please refer to the Certificate of Insurance for this benefit.

# Accidental Death and Dismemberment (AD&D) Insurance Options

## Employee AD&D Option Coverage Choices

You can choose any of the Employee AD&D option coverage choices available through the Plan (see sidebar).

You can choose coverage for yourself in increments of your annual base pay up to six times your annual base pay. If the result is not an even multiple of $1,000, it is rounded up to the next higher $1,000.

Coverage for eligible part-time employees is based on 20 hours of work each week. So your annual base pay is calculated by multiplying your hourly rate of earnings by 1,040 hours.

AD&D Insurance Options

**Basic AD&D (company paid)**
1 × pay

**Optional AD&D Coverage Choices**
1 × pay
2 × pay
3 × pay
4 × pay
5 x pay
6 x pay

## Dependent AD&D Option Coverage Benefits

If you choose the Dependent AD&D option, following are the benefit levels that would be paid for each family member:

- If you have a spouse only (no children): 60% of Employee AD&D option
- If you have children only (no spouse): 15% of Employee AD&D option
- If you have a spouse and children: Spouse coverage is 50% of Employee AD&D option; child coverage is 10% of Employee AD&D option

For more information about making your Plan elections, see the “Plan Participation” section.

## Eligible Dependents

Your eligible dependents for AD&D coverage are defined in the same way as for dependent life insurance coverage.

## What AD&D Covers

AD&D benefits are payable if you or your dependents die or suffer certain losses as the result of an accident.

AD&D covers certain losses of body parts, and it covers death caused by accidental injuries. If your loss occurs within 12 months of the accident, you or your beneficiary will receive a predetermined amount based on your annual base pay.

AD&D benefits are paid according to the following schedule:

| Accidental Loss | Percentage of Benefit Paid |
| --- | --- |
| Loss of life | 100% |
| Loss of two or more: hand, foot, or sight of eye | 100% |
| Loss of one: hand, foot, or sight of eye | 50% |
| Thumb and index finger of same hand | 25% |
| Speech and hearing | 100% |
| Speech or hearing in both ears | 50% |
| Quadriplegia | 100% |
| Paraplegia | 50% |
| Hemiplegia | 50% |

**Loss of hands and feet** means the loss by severance at or above the wrist or ankle. **Loss of thumb and index finger** means actual severance through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb. **Quadriplegia, paraplegia, and hemiplegia** mean the total paralysis, or permanent and complete loss of use of a limb, as determined by a physician, of both upper and lower limbs (quadriplegia), both lower limbs (paraplegia), or upper and lower limbs on one side of the body (hemiplegia). **Loss of sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees. **Loss of speech** means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury. **Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

Only the loss providing the highest amount of insurance is paid for each accident. Once benefits for one loss have been paid, you cannot submit claims for later losses caused by the same accident.

## Beneficiary

The Employee AD&D option pays a benefit to the beneficiary you name (see the “Plan Participation” section) if you die in an accident. You are the beneficiary for AD&D benefits if you are injured in an accident or if your covered spouse or child dies or is injured in an accident.

## When AD&D Benefits Are Not Paid

Some losses are not covered. AD&D benefits are not paid for a loss if it in any way results from, or is caused or contributed to by (additional details are available in the Certificate):

- Physical or mental illness, diagnosis of or treatment for the illness
- An infection, unless it is caused by an external wound that can be seen and which was sustained in an accident
- Suicide or attempted suicide
- Self-inflicted injury

- The voluntary intake or use by any means of:
  - Any drug, medication or sedative unless it is taken or used as prescribed by a physician
  - An over-the-counter drug, medication or sedative unless it is taken as directed
  - Alcohol in combination with any drug, medication or sedative
- A war or warlike action in time of peace, including terrorist acts, participation in an insurrection, rebellion or riot
- Committing or trying to commit a felony or other serious crime or an assault
- Any poison or gas, voluntarily taken, administered or absorbed
- Service in the armed forces of any country or international authority, except the United States National Guard. Service in reserve forces does not constitute service in the armed forces.
- While in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self-preservation). Travel in an aircraft in any capacity other than as a passenger, or for the purpose of parachuting, except for self-preservation
- Driving a vehicle while intoxicated, as defined by the laws of the jurisdiction in which the vehicle was being operated

## When AD&D Coverage Ends

In addition to other situations, coverage under the AD&D Insurance options (including coverage for your dependents) ends when you retire, when your employment ends, or when you enter the armed forces, or you go out on Long-Term Disability. Coverage for your dependents also ends if they no longer meet the eligibility requirements for coverage. There are no conversion or portability rights for AD&D coverage. For a complete list of events that may result in the end of coverage, please refer to the Certificate of Insurance for this benefit.

# Program A

## Eligibility

If you previously elected Program A and have not disenrolled, you have the employee and dependent life insurance described on this page instead of the Employee Life option, Spouse Life option, and Child Life option described earlier in this “Life and Accidental Death and Dismemberment (AD&D) Insurance” section.

You can change to the Employee Life option under the Plan during any open enrollment period or if you have a qualified status change (see the “Plan Participation” section). However, once you move out of Program A, you cannot re-enroll in Program A.

## Program A Coverage

| Type of Coverage | Coverage Amount |
|---|---|
| **Employee Life insurance**<br>• Company-paid coverage<br>• Employee-paid coverage | <br>First $20,000<br>2 × pay (less $20,000 company paid) |
| **Spouse Life insurance** | $15,000 |
| **Child Life insurance** | $5,000 |

### Employee Life Insurance Options

Under Program A, you have coverage of two times your annual pay, of which the company pays for the first $20,000.

### Dependent Life Insurance

You can elect dependent life insurance of $15,000 for your spouse and $5,000 for each child.

## Accelerated Benefits Option

If you have a terminal illness with a life expectancy of 24 months or less, you can elect to receive a portion of your life insurance benefit before your death.

You can receive up to 80% of the face value of your insurance coverage. The minimum payout is $20,000. The maximum is $500,000.

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

All claims for this option must be certified by a licensed physician and approved by the insurance carrier.

## When Coverage Ends

In addition to other situations, Employee coverage ends when you retire or leave the company. In some cases, you can convert coverage to an individual policy; however, portability is not applicable to Program A employees.

Dependent life insurance ends when your employment ends, you retire, or you are no longer participating in the life insurance program, your employment otherwise ends, or the plan ends. A conversion privilege may apply for spouse life insurance.

For a complete list of events that may result in the end of Employee and/or Dependent coverage, please refer to the Certificate of Insurance for this benefit.

# Program B

## Eligibility

You participate in Program B if you are receiving LTD benefits for a disability that started before 2002.

## Program B Coverage

| Type of Coverage | Coverage Amount |
|---|---|
| **LTD Employee Life insurance**<br>• Basic coverage<br>• Optional Employee-paid coverage | <br>1 × pay<br>1, 2 or 3 × pay |
| **Spouse Life insurance** | $15,000 |
| **Child Life insurance** | $5,000 |

### LTD Employee Life Insurance Options

Under Program B, the company provides coverage equal to one times your annual pay. You can choose employee-paid coverage of an additional one, two or three times annual pay. The cost of this additional coverage is age-related. The rates are announced each year during the open enrollment period.

### Dependent Life Insurance

You can elect dependent life insurance of $15,000 for your spouse and $5,000 for each child.

## Accelerated Benefits Option

If you have a terminal illness with a life expectancy of 24 months or less, you can elect to receive a portion of your life insurance benefit before your death.

You can receive up to 80% of the face value of your insurance coverage. The minimum payout is $20,000. The maximum is $500,000.

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

All claims for this option must be certified by a licensed physician and approved by the insurance carrier.

## When Coverage Ends

In addition to other situations, coverage ends when you retire, on the date you die, or if you stop paying the premiums. In some cases, you can convert coverage to an individual policy.

Dependent life insurance ends when you retire, you are no longer participating in the life insurance program, your employment otherwise ends, or the plan ends. A conversion privilege may apply for your spouse.

For a complete list of events that may result in the end of Employee and/or Dependent coverage, please refer to the Certificate of Insurance for this benefit.

# Filing a Claim

In the event of your death, please ensure that your beneficiary knows to contact the Benefits Service Center as soon as possible for information about benefits that are payable and about available payment options.

If a dependent dies or has a covered AD&D loss, or if you have an AD&D loss other than death, you should notify the Benefits Service Center.

A death certificate or proof of other loss will be required when you file the claim. You or your beneficiary should file the claim as soon as possible after the death or loss.

## Source of Payments

All of the benefits described in this section are paid through insurance policies with Metropolitan Life Insurance Company (MetLife).

## If a Claim Is Denied

If a claim is denied but you or your beneficiary believes it should be paid, you can request a full and fair review of the claim. For more information, see "Claim Review and Appeal Process" in the "Plan Administration" section.

# Situations Affecting Plan Benefits

The Plan is designed to provide a wide range of protection. But some situations could affect your benefits. Those situations are summarized below.

- If you leave the company for any reason other than retirement or long-term disability, or if you are no longer a member of the eligible employee group, coverage will end. However, you can continue coverage through the Plans' portability or conversion features. For more information, contact the Benefits Service Center.

- If you are no longer eligible for benefits under the company's Long-Term Disability (LTD) Benefit options and you do not return to work for the company, your coverage will end. You can continue coverage through the Plans' portability or conversion features. For more information, contact the Benefits Service Center.

