2026

Retiree Benefits Guide

Benefit Information for Non-Medicare Eligible Participants

CPS ENERGY

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CPS Energy is proud to provide you and your dependents with valuable and significant benefits. This Guide is an overview of the benefits available for individuals who are non-Medicare eligible and covered under the CPS Energy Health plan.

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See page 17 for important information concerning Medicare Part D coverage.

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

Important Open Enrollment Information

The election period **starts October 20 and ends November 7**. All changes will become effective January 1, 2026. More information will be provided during the upcoming Open Enrollment meetings in October.

Benefit Information for Non-Medicare Eligible Participants

Who is eligible to continue benefit coverage through the CPS Energy PPO Group Health Plan (Plan A, B, and HDHP C)?

Only Non-Medicare eligible retirees and dependents who are currently enrolled in CPS Energy Health Plan.

Eligible dependents include:

- Non-Medicare eligible Spouse
- Children up to age 26
- Children of any age who were physically or mentally disabled before their 26th birthday and are not eligible for Medicare.

If you waive health coverage for the 2026 plan year, you will not be allowed to re-enroll in the future.

Important Notice for Medicare eligible participants:

Beginning January 1, 2026, CPS Energy will be offering Medicare Supplement plans to Medicare eligible retirees and their covered dependents. Participants who are eligible for the Supplement plans will not be able to continue coverage in the CPS Energy Group Health Plan options Plan A, Plan B, or the HDHP Plan C. CPS Energy has partnered with Amwins to assist with the administration of the new Supplement plans. Those who are eligible for Medicare will receive a separate enrollment kit from Amwins that will include details about the new plans and enrollment information.

Many retiree families may be part of a "split family." A split family means that one or more of the participants covered under the CPS Energy Group Health Plan are eligible for Medicare, but others are not. Only family members who are not eligible for Medicare can continue coverage under Plan A, Plan B, or Plan C until they become eligible for Medicare. *These participants are required to submit Section 3 of the enrollment form to Employee Benefits (see page 22.) Split family members who do not submit this form (and who are currently covered under the CPS Energy Health Plan), will be defaulted to their current Health Plan under their new coverage tier.*

Split families will receive two separate invoices per family for their health premiums. They will receive one invoice from CPS Energy for Non-Medicare eligible participants (covered under the CPS Energy PPO Group Health Plan), and another invoice from Amwins for the Medicare eligible family member(s) (covered under the CPS Energy Medicare Supplemental plan).

Approximately three months prior to being eligible for Medicare, Amwins will send qualifying participants an enrollment kit so that they may transition to one of the new Supplemental plans.

All participants should review the top of page 21 for instructions on how to enroll in benefits

Medical Benefits

BlueCross BlueShield of Texas

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

Medical Benefits for Non-Medicare Participants

All non-Medicare eligible Participants can enroll in one of the three CPS Energy Health Plans. (Plan A, Plan B, or the HDHP Plan C.)

	PLAN A PPO[1]		PLAN B PPO[1]		PLAN C HDHP	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$1,800	$3,600	$950	$1,900	$1,900	$3,800
FAMILY	$5,200	$10,400	$2,850	$5,700	$3,800[2]	$7,600
COINSURANCE	20%[3]	40%[3]	20%[3]	40%[3]	20%[3]	40%[3]
ANNUAL OUT OF POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$5,600	$11,200	$6,200	$12,400	$3,800	$10,200
FAMILY	$11,200	$22,400	$12,400	$24,800	$7,600	$20,400
COPAYS/COINSURANCE						
PREVENTIVE CARE	$0	40%[3]	$0	40%[3]	$0	40%[3]
PRIMARY CARE VISIT	20%[3]	40%[3]	$20 Copay	40%[3]	20%[3]	40%[3]
SPECIALIST VISIT	20%[3]	40%[3]	$40 Copay	40%[3]	20%[3]	40%[3]
VIRTUAL VISITS	20%[3]	Not Covered	$20 Copay	Not Covered	20%[3]	Not Covered
DIAGNOSTIC SERVICES	20%[3]	40%[3]	20%[3]	40%[3]	20%[3]	40%[3]
URGENT CARE	20%[3]	40%[3]	$35 Copay	40%[3]	20%[3]	40%[3]
EMERGENCY ROOM	$200 Copay + 20%[3] (copay waived if admitted)	$200 Copay + 20%[3] (copay waived if admitted)	$200 Copay + 20%[3] (copay waived if admitted)	$200 Copay + 20%[3] (copay waived if admitted)	20%[3]	20%[3]

[1]All covered family members' eligible expenses count toward the family deductible; however, no one family member will have to meet more than the individual deductible and out-of-pocket maximum.
[2]All covered family members' eligible expenses count toward the family deductible. $3,800 family deductible must be met before coinsurance applies to anyone in the family, to include RX costs.
[3]After Deductible

	PLAN A PPO	PLAN B PPO	PLAN C HDHP	DENTAL	VISION
MONTHLY RETIREE CONTRIBUTIONS*					
PARTICIPANT	$106.17	$162.37	$153.13	$6.01	$1.75
PARTICIPANT + SPOUSE	$342.11	$458.62	$450.81	$20.50	$4.36
PARTICIPANT + CHILD(REN)	$271.33	$371.29	$355.26	$15.94	$3.82
FAMILY	$450.91	$609.91	$583.10	$27.32	$7.51
MONTHLY EMPLOYER CONTRIBUTIONS					
PARTICIPANT	$661.82	$649.29	$649.35	$29.71	$6.99
PARTICIPANT + SPOUSE	$1,270.74	$1,244.79	$1,234.02	$54.52	$13.09
PARTICIPANT + CHILD(REN)	$1,034.30	$1,008.56	$1,007.60	$44.79	$11.47
FAMILY	$1,699.56	$1,662.79	$1,662.08	$72.69	$17.52

*Monthly contributions for retiree healthcare will differ based upon your age and years of service at the time of your retirement. Split families will pay the rates indicated on this chart by tier level.
The premiums shown apply if you retired at age 55 or after with 35 years of benefits service. Surviving Spouses pay the full premium equal to the Retiree Contribution plus Employer Contribution.

Helpful Resources

Virtual Visits

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

Conditions Commonly Treated Through a Virtual Visit

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

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

Virtual Visits with licensed behavioral health therapists are available by appointment for conditions such as:

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

Access Virtual Visits

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

Use virtual visits when:

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

Not good for:

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

How to Find a Provider

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

Urgent Care Centers vs. Freestanding Emergency Rooms

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

Get the Most Out of Your Benefits

24/7 Nurseline can help you identify some options when you or a family member have a health problem or concern. Nurses are available at 800-581