- If you do not furnish proof of loss, or if you do not furnish it within the prescribed time period, payment of your benefits will be delayed or denied.

- If you fail to make any required contributions for coverage when they are due, your coverage will end.

## If the Plan Ends

The company currently intends to continue these benefits indefinitely. However, the company reserves the right to end, suspend, withdraw, or amend the Plan in whole or in part, from time to time, in the sole discretion of the company. If the Plan should end, benefits may be paid for any valid claims incurred prior to such termination.

# Portability and Conversion

When you leave Vistra Energy, you can continue the Employee Life option coverage through portability or by converting your coverage to an individual policy.

- MetLife's portability provision gives you two advantages: You can continue coverage without providing the Evidence of Insurability that would be required if you were applying for an individual policy, and you can continue a significant level of coverage at the lower group rates that Vistra Energy can get through group purchasing power.
- MetLife's conversion policy allows you to convert coverage to an individual policy without providing Evidence of Insurability. Or, if you elect the portability provision, you can convert any remaining amount that exceeds the portability maximum.

## Portability

Under most circumstances, you can continue the Employee Life option (not including Program A and B), the Spouse Life option, and the Child Life option through the Plan's portability provisions if your employment ends or you are no longer eligible for coverage. Your spouse can continue the Spouse Life option and the Child Life option in the event you die or you are divorced. A child cannot continue the Child Life option unless you or your spouse is also continuing coverage.

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

To continue coverage, you (or your spouse) must, within 31 days after the date your coverage ends, give MetLife written notice of your intention to continue coverage. Conversion or portability should be applied for **within 31 days** from the date benefits are terminated **or** 45 days from the date a notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated.

You can continue the same amount of coverage you had with the company on the date your coverage ends. You may contact MetLife Recordkeeping Center at 1-866-492-6983 for any additional questions regarding portability. You cannot continue a higher amount of coverage for your dependents than you continue for yourself.

You pay the coverage premiums directly to MetLife.

## Converting Your Coverage

Under most circumstances, you can convert the Employee Life option (including Program A), the Spouse Life option, and the Child Life option when coverage ends (for example, if your employment ends or if you or a dependent is no longer eligible for coverage). If you choose the portability feature but are not able to port your entire amount of life insurance coverage, you can convert any remaining amounts to an individual policy.

When you convert coverage to one of the insurance company's individual life policies, you do not need to provide Evidence of Insurability (proof of good health).

The benefits and provisions of the individual policy will be different from the Vistra Energy Life Insurance options. For example, the individual policy will *not* be a term life insurance policy. You may be able to find better rates or coverage on your own through another insurance carrier.

To convert coverage, you must:

- Notify the Benefits Service Center of your intention to convert coverage
- Complete and submit an application within 31 days after coverage ends
- Pay the first premium within 31 days after coverage ends

If you have questions about converting your coverage, contact MetLife directly. Note that special provisions and limits apply if your coverage should end because of a Plan amendment or termination. Since MetLife does not currently hold responsibility for providing the conversion notice, terminated employees should first contact the Benefits Service Center for the conversion/portability form with completed Employer information. Once they are provided with the form, they may contact MetLife directly at 1-877-ASKMET7.

You cannot convert AD&D coverage to an individual policy.

# Disability

# Disability Contents

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# Long-Term Disability (LTD) Benefit Option

No one wants to be sick or injured. Besides the worry of medical expenses and getting back to good health, you still need to receive an income to pay the bills. That's what LTD is all about – coverage that replaces part of your income while you are disabled.

If you are an eligible employee, you have two types of disability coverage available under the Plan:

- Short-term disability (STD)
- Long-term disability (LTD) coverage to protect your income if you are disabled for an extended period of time

Short Term Disability is a payroll practice and coverage is described on Connect under "Policies and Procedures." This section of your handbook describes LTD. If you have any questions about your LTD coverage, log on to the http://efhconnect/ or call the Benefits Service Center at 1-844-469-9539.

For more information on LTD benefits, please see the Certificate of Insurance .

## LTD Benefit Option Coverage Choices

See the "Plan Participation" section for more information about enrolling for the Plan. As an employee, you are provided LTD coverage at 60% pay replacement on a pretax basis. Any benefits received will be taxed. You have the option to elect a 60% post tax benefit which means any benefits received will not be taxed.

## Pretax or After-Tax Contributions

If you elect to pay the premiums for LTD coverage using after-tax contributions, any benefit payments you receive while you are disabled will not be taxed.

## Medical Coverage For Employees Receiving LTD Benefits

For disabilities beginning on or after January 1, 2016, after completing the required elimination period and becoming eligible for LTD benefits, you can continue to pay for all of your Medical, Dental, Vision, and Life Insurance coverages provided you were enrolled in them prior to your disability at employee rates for a maximum of 2 years.

After 2 years you have the following options:

- If you are age 55 with 16 years of service, you can retiree and continue your medical, dental, vision and life insurance as a retiree
- If you are not age 55 with 16 years of service, you can continue medical coverage through Medicare and any dependents covered under the Medical Option plan will be offered COBRA.

For those disabilities that began before January 1, 2016, after completing the required elimination period and becoming eligible for LTD benefits, you can continue to pay for all of your Medical, Dental, Vision, and Life Insurance coverages provided you were enrolled in them prior to your disability at employee rates until you are eligible for Medicare.

# How Your LTD Benefit Is Calculated

If you become disabled, you may be eligible for income from several different sources (see sidebar). The LTD benefit options are designed to work with these other sources to continue a total of 60% of your monthly pay (depending on your Plan election). In other words, the LTD benefit options are designed to make up the difference between the 60% benefit level and any benefits payable from these other sources.

**Other Sources of Disability Income**
Examples of other sources of disability income that may be payable because of your disability include:

- Social Security disability or retirement benefits that you receive or are eligible to receive because of your disability
- Workers' compensation
- Any third-party award, settlement, or payment resulting from your disability
- Any other disability benefit you receive under any applicable federal, state, or local statute, rule, or ordinance

For the LTD benefit options, your "pay" means your regular predisability earnings. Predisability earnings means gross salary or wages you were earning from Vistra Energy as of your last day of Active Work before your disability began. The term does not include:

- commissions;
- bonuses;
- overtime pay;
- awards and the grant, award, sale, conversion and/or exercise of shares of stock or stock options;
- Vistra Energy's contributions on your behalf to any deferred compensation arrangement or pension plan; or
- any other compensation from Vistra Energy

## An Example

Following is an example to show how an LTD benefit might be calculated. Your annual pay is $36,000, so your monthly pay is $3,000. You are eligible for a monthly Social Security benefit of $1,200. Your benefit would be calculated like this:

| LTD Benefit Example | |
|---|---|
| Monthly LTD benefit level equals 60% of your $3,000 monthly pay | $1,800 |
| Monthly Social Security pays this amount | $1,200 |
| Monthly LTD benefit makes up remainder | $600 |

If you apply for, but are not eligible for Social Security or other sources of income, the LTD benefit would be the entire amount, or $1,800 a month.

# When Can I Receive LTD Benefits?

LTD benefits are payable if you have a disability that prevents you from working and you meet the Plan's disability requirements. Disabled or disability means that, due to sickness or as a direct result of accidental injury, you are prevented from working. You're considered disabled if you have a physical or mental illness or an injury and if:

- you are receiving appropriate care and treatment and complying with the requirements of such treatment; and
- during the elimination period and the next 24 months of sickness or accidental injury, you are unable to earn more than 80% of your predisability earnings at your own job from any employer in your local economy; and unable to perform each of the material duties of your own job; and
- after 24 months of disability, the disability prevents you from working at any job for which you're qualified by education, training or experience and unable to earn more than 60% of your predisability earnings from any employer in your local economy at any gainful occupation for which you are reasonably qualified taking into account your training, education and experience

In order to receive, and to continue to receive, LTD benefits, you must be under the care or supervision of a physician at all times for the disability. From time to time, to confirm your disability status, MetLife will ask you to have a physical exam by a doctor chosen by MetLife. To continue to receive LTD benefits, you must take these examinations, and you must supply MetLife with the result, along with other requested information concerning your condition. For participants who began LTD benefits prior to January 1, 2011 and after July 1, 2008, these requests will continue to be made by Aetna. LTD benefits that began prior to July 1, 2008 or after January 1, 2011 are administered by MetLife.

**Responsibilities of a Participant**

If you are disabled and eligible for disability benefits, it is your responsibility to cooperate with MetLife, to comply with all Plan provisions, and to make your period of disability as manageable as possible. Your failure to do so may result in a loss of benefits. In addition to any other responsibilities described in this section, you are responsible for the following:

- You must obtain medical treatment and follow your doctor's medical advice.
- You must file a complete disability benefit application while you are still a regular full-time employee of a Participating Employer and provide any medical information requested.
- You must apply for Social Security disability benefits and appeal any denial of these benefits.
- You must enroll in Medicare Part B when you become eligible.
- You must promptly notify MetLife or Aetna of any Social Security benefits (including Social Security disability and retirement benefits), workers' compensation benefits, or third-party awards, settlements or payments and provide the necessary documentation for these benefits or payments upon request.
- You must comply with MetLife's or Aetna's rehabilitation requests, including requests to participate in or pursue vocational and/or medical rehabilitation.
- You must make a diligent effort to return to work with Vistra Energy, a Participating Employer, or elsewhere – either as an employee or on rehabilitation status.
- You must notify MetLife or Aetna of any and all information concerning your outside employment or income-producing activities.
- You must promptly notify the Benefits Service Center if your address changes while you are receiving benefits.

## When LTD Benefits Are Not Paid

LTD benefits are not payable for a disability resulting from any of the following circumstances:

- war, whether declared or undeclared, or act of war, or participation in an insurrection, rebellion, riot or terrorist act;
- intentional self-inflicted injury;
- attempted suicide; or
- commission of or attempt to commit a felony; or
- a disability occurring due to any income producing activity outside of Vistra Energy's employment

# When LTD Benefits Start and End

## When LTD Benefits Start

If you are eligible, your LTD benefits start upon exhaustion of the required elimination period (typically, 180 days). If approved, LTD benefits begin the day after completion of the elimination period.

## When LTD Benefits Stop

As long as you remain disabled, LTD benefits may continue until you reach retirement age. If you become disabled before age 62, benefits are paid until you reach age 65. If you become disabled after age 62, benefits are paid for a specific number of years, as shown in the following chart:

| Age at Date of Disability | Benefit Period for LTD Benefits |
|---|---|
| Less than 62 | You reach age 65 |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 and over | 12 months |

Coverage will end at the earliest of:

- the date the Group Policy ends; or
- the date insurance ends for your class; or
- the end of the period for which the last premium has been paid; or
- the date you cease to be in an eligible class. You will cease to be in an eligible class on the date you cease Active Work in an eligible class, if you are not disabled on that date; or
- the date your employment ends; or
- the date you retire

## Rehabilitation Benefits

If, during the first 12 months of LTD, you are able to work at a job approved by MetLife or Aetna (depending on which vendor is administering your benefit), you may continue to receive your LTD benefits in addition to your pay from the approved job. However, if the income you receive from all sources during this rehabilitative employment exceeds your pre-disability earnings, your LTD benefit will be reduced.

If you participate in a rehabilitation program, MetLife will increase your monthly benefit by an amount equal to 10% of the monthly benefit. This will occur before your monthly benefit is reduced by any other income.

## Work Incentive

While you are disabled, we encourage you to work. If you work while you are disabled and receiving monthly benefits, your monthly benefit will be adjusted as follows:

- Your monthly benefit will be increased by your rehabilitation program incentive, if any; and
- Your monthly benefit will be reduced by other income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section of the Certificate of Insurance.

Your monthly benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted monthly benefit plus the amount you earn from working and the income you receive from other income exceeds 100% of your pre-disability earnings as calculated in the definition of disability in the Certificate of Insurance for this benefit.

## If Your Disability Recurs

If you return to work with a Participating Employer after receiving LTD benefits and then become disabled again for the same cause within 60 days after returning to work, you may be eligible to have your LTD benefit resume in the same amount that was paid during the first disability.

If a different disability occurs at any time, or if the same disability recurs later than 60 days after you return to work, that disability will be considered a separate period of disability. Your LTD benefits will be based on your pay before you became disabled the second time. However, if the second disability is due to the same cause as the first, your benefit won't be less than the amount payable during the first disability.

## If Your Disability Is Caused by a Mental or an Emotional Condition or by Chemical Dependency

You can receive LTD benefits for a maximum of two years if you are disabled due to a mental or an emotional condition or to chemical dependency. Disability benefit payments will end at the earliest of:

- the date you receive 24 months of disability benefit payments;
- the date you cease or refuse to participate in the recovery program; or
- the date you complete such recovery program

# If You Were Disabled Before May 1, 2001

On May 1, 2001, the LTD Plan changed from a self-insured plan to an insured plan. If you were disabled before that date, your benefits are paid under the self-insured arrangement.

In addition, if you were covered by the ENSERCH LTD Plan and became disabled before January 1, 1998, there are some differences in the calculation and payment of your benefits, which are described below.

## Self-Insured Benefits

If you were covered by the LTD Plan and became disabled before May 1, 2001, or if you are receiving benefits under the ENSERCH LTD Plan, benefits are provided by and paid from the general assets of the company (rather than through an insurance policy). MetLife is the Claims Administrator, so you should send all claims, doctor's statements, address changes, and other information directly to MetLife. MetLife also began paying fully insured claims to those participants who become disabled beginning January 1, 2011. If you became disabled between July 1, 2008 and December 31, 2010, under the fully insured plan, Aetna is the Claims Administrator. If you became disabled between May 1, 2001, and June 30, 2008, under the fully insured plan, MetLife is the Claims Administrator.

## Disability While Covered by the ENSERCH LTD Plan

If you were disabled before January 1, 1998, and were covered by the ENSERCH LTD Plan, the following provisions apply to you.

### How Benefits Are Calculated

Your LTD benefits will be up to 60% of your pre-disability pay, minus the other sources of income.

If your pre-disability pay was $5,000 or more, your LTD benefit will be the greater of:

- $2,500 per month, or
- Disability income from all sources, not to exceed 50% of your pre-disability pay

**Other Sources of Disability Income for Disabilities Occurring Under the ENSERCH LTD Plan**

Examples of other sources of disability income that may be payable because of your disability include:

- Social Security disability or retirement benefits that you or your dependents receive or are eligible to receive because of your disability
- Workers' compensation
- Any third-party award, settlement or payment resulting from your disability
- Any other disability benefit you receive under any applicable federal, state or local statute, rule or ordinance
- Any benefits you receive from the Retirement Plan

### Other Sources of Income

The Plan takes the same sources of income into account and two additional sources: If you were receiving disability benefits under the ENSERCH LTD Plan on December 31, 1997, your benefits may also be offset by benefits from the Vistra Energy Retirement Plan and by Social Security benefits your dependents are entitled to receive because of your disability.

### When Payments Stop

LTD benefits continue until you are no longer considered disabled, until you reach the maximum payment period, or until you reach Social Security retirement age.

The maximum payment period is determined by the following schedule:

| Age at Date of Disability | Maximum Payment Period for ENSERCH LTD Plan Benefits |
|---|---|
| Less than or equal to 60 | To Social Security retirement age |
| 61 | 4 years |
| 62 | 3½ years |
| 63 | 3 years |
| 64 | 2½ years |
| 65 | 2 years |
| 66 | 1¾ years |
| 67 | 1½ years |
| 68 | 1¼ years |
| 69 or older | 1 year |

# How to File a Claim for LTD Benefits

**If you are on an approved Short-Term Disability leave administered by MetLife, your LTD claim will be initiated before the exhaustion of the elimination period. For all other leaves which may last longer than the elimination period, you should contact MetLife as soon as possible to initiate an LTD claim review.**

## Apply for Social Security Benefits

Social Security disability benefits are payable after about six months of disability. However, it can take several months to apply for Social Security benefits, so it's a good idea to apply as soon as you think your disability may last for at least six months. You should contact your local Social Security office to apply for these benefits.

When you know the amount of your Social Security benefit, or if your claim for Social Security benefits is denied, contact MetLife or Aetna. MetLife or Aetna may be able to help you with your claim for Social Security disability benefits.

If you do not apply for Social Security benefits when eligible, MetLife or Aetna may estimate the amount of your Social Security benefits and reduce your LTD benefits by that estimate. Your LTD benefits will be adjusted accordingly when you provide MetLife or Aetna with required information concerning the approval or denial of your claim for Social Security benefits.

## Payment of LTD Benefits

LTD benefits are paid near the end of each month. Federal taxes, where applicable, will be withheld from LTD Plan benefits payable to you. Note that you do not pay LTD premiums after your LTD leave begins.

## Sources of Plan Benefits

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

MetLife
200 Park Avenue
New York, New York 10166

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

**Insured vs. Self-Insured Plans**
When benefits are insured, they are funded and issued by an insurance company according to the provisions of the insurance policy. When benefits are self-insured, they are funded by Vistra Energy, out of the company's general assets.

**Claims Administrator**
Whether benefits are insured or self-insured, MetLife (or Aetna) administers claims for Vistra Energy LTD benefits. You should send all claims, doctor's statements, address changes, and other information to the appropriate administrator (MetLife or Aetna, based on your date of disability), as well as to the Benefit Service Center.

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

MetLife
200 Park Avenue
New York, New York 10166

**If Your Application Is Denied**

If your application is denied, you are entitled to a full review. The steps in the review process are outlined in the "Plan Administration" section.

## Subrogation Rights

Subrogation rights apply when another party is responsible for your injury or illness or your enrolled spouse's or child's injury or illness (for example, in the case of an automobile accident) and the Vistra Energy Plan pays benefits relating to that illness or injury. By participating in the Plan, you agree that if you or your enrolled spouse or child are injured by a third party, the Plan will be subrogated to your rights against the third party, and/or the third party's insurance carrier, and will be entitled to full reimbursement for any benefits paid by the Plan that are related to the injury. The Plan has the right to recover benefit amounts from funds that you or your spouse or child receive from the responsible third party, whether through a judgment, settlement, or otherwise (including but not limited to an uninsured motorist award or settlement from your own or another's insurance) whether or not you have been fully compensated for your losses, and without offset for any costs of recovery. This means that the Plan may sue the third party and/or its insurance carrier and recover any and all amounts paid by the Plan from the third party or its insurance carrier, up to the total amount that the Plan paid, or may pay, for expenses related to the injury. The Plan's right of recovery is without any reduction for attorney fees or court costs, and without regard to whether (i) you and/or your enrolled spouse or child would be fully compensated or made whole by the amount recovered, (ii) the third party admits causing the injury, or (iii) the amount recovered is awarded specifically for medical

expenses. The Plan will have a lien on any and all amounts you recover up to the full amount paid by the Plan.

If the Plan advances payment for any benefits, such payment will be advanced on the condition that you (or the injured person) execute a subrogation agreement that requires you to acknowledge, among other things, (i) the conditional nature of the Plan's payment, (ii) the Plan's right to subrogation and full reimbursement, and (iii) your obligation to cooperate in protecting the Plan's rights. The subrogation agreement may contain additional terms and conditions determined by the Plan Administrator to be necessary or appropriate. Additionally, you and/or your enrolled spouse or child must, as a condition to receiving Plan benefits, assist with the Plan's recovery. In this connection, you must provide the Plan Administrator with information about the facts surrounding your injury, your future medical needs, and any claim you may have against a third party. The Plan has the right to withhold benefits that you or your enrolled spouse or child may be entitled to receive under the Plan unless (and until) you fully comply with all the obligations explained, including executing a subrogation and reimbursement agreement. The Plan also has the right to reduce future payments payable to or on behalf of you and/or your enrolled spouse or child by the amount that the Plan is entitled to reimbursement until the time that the entire amount has been recouped in full, including any costs of collection.

You and/or your enrolled spouse or child must contact the Plan Administrator and obtain the Plan Administrator's consent before settling any claim against a third party. You and/or your enrolled spouse or child and your attorney will hold any amounts recovered from a third party in constructive trust to satisfy the Plan's lien.

The Plan's subrogation and reimbursement rights do not limit your right or your spouse's or child's right to take legal action against the person who caused your (or your enrolled spouse's or child's) injury. You can pursue legal action to recover medical expenses and other damages. Again, however, you must obtain the Plan Administrator's consent before you settle any claim or release any third party from liability. The Plan will not be responsible for attorney fees or court costs that you and/or your spouse or child incur and will not reduce the amount of the required reimbursement by the amount of your attorney fees or court costs.

# Situations Affecting Plan Benefits

The Plan is designed to provide a wide range of protection. But some situations could affect your benefits. Those situations are summarized below.

- If you leave the company for any reason, or if you are no longer a member of the eligible employee group, coverage will end
- If you are no longer eligible for benefits under the company's Long-Term Disability (LTD) Benefit options and you do not return to work for the company, your coverage will end
- If your disability is the result of a non-covered incident, you will not receive benefits
- If you fail to follow your doctor's medical advice, your benefits will stop
- Your benefits will be limited if your disability is caused by a mental or emotional condition or by chemical dependency
- If you fail to comply with the Claim Administrator's rehabilitation requests, your benefits may stop
- If you do not furnish proof of disability, or if you do not furnish it within the prescribed time period, payment of your benefits may be delayed or denied
- You may be required to repay the Plan for benefits paid if you recover monetary damages for an illness or injury caused by a third party
- The Plan may recover against future plan benefits any benefits that have been overpaid
- If you fail to make any required contributions for coverage when they are due, your coverage will end

## If the Plan Ends

The company currently intends to continue these benefits indefinitely. However, the company reserves the right to end, suspend, withdraw, or amend the Plan in whole or in part, from time to time, in the sole discretion of the company. If the Plan should end, benefits may be paid for any valid claims incurred prior to such termination.

# Life Events

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# How Some Major Life Events Affect Your Benefits

When various events (which we call "life events") occur in your personal or work situation, your benefits may be affected. In some cases, you can change your elections to account for your new situation, or you can receive payment of your benefit. In other cases, your coverage may be continued or suspended. If your health care coverage ends, you may be able to continue coverage under COBRA.

## Changing Your Elections

During the open enrollment period each fall, you have an opportunity to make your Plan elections for the next year. This includes your elections for medical, dental, and vision coverage; LTD, life insurance, and AD&D coverage; and Flexible Spending Accounts.

Your Plan elections go into effect on January 1 and remain in effect for an entire Plan Year. You cannot change your elections until the next open enrollment period unless you have a qualified status change (see sidebar). To make a change:

- Log on to MyWorkday at myworday.energyfutureholdings.com or call the Benefits Service Center **within 31 days** following the qualified status change.

- Any changes you make to your benefit options must be consistent with the qualified status change.

**Qualified Status Changes**

- Your marriage, divorce, annulment or legal separation
- The birth, adoption or placement for adoption of a child (**60 days**)
- The death of your spouse or a covered dependent child
- Your gain or loss of Legal Custody of an eligible dependent
- A child's gain or loss of status as an eligible dependent
- A change in the employment status of you, your spouse, or your dependent (part-time to full-time, etc.), resulting in gain or loss of coverage
- Your or your covered dependent's eligibility for Medicare or Medicaid
- A court order requiring a change in coverage (such as a qualified medical child support order)

For more information about making changes to your benefit options, see "Changing Your Coverage" in the "Plan Participation" section of this handbook.

For information about each benefit option, see the corresponding section of this handbook. Please note that any change is subject to the discretion of the Plan Administrator and must be permitted by the terms and conditions governing the applicable benefit option and relevant Internal Revenue Service regulations.

## When Coverage Ends

Your coverage under the Plan generally ends when you leave Vistra Energy, are severed from the company, retire, are laid off, die, you fail to remit required premiums, or no longer meet the eligibility requirements for coverage, or if Vistra Energy terminates the Plan or ceases to offer a benefit under the Plan. A covered individual may also lose coverage for committing fraud, or providing false or inaccurate information, to obtain benefits under the Plan. In some situations, you

may be able to continue coverage under COBRA, as described later in this section. If you retire, you may be eligible for retiree medical, dental, vision, and life insurance coverage. In the event of your death, your survivors may be eligible for survivor health care coverage as described below.

Coverage for your dependents usually ends at the same time as your own coverage. Coverage for your spouse ends if you are divorced. Coverage for your children ends if they reach the maximum age or no longer meet the eligibility requirements. For more information, see "Dependent Eligibility" in the "Plan Participation" section. Coverage for your spouse or dependents may also end if they fail a dependent audit. If coverage is terminated due to failed dependent audit, coverage cannot be continued under COBRA.

## Continuation of Coverage During Leaves of Absence

You can continue your health care coverage and your employee and dependent life insurance during an approved leave of absence or during a disability leave (as long as you are receiving LTD benefits).

# Health Care Continuation Coverage (COBRA)

## Coverage Continuation Rights Under the Consolidated Omnibus Budget Reconciliation Act of 1985

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) created the right to COBRA continuation coverage. This section contains important information about your right to COBRA continuation coverage. It explains when COBRA coverage may become available and what you need to do to protect your right to receive COBRA coverage.

For additional information about your rights and obligations under federal law and under Vistra Energy's group health care plans – medical, prescription drug, on-site clinic, dental, and vision coverage and the Health Care Spending Account option (an FSA) – contact the Benefits Service Center.

## What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary continuation of health care coverage when it otherwise would end because of a life event, known as a "qualifying event." (Specific qualifying events are listed under "COBRA Qualifying Events and Qualified Beneficiaries" below.)

After a qualifying event, COBRA continuation coverage must be offered to each "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the health care plans is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for it.

Your COBRA continuation coverage rights under the Plan apply only with respect to Vistra Energy's group health care plan options (medical, prescription drug, dental, and vision coverage and the Health Care Spending Account option).

## COBRA Qualifying Events and Qualified Beneficiaries

### Employees

You become a COBRA-qualified beneficiary if you lose your coverage under the health care plan options because of either of the following qualifying events:

- Your hours of employment are reduced
- Your employment ends for any reason (other than your gross misconduct)

### Spouse of the Employee

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

- You die

- Your hours of employment are reduced
- Your employment ends for any reason (other than your gross misconduct)
- You become divorced or legally separated from your spouse

**Dependent Children**
Your dependent children become COBRA-qualified beneficiaries if they lose coverage under the health care plan options because of any of the following qualifying events:

- You die
- Your hours of employment are reduced
- Your employment ends for any reason (other than your gross misconduct)
- You and your spouse become divorced or legally separated
- Your child loses eligibility for coverage as a "dependent child" under the health care plans (for example, he or she attains the maximum age)

Qualified beneficiaries also include any children born to you or placed with you for adoption during the COBRA continuation period.

## Notification of Qualifying Events

The Plan offers COBRA when a qualifying event has occurred. The company will automatically issue a notification of eligibility in these cases:

- Your employment ends or your hours are reduced
- You die

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

- Your death
- Your divorce or legal separation
- Your child's loss of eligibility for coverage under the health care plans (for example, he or she reaches the maximum age)

This notification must occur within 31 days from the latest of the following:

- The qualifying event

**How to Notify the Benefits Service Center When You Have a Qualifying Event**
You, your qualified beneficiary, or a representative should log on to the MyWorkday to initiate a benefit change event or call the Benefits Service Center within 31 days following the qualified status change.

This section of your handbook meets the SPD's COBRA notice requirement. However, you and your qualified beneficiaries will receive another notice if you have a qualifying event.

- The date you or your qualified beneficiary loses (or would lose) coverage as a result of the qualifying event

- The date you or your qualified beneficiary is informed, through the SPD (see sidebar above) or general COBRA notice, about the responsibility to submit a completed COBRA election form to the COBRA administrator as notification

**If You or Your Qualified Beneficiary Is Disabled**
With respect to a disability determination, **you or your qualified beneficiary must notify the Benefits Service Center** of the disability determination, in writing, within 60 days after the latest of the following:

- The date of the Social Security Administration disability determination

- The date the qualifying event occurs

- The date you or your qualified beneficiary loses (or would lose) coverage due to the qualifying event

- The date you or your qualified beneficiary is informed, through the SPD (see sidebar above) or general COBRA notice, of the responsibility to provide the disability notification

**Be Sure to Keep Your Address and Your Dependents' Addresses on File With the Vistra Energy Benefits Service Center**
It is critical that you (or anyone who may become a qualified beneficiary) maintain your current address to ensure that you receive COBRA election information following a qualifying event, and that you receive all related information and billing notices while you are on COBRA. Be sure to update your address with the Vistra Energy Benefits Service Center.

**Please note:** You or your qualified beneficiary must provide notification of the disability determination, in writing, to the Benefits Service Center before the end of the initial 18 months of COBRA coverage.

If you or your qualified beneficiary is subsequently determined by the Social Security Administration to no longer be disabled, you or your qualified beneficiary must provide notification, in writing, to the Benefits Service Center within 30 days of the date of the final determination.

## How COBRA Coverage Is Offered

When the Benefits Service Center is notified of a qualifying event, COBRA continuation coverage is offered to each qualified beneficiary.

The COBRA administrator will mail a COBRA continuation notice and a COBRA election notice within 14 days after receiving notice of the qualifying event. This information is sent to the last known address that you provided to the Benefits Service Center. If your qualified beneficiary lives at another address, a separate information packet will be sent if that address is provided.

To notify the Benefits Service Center of your new address, call 1-844-469-9539. Customer service representatives are available Monday through Friday between 8:00 a.m. and 5:00 p.m. Central time.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees can elect COBRA continuation coverage on behalf of their spouses, and parents can elect COBRA continuation coverage on behalf of their children.

## Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

## If COBRA Coverage Is Elected

If you or your dependent elects COBRA continuation coverage, you have the following options available to you:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage.
- Your or your dependent's coverage is effective as of the date of the qualifying event, unless you or your dependent waives COBRA coverage and then revokes the waiver within the 60-day election period. (In this case, your elected coverage begins on the date you revoke your waiver.)
- You or your dependent can change coverage (if enrolled within the initial 60-day enrollment window) in either of the following circumstances:
  - During the open enrollment period
  - If you or your dependent has a qualified status change or another change in circumstances recognized by the Internal Revenue Service (IRS) and the company
- You can enroll any newly eligible spouse or dependent child under the health care plan's rules.

## What COBRA Coverage Costs

COBRA participants must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person, set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

Payment is due at election, but there is a 45-day claims deadline (from the date you send your election form) to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s), retroactively to the date benefits terminated under the Plan.

Ongoing monthly payments are due on the first of each month, but there is a 30-day claims deadline. (For example, the June payment is due June 1, but will be accepted if postmarked by June 30.)

You may be able t**o get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** You can learn more about the Marketplace **in sections below.**

## How Long COBRA Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is due to any of the following:

- Your death
- Your divorce or legal separation
- Your dependent child's loss of eligibility as a dependent child

COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or is a reduction of your hours of employment. This 18-month period of COBRA continuation coverage can be extended in two ways:

- **Disability Extension of 18-Month Period of Continuation Coverage**
  If a qualified beneficiary covered under the health care plan(s) is determined by the Social Security Administration to be disabled and you notify the Benefits Service Center in a timely fashion, you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage (for a total maximum of 29 months) if *all* of the following conditions are met:
  - Your COBRA-qualifying event was a termination of employment or a reduction in hours
  - The disability began at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage
  - A copy of the Notice of Award from the Social Security Administration is provided to the Benefits Service Center within 60 days of the date of the Notice of Award and before the end of the initial 18 months of COBRA coverage
- **Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**
  If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Benefits Service Center.

This extension may be available to your spouse and any dependent children receiving continuation coverage if you divorce or legally separate, or if your child is no longer eligible as a dependent child under the health care plan(s), but only if the event would have caused your spouse or child to lose coverage under the plan(s) had the first qualifying event not occurred.

**Situations When COBRA Coverage May End Earlier**
COBRA coverage under a group health care plan ends before the maximum continuation period if one of the following occurs:

- You or your covered dependent does not make timely premium payments or contributions as required
- Vistra Energy stops providing any such group health care plan to any employees
- After electing COBRA continuation coverage, you or any of your covered dependents become covered under another health care plan not offered by the company, provided that plan does not have a legally valid pre-existing condition exclusion or limitation affecting the qualified beneficiary; if it does, COBRA coverage for that pre-existing condition continues as long as you pay the premium
- During an extended period of COBRA coverage based on the disability extension (and assuming there has not been a second qualifying event), a final determination is made by the Social Security Administration that the qualified beneficiary is no longer disabled

Continuation coverage also can be terminated for any reason the health care plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (for example, in the case of fraud or providing of false/inaccurate information).

## Special Rules for the Health Care Flexible Spending Account Option

Under certain circumstances, a qualified beneficiary can elect to continue benefits under the Health Care Flexible Spending Account (FSA) by electing COBRA continuation coverage, but only for the period from the date of the qualifying event through the end of the Plan Year in which the qualifying event occurs. Further, COBRA continuation coverage will be available for the Health Care Flexible Spending Account only if you have a positive net balance in the account as of the date of the qualifying event. This means that the amount of contributions to the Health Care Flexible Spending Account exceeds the qualified eligible expenses and reimbursements.

The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year. Unless otherwise elected, all qualified beneficiaries who were covered under the Health Care FSA will be covered for this COBRA continuation coverage.

## Special Rules if You Qualify for Trade Act Assistance

If you are eligible for Trade Act assistance (TAA) or alternative Trade Act assistance (ATAA) and you did not elect COBRA continuation coverage during the COBRA election period that applied to your loss of health care coverage due to your separation from employment, you might have an additional COBRA election period. You can elect COBRA continuation coverage during the 60-day period that starts on the first day of the month that you become a TAA-eligible or an ATAA-eligible individual. Your election for COBRA continuation coverage must not be made later than six months after the date of the TAA-related or ATAA-related loss of coverage (the date that you lost health care coverage due to your separation from employment that gives rise to your being a TAA-eligible or an ATAA-eligible individual).

**Trade Act Tax Credit**
The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 80% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you can call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TTY callers can call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/.

## What Is The Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

## When Can I Enroll in Marketplace Coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

## If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

## Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

## What Factors Should I Consider When Choosing Coverage Options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

## If You Have Questions

Questions concerning your group health care plan and your COBRA continuation coverage rights should be addressed with the Benefits Service Center.

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other laws affecting group health care plans, 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 Web site at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's Web site.)

## Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Benefits Service Center informed of any changes in your address or the addresses of family members. Also, for your records, you should keep a copy of any notices you send to the Plan Administrator or to the Benefits Service Center.

# Continuation of Health Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

## Health Care Coverage

If you are absent from work because of your service in the uniformed services (including Reserve and National Guard duty), you can continue health coverage (medical, dental, and vision) for yourself and your eligible dependents under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

### Paying for Coverage

You may be required to pay all or a portion of the cost of your coverage.

- **If your military service is 31 days or less:** You are required to pay no more than your usual share of the cost for this period of coverage.
- **If your military service is more than 31 days:** You must pay the entire cost of the coverage (not to exceed 102% of the applicable premium, similar to the manner in which the cost for COBRA continuation coverage is calculated).

### Notification of Uniformed Service

You must notify your manager and the Benefits Service Center that you will be absent from employment due to military service (unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable). You also must notify the Benefits Service Center that you want to elect continuation coverage for yourself and/or your eligible dependents under the USERRA provisions.

### How Long Coverage Continues

Generally, the maximum length of time coverage continues is 24 months.

When you are discharged, you are required to apply for a return to work within a certain period of time, depending on the length of your uniformed service. *If you don't apply for a return to work within these time frames, your coverage will end on the next day.* Here are the time frames for applying for return to work:

- **If your uniformed service is less than 31 days:** You are generally required to return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service. (Your period of uniformed service ends after you return from your place of service to your residence.)
- **If your uniformed service is between 31 and 180 days:** You are generally required to return to work within 14 days of your discharge.
- **If your uniformed service is at least 181 days:** You are generally required to return to work within 90 days of your discharge.

# Amendment or Termination of the Plan

Vistra Energy reserves the right to amend, modify or terminate all of its employee benefit plans, in whole or in part, at any time and for any reason, including but not limited to by increasing, reducing or terminating benefits for all employees or retirees, or for any group of employees or retirees; changing carriers, network administrators, or benefits; increasing premiums, Deductibles or other payments; or any other changes. If a plan or benefit option is terminated or if material benefit changes are made, you will be notified. If the Plan is changed or terminated, benefits will be paid for any valid claims incurred prior to the change or termination.

# Plan Administration

# Plan Administration Contents

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# How the Plan Is Administered

Here are details about how the Plan is administered.

## Plan Sponsor and Administrator

The Plan Sponsor and the Plan Administrator is:

Vistra Operations Company LLC “Vistra Energy”
6555 Sierra Drive
Irving, TX 75039
214-812-4600

The information in this section is required by law. It includes information about how the Plan is administered and your legal rights.

The company has also chosen outside administrators to help Vistra Energy administer the health and welfare benefit plans (see “Claims Administrators, Third-Party Administrators, and Insurers”). These organizations have been authorized to carry out certain administrative functions of the Plan.

## Employer Identification Number

Vistra Energy’s employer identification number is 46-2488810.

## Plan Year

The Plans are operated on a calendar-year basis, beginning January 1 and ending December 31.

## Agent for Service of Legal Process

Service of legal process can be made to the Plan Administrator above.

## Types of Plans/Plan Identification

The Vistra Energy Health and Welfare Benefit Program is a program that provides medical, prescription drug, dental, flexible spending accounts, life and accidental death and dismemberment, disability, vision, and other specified health and welfare benefits. The Vistra Energy Health and Welfare Benefit Program is comprised of two underlying benefits plans: (1) the Vistra Energy Health Care and Life Insurance Plan and (2) the Vistra Energy Welfare Benefit Plan. While both are set out in the Vistra Energy Health and Welfare Benefit Program document, the Vistra Energy Health Care and Life Insurance Plan and Vistra Energy Welfare Benefit Plan both maintain separate plan numbers and are treated as separate plans for financial reporting and audit purposes.

The chart that follows shows which of these two plans provide each of our benefit options. The plan name, plan number, and Vistra Energy’s EIN identify the plan with the federal agencies governing benefit operations.

| Plan Name | Plan Number | Benefits Provided by Plan |
|---|---|---|
| Vistra Energy Health Care and Life Insurance Plan | 501 | Medical Plan options<br>Dental Plan options<br>Life Insurance options |
| Vistra Energy Welfare Benefit Plan | 507 | Vision Plan option<br>Health Care Spending Account option<br>Dependent Care Spending Account option<br>Accidental Death and Dismemberment (AD&D) Insurance options<br>Long-Term Disability (LTD) Benefit options<br>Severance Benefit option<br>Severance Benefit option for Certain Collectively Bargained Employees |

These plans are subject to the Employee Retirement Income Security Act of 1974 (ERISA). Any other benefit options described in this handbook are not regulated by ERISA.

## Collective Bargaining Agreements

Participation in benefit options for employees in a collective bargaining unit is subject to the applicable collective bargaining agreement.

## Privacy of Health Information

The Plan is required to comply with the Standards for Privacy and Security of Individually Identifiable Health Information (the "privacy standards") issued under the federal Health Insurance Portability and Accountability Act, commonly referred to as HIPAA. The privacy standards require certain of the welfare plans to provide notice to covered participants describing the Plan's policies and procedures with respect to a participant's health information. A copy of the Vistra Energy Notice of Privacy Practices is available online at any time through Vistra Energy Connect (use Quick Links to search "HIPAA" or by accessing MyWorkday Knowledge Base. If you have any questions about the Vistra Energy Notice of Privacy Practices or if you would like to request a paper copy, please contact the Benefits Service Center. As further described in the notice, the privacy standards require the benefit administrators to take certain precautions in using and disclosing specified information about your health and that of your dependents, and place limitations on the disclosure of such information to Vistra Energy and other third parties.

# Claims Administrators, Third-Party Administrators, and Insurers

The chart below lists the organizations that provide day-to-day administrative services for each benefit option. The Claims Administrators, third-party administrators, and insurers make benefit payments as authorized by the benefit option.

| Options/Programs | Name |
|---|---|
| **Medical Plan Options**<br><br>MyHealth HSA Option | <br><br>Blue Cross Blue Shield of Texas<br>P. O. Box 660044<br>Dallas, TX 75266–0044<br>1-800-762-8532<br>www.bcbstx.com |
| **Prescription Drugs** | CVS Caremark<br>P.O. Box 829518<br>Pembroke Pines, FL 33082-9913<br>1-877-775-5642<br>Retail:<br>www.caremark.com<br>Mail Order:<br>www.caremark.com/rxhomedelivery.com |
| **Mental Health and Chemical Dependency**<br><br>BCBSTX Behavioral Health | <br><br>BCBSTX<br>P. O. Box 660044<br>Dallas, TX 75266–0044<br>1-800-528-7264<br>www.bcbstx.com |
| **Dental Benefit Options** | MetLife<br>P.O. Box 981282<br>El Paso, TX 79998-1282 |
| **Vision Benefit Option** | UnitedHealthcare Vision<br>Attn: Claims Department<br>P.O. Box 30978<br>Salt Lake City, UT 84130<br>1-800-638-3120<br>www.myuhcvision.com |
| **Life Insurance Options** (includes Employee Life option, Spouse Life option, and Child Life option) | MetLife<br>Group Life Claims<br>P.O. Box 6100 |

| Options/Programs | Name |
|---|---|
| **AD&D Insurance Options** (includes Employee AD&D option and Dependent AD&D option)<br><br>**Long-Term Disability (LTD) Options** | Scranton, PA 18505-6100<br>1-800-300-4296<br>www.metlife.com |
| **Flexible Spending Accounts (FSAs)**<br>(includes Health Care Flexible Spending Account and Dependent Care Flexible Spending Account)<br><br>**Health Savings Account (HSA)** | WageWorks<br>1100 Park Place, 4th Floor<br>San Mateo, CA 94403<br>1-877-924-3967<br>www.wageworks.com |

# Coordination of Benefits

Your health care plans are coordinated with other group insurance plans to which you or your covered dependents belong. This means that all plans together pay no more than 100% of allowable health care expenses. An "allowable expense" is any expense covered at least in part by one of the health care plans.

Coordination of benefits does not apply to individual or private insurance policies maintained by you.

Here's how benefits are coordinated when a claim is made:

- First, the primary plan pays its benefits without regard to any other plan.
- Then, the secondary plan adjusts its benefits so that the total benefit available will not be greater than the allowable expense of the secondary plan.

No plan pays more than it would without the coordination provision.

The following provisions determine which plan is primary (and pays benefits first):

- A plan without a coordination provision is always the primary plan.
- The plan covering the patient as an employee rather than as a dependent will be the primary plan.
- If a child is covered under both parents' plans, the plan of the parent whose birthday is earlier in the year pays first. The plan of the parent whose birthday is second during the year pays second. If both parents' birthdays fall on the same date, the plan that covered the person longer is primary. This rule applies only if the other group health plan has a birthday rule. Otherwise, the other group health plan that covers a person as a dependent of a male is primary.
- If the parents are divorced and there is no court decree that establishes financial responsibility, the plan covering the parent who has custody of the children is the primary plan.

When they are the primary plan, the Medical Plan option, Dental Plan options, and Vision Plan option will pay the benefits described in this handbook. When they are the secondary plan, they adjust their benefits so that the total benefit available will not be greater than their allowable expense as a secondary plan.

# Claim Review and Appeal Process

When a request for benefits is denied there is a formal claims review process established for a participant to appeal the denial.

There are two types of "claims": an "eligibility claim" and a "benefit claim".

## Eligibility Claim

An eligibility claim is a request to enroll, disenroll or change participation in a specific benefit option (for example, a request to enroll a dependent in the Medical Plan option).

## Benefit Claim

A benefit claim is a request for a particular benefit under one of the benefit options (for example, a claim for a certain type of surgery under the Medical Plan option). Another example of a benefit claim is a request for a specific prescription drug that has been denied.

For both eligibility claims and benefit claims there are up to two levels of review. If the first claim has been denied, a participant can appeal the initial claim and submit a request for a second review. If the appeal, or the second review is denied, meaning the person has exhausted their administrative remedies, the participant has the right to file a civil action under section 502(a) of ERISA.

## Filing Claims

**All eligibility claims** are filed with the Plan Administrator. Eligibility claims are filed by calling the Benefits Service Center.

**Benefit claims** are filed with the following entities, as specified in the table below.

| Benefit | Entity |
|---|---|
| Medical Plan | Blue Cross Blue Shield of Texas* |
| Prescription Drugs | CVS Caremark* |
| Dental | MetLife* |
| Life Insurance/AD&D Insurance | MetLife* |
| Long-Term Disability | MetLife* |
| Vision | UnitedHealthcare Vision* |
| Flexible Spending Accounts | WageWorks |

*These entities are "claims fiduciaries" for these benefits. Claims fiduciaries are solely responsible for the decisions made for any claim filed relating to the specified benefits. When a claim is denied by one of the listed entities the Explanation of Benefits (EOB) statement received will provide directions on the procedure for filing a claim.

## When a Claim Has Been Filed

When a claim has been filed, the entity with which you filed the claim will respond to you within certain prescribed time frames. In some situations, the entity may need an extension of time to process your claim (for example, if additional information is needed to process your claim). In these cases, you will be notified of the extension.

The chart below shows the various types of claims and the response timeframes for each type of claim.

### When You Receive the Initial Notification

| Type of Claim | Notice of Claim Decision or Extension | Extension Rules |
|---|---|---|
| **Health Care Benefit Claims (including Rx and dental):** | | |
| **Urgent Care Benefit Claim.** An urgent care benefit claim is a claim for medical care or treatment where a delay in making a determination could result in any of the following:<br>• Could jeopardize the life or health of you or your dependent<br>• Could jeopardize the ability of you or your dependent to regain maximum function<br>• In the opinion of your or your dependent's physician, would subject you or your dependent to severe pain that could not be adequately managed without the requested treatment | As soon as possible, and, in any event, within 72 hours | None |
| **Concurrent Care Benefit Claim Decisions.** Concurrent care benefit claim decisions are decisions for treatment over a period of time or for a specified number of treatments. Examples include an extended number of days in a hospital, an extended number of physical therapy treatments, or a situation where the Plan reduces the number of treatments previously agreed upon. | Same as urgent care or pre-service, as applicable. | Same as urgent care or pre-service, as applicable. |
| **Preservice Benefit Claims.** A preservice benefit claim is a request for approval of a medical benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. Examples include preauthorization for hospital stays, second surgical opinions, etc. | Within 15 days | If necessary, the period can be extended for an additional 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll have 45 days to provide the information. |
| **Post-service Benefit Claims.** A post-service benefit claim is any claim that is | Within 60 days | If necessary, the period can be extended for an additional 15 days. If an extension is |

| Type of Claim | Notice of Claim Decision or Extension | Extension Rules |
|---|---|---|
| processed after a service is provided. | | necessary because additional information is needed, the extension notice will describe the information needed, and you'll have 45 days to provide the information. |
| **Disability Benefit Claims** | Within 45 days | If necessary, the period can be extended two times for up to 30 days each. The extension notice(s) will explain the standards upon which eligibility is based, the unresolved issues that prevent a decision, and any additional information needed to resolve the issues. You'll have 45 days to provide the information. |
| **All Other Claims** (life and AD&D insurance and all eligibility claims) | Within 90 days | If special circumstances require an extension, the period can be extended for an additional 90 days. |

## Claim Denial Notice

If your claim is denied, you will receive a written notice that includes:

- The specific reasons for the denial, including a reference to the specific Plan provisions on which the benefit determination is based
- The Plan's provisions on which the denial is based. If an internal rule, guideline or protocol was relied upon to determine a health or disability claim, you'll receive a copy of the actual rule, guideline or protocol, or a statement that the rule, guideline or protocol was used and that you can request a copy free of charge. If the denial is based on a provision such as medical necessity, experimental treatment, or a similar exclusion or limit, you'll receive an explanation of the scientific or clinical judgment for the determination, based on the terms of the Plan and your medical circumstances.
- A description of any additional material or information needed and an explanation of why it is necessary
- An explanation of the Plan's internal and external claim review procedures, applicable time limits, and your rights to bring a civil action following a denial (if for an urgent care benefit claim under a health care plan, you'll receive an explanation of the expedited benefit claim review procedure)
- The date of service, the health care provider, the claim amount (if applicable), and any denial code and its corresponding meaning (including a statement explaining that you may also request, and receive free of charge, a statement of the applicable diagnosis code and treatment code and their corresponding meanings)
- A statement indicating that you can have access to receive, upon request and at no charge, copies of all documents, records, and information relevant to your claim

- The availability of – and contact information for – any applicable office of health insurance consumer assistance or ombudsman established under the Act to assist individuals with the internal claims and appeals and external review procedures

In the case of an urgent care benefit claim, the Plan can notify you by phone or fax and follow up with a written notice.

## Request for Review if Your Claim Is Denied

After receiving the notice, you, your beneficiary, or your legal representative can ask for a full and fair review of the decision by writing to the Claims Fiduciary. You must make this request within 180 days for a health care or disability claim or within 60 days for all other claims. During the 60-day or 180-day period, you or your authorized representative will be given reasonable access to all documents and information relevant to the claim, and you can request copies free of charge. You can also submit written comments, documents, records, and other information to the Claims Fiduciary or Plan Administrator.

For an urgent care benefit claim, information can be provided by phone or fax.

## Final Decision

The Claims Fiduciary or Plan Administrator will then review the claim again and make a decision based on all comments, documents, records, and other information you've submitted. For a health care or disability claim:

- A different person will review the decision.

- If the denial was based on a medical judgment, the person will consult with a health care professional who has training and experience in the field involving the judgment. That professional cannot be the same person who made the initial decision of denial. Medical or vocational experts who are consulted in the claim process are identified in the final decision.

In most cases, you'll receive the Claims Fiduciary's or Plan Administrator's final decision within the following time frames:

| Type of Claim | Notice of Final Decision or Extension |
|---|---|
| **Health Care Claims** | |
| Urgent Care Benefit Claims | As soon as possible, but not later than 72 hours after receipt of your request for review |
| Preservice Benefit Claims | As soon as reasonably possible, given the medical condition, but not later than 30 days after receipt of your request for review |
| Post-service Benefit Claims | Within a reasonable time, but not later than 60 days after receipt of your request for review |
| **Disability Benefit Claims** | Within a reasonable time, but not later than 45 days after receipt of your request for review. If necessary, the period can be extended for an additional 45 days |

| Type of Claim | Notice of Final Decision or Extension |
|---|---|
| **All Other Benefit Claims (life and AD&D insurance) and All Eligibility Claims** | Within a reasonable time, but not later than 60 days after receipt of your request for review. If necessary, the period can be extended for an additional 60 days |

**Appeal Denial Notice**
If your appeal is denied, the Claims Fiduciary will send you a statement containing the following:

- Specific reasons for the denial
- Specific references to pertinent Plan provisions
- A statement indicating that you can have access to or receive, upon request and at no charge, copies of all documents, records, and information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the Plan, including your right to bring an action in federal court under section 502(a) of ERISA. Under the Plan, an action under Section 502 (a) of ERISA must be filed no later than two (2) years following the date of the final denial of a claim on appeal, or such action will be time-barred.

In addition to the information above, if your claim is a medical benefits or disability claim, the notice will contain any information regarding an internal rule, guideline or protocol used in making the appeal decision, and an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge.

## Additional Requirements Related to External Review of Final Action on Internal Appeal

Different external review rules apply depending on whether the relevant health care coverage is subject to a state insurance law external review requirement that meets standards specified in federal regulations, or whether the coverage is not subject to such a state law.

Where the health care coverage is subject to a state standard that complies with applicable federal regulations, such state standard shall apply to the insurer (where the coverage is insured) or the Plan (where the coverage is self-insured). Where the relevant health care coverage is not subject to a state standard, or subject to a state standard that does not meet federal regulatory requirements (taking into account any period of deemed compliance during a transition period provided for under federal regulations), then the following rules apply to the Plan to the extent and as of the date required by applicable federal regulations:

(a) A Claimant may file a request for external review within 4 months of receipt of notice of an adverse determination (to the extent permitted by applicable law, however, the Plan may require the Claimant to exhaust any reasonable internal appeal process); for this purpose, and to the extent permitted by applicable federal regulations, an “adverse determination” means an adverse determination as defined elsewhere in these provisions, but only to the extent it involves medical judgment or a retroactive rescission of coverage.

(b) Within 5 business days following receipt of the request for external review, the Plan shall determine whether:

the Claimant was covered under Plan and applicable health care coverage when the health care item or service was requested (or provided, where the review is for a post-service claim);

the adverse determination was not due to ineligibility of the Claimant;

the Claimant exhausted any required internal appeal process; and

the Claimant has provided all information required.

(c) The Plan shall issue notice to the Claimant within one business day after the Plan's preliminary review of the request for external review. If the Claimant is not eligible for external review, the notice must include reasons for ineligibility and contact information for the Employee Benefit Security Administration. If the request for external review is not complete, the notice must describe information that is needed and allow the Claimant to complete or perfect his request within the four-month filing period described above or 48 hours, whichever is later.

(d) If the request for external review is appropriate, the Plan (or an entity on behalf of the Plan) shall refer the appeal to an Independent Review Organization (IRO), with which the Plan has contracted in accordance with applicable federal regulations. The IRO shall conduct its review and supply appropriate notices in accordance with applicable federal standards. If the IRO reverses the Plan's decision, the Plan shall without delay provide coverage or payment upon receipt of notice of the IRO's decision, without regard to the Plan's intention to seek judicial review of the IRO's decision.

(e) The Plan shall make available, to the extent required by and in accordance with applicable federal law, an expedited external review process where a Claimant receives an adverse determination or final internal adverse determination under circumstances where completion of an expedited internal appeal or standard external review would seriously jeopardize the life or health of the Claimant.

(f) No Conflicts of Interest: The Plan shall adjudicate claims in a manner ensuring the independence and impartiality of those involved in decision making. For example, the Plan may not hire, promote, provide incentives to or terminate the employment of individuals based on their support of a denial of benefits or on the number of claims denied.

# Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which are listed below.

## Receive Information About Your Plan and Benefits

As a Plan participant, you are entitled to:

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

## Continue Group Health Plan Coverage

If you or your dependents lose health coverage as a result of a qualifying event, you or your dependents have the right to continue health care coverage. You or your dependents may have to pay for such coverage. For rules governing your COBRA continuation coverage rights, see the "Life Events" section or the Plan documents governing the Plan.

If you have creditable coverage from another plan, any exclusionary periods of coverage for pre-existing conditions under your group health plan may be reduced or eliminated. In the following circumstances, your group health plan or health insurance issuer should provide you a certificate of creditable coverage, free of charge:

- When you lose coverage under the plan

- When you become entitled to elect COBRA continuation coverage

- When your COBRA continuation coverage ends, if you request the certificate before losing coverage

- Within 24 months after losing coverage, if you request the certificate

You can request the certificate before losing coverage, or up to 24 months after losing coverage.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals responsible for the operation of the Plan. The individuals who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

## Claim Review

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

## Enforce Your Rights

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court. In addition, if you disagree with a Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you can file suit in a federal court.

If it should happen that Plan fiduciaries misuse a Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court can order the person you have sued to pay these costs and fees. If you lose, the court can order you to pay these costs and fees; for example, if it finds your claim is frivolous.

## Assistance With Your Questions

If you have any questions about the Plan, you should call the Benefits Service Center or contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact one of the following:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory (or call 1-866-444-3272 to obtain the address and phone number)

- Division of Technical Assistance and Inquiries
  Employee Benefits Security Administration
  U.S. Department of Labor

200 Constitution Avenue NW
Washington, D.C. 20210

You can also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

# The Legal Documents as Final Authority

This handbook is a summary of certain key provisions of the Plan. This summary is not intended to cover every Plan detail. The Plan is governed by formal plan documents. *If any conflict exists between this summary and the provisions of the legal Plan documents, the Plan documents govern.* The legal Plan documents are available for you to review by contacting the Plan Administrator or the Benefits Service Center during regular office hours.

# Glossary

# Glossary

**Active Work or Actively at Work**
You are an active employee, or Actively at Work, if you are at work performing the essential functions of your job:

- On a full-time basis, or
- For at least 20 hours per week, if you are eligible for the benefits as a part-time employee

You also are Actively at Work if you are not disabled and are away from work due to a holiday, vacation or other approved absence, or due to any health-related reason, including a medical condition or a hospital confinement.

**Allowable Amount**
The maximum amount determined by the Claims Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- *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, negotiated rates, or other payment methodologies.

- *For Hospitals and Facility Other Providers not contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan outside of Texas* – The Allowable Amount will be the amount the Claims Administrator would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate, the Allowable Amount will be the lesser of billed charge or a per diem established by the Claims Administrator.

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

  If the Claims Administrator does not have sufficient data to calculate the Allowable Amount for a particular procedure, service, or supply, the Claims Administrator will determine an Allowable Amount based on the complexity of the procedure, service, or supply and any

unusual circumstances or medical complications specifically brought to its attention, which require additional experience, skill, and/or time.

- *For 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.

- *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.

**Claims Administrator**
A company that reviews, processes, and/or pays health care claims. The current Claims Administrators are shown in the "Plan Administration" section.

**Claims Fiduciary**
A provider who assumes sole responsibility for the decision made and financial responsibility for any claim filed for a specific benefit. The current claims fiduciaries are shown in the "Plan Administration" section.

**Coinsurance**
The percentages of the total cost of services that you and the options pay when you receive care. For example, if the option pays 80% Coinsurance for a covered service, you pay the remaining 20%. You need to meet the option Deductible before the option pays its share of Coinsurance.

**Copayment (Co-pay)**
The amount you are responsible for paying the provider at the time you receive certain health care services.

**Deductible**
When required by the option, the amount you are required to pay each year before benefit payments are made.

**Dependent (for FSAs)**
For purposes of the Dependent Care Spending Account option, a dependent is either (i) a dependent child who is under 13 years of age at the time the care is provided and for whom you can claim an exemption on your federal income tax return, or (ii) a spouse, or any other person that qualifies as your dependent for federal income tax purposes and for whom you can claim an exemption on your federal income tax return, who is incapable of self-care due to a mental or physical condition.

Under the Health Care Flexible Spending Account option, a dependent is anyone who qualifies as your dependent for federal income tax purposes, in accordance with section 152 of the Internal Revenue Code (without regard to section 152(b)(1) and (2) and section 152(d)(1)(B)).

In general, a dependent for federal income tax purposes includes certain qualifying relatives dependent upon you for at least half of their financial support. A dependent's eligible expenses can

be reimbursed from the Dependent Care Spending Account option even if he or she does not qualify as a dependent eligible for coverage under other company-sponsored benefit options.

**Eligible Charge**
The reasonable and customary, or negotiated, fee for services and supplies prescribed by a doctor or dentist. The services must be medically or dentally necessary, covered under the option for the treatment of a non-work-related injury or illness, and not provided primarily for the convenience of you, your dependent, the hospital, or the doctor.

For purposes of prescription drug benefits, an Eligible Charge is the negotiated charge for a prescription drug specified as covered under the Medical Plan option. The fee must not be in excess of the charge for a generic drug, less the required Copayment when a generic drug is available but a brand-name drug is selected.

**MyWorkday (www.myworkday.energyfutureholdings.com)**
You use this Web site to make your benefit elections during open enrollment and to access, learn about, and make changes to your benefits throughout the year. The site also includes helpful year-round resources with additional information about your benefits.

**Evidence of Insurability (EOI)**
Also known as proof of good health. A statement of your medical history or, in some cases, a medical exam.

**Explanation of Benefits (EOB)**
A statement from the Claims Administrator that shows what the option paid – and what you owe – for a covered service.

**Full-Time Student (for FSA)**
For purposes of the Dependent Care Flexible Spending Account option, anyone who is enrolled in a school or college on a full-time basis. You may qualify for reimbursement of expenses from the Dependent Care Flexible Spending Account option while you are working and your spouse is a full-time student.

**In-Network Services**
Services or supplies provided by a doctor, hospital or other health care provider who is part of the network for a Medical Plan option you select.

**Legal Custody**
Custody granted and documented by the courts through appropriate legal processes, appointing an adult to exercise parental duties, rights, and responsibilities.

**Medically Necessary**
The most appropriate and necessary service, treatment or supplies for the direct care and treatment of a medical condition as generally accepted by medical standards and known to be effective in improving health outcomes, all as determined by the Plan Administrator or the Claims Administrator.

**Network**
A select group of doctors, hospitals, and other health care providers that contract with the Plan's Claims Administrators (BlueChoice PPO Plan Network) to offer negotiated rates to their participants.

If you use an in-network doctor, hospital or other health care provider, you will not be charged more than the network's negotiated rate for a service.

**Out-of-Network Services**
Services or supplies provided by a doctor, hospital or other health care provider who is *not* part of the network for the Medical Plan option.

**Participating Employer**
Vistra Energy Corp. and each of its U.S.-based subsidiary companies.

**Plan Year**
The calendar year.

**Program A**
If you were employed prior to January 1, 1991, you had, at that time, the option to keep your coverage under the frozen former life insurance program. This frozen coverage is called Program A. Only those employees previously participating in Program A are eligible to continue that coverage.

**Program B**
A life insurance option that is available only to LTD participants who went on LTD prior to May 1, 2001. Participants enrolled in this option are not eligible for the current Life Insurance Plan.

**Qualified Child Care Provider**
Child care that is provided by either of the following:

- A dependent care facility that maintains all required licensure under relevant state and local laws, regulations, rules, and ordinances applicable to those facilities

- An individual or facility not required to maintain licensure under relevant laws, regulations, rules, and ordinances to provide care for individuals

**Qualified Medical Child Support Order (QMCSO)**
A medical child support order is a judgment, an order, or a decree that is made under state domestic relations law and provides for child support or health benefit coverage for an "alternate recipient." An alternate recipient is a child of a participant under a group health plan who is recognized under the order as having the right to enrollment under the Plan with respect to the participant. A medical child support order that is "qualified" creates or recognizes the right of the "alternate recipient" to receive benefits for which the participant is eligible under a group health plan. The order is recognized as "qualified" by the Plan Administrator of the group health plan when it includes certain information that meets the QMCSO statutory requirements. In addition, a properly completed National Medical Support Notice (NMSN) issued by a state child support enforcement agency must be treated as a QMCSO. The Plan Administrator is required by law to honor a QMCSO or an NMSN.

**Recognized Charge**
The covered expense is only that part of a charge which is the Recognized Charge.

As to dental expenses, the Recognized Charge for each service of supply is the lesser of;

- What the provider bills or submits for that service or supply; and

- A designated percentile of the Prevailing Charge Rate; for the Geographic Area where the service is furnished

**Surviving Dependent Coverage**
Under the terms described herein, health care coverage that may be made available to your spouse and dependents, if they are eligible and elect such continued coverage in the event of your death.

**Treatment Plan (for the Dental Plan options)**
A treatment schedule for orthodontia services that outlines the orthodontia services to be provided, how long the services will take, and how much they will cost.

**Urgent Conditions**
The option covers care by an urgent care provider for urgent conditions. An urgent care provider is an urgent care facility or a Doctor's office designated by the option as an urgent care provider. An urgent condition is an illness, an injury, or a condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of the person's health

- Would subject the person to severe pain that could not be adequately managed without treatment

- Does not require the level of care provided by an Emergency room or a Hospital

- Requires immediate outpatient medical care that cannot be postponed until the person's Physician is available

In case of an Emergency, you should *not* seek care from an urgent care provider. Instead, go directly to the Emergency room or call 911 (or the local equivalent) for an ambulance or medical assistance.

Urgent care does not include routine or Preventive Care, immunizations, follow-up care, physical therapy, elective surgical procedures, or any lab or radiologic exams that are not related to the treatment of the urgent condition. If you receive these services from an urgent care provider, no benefits are payable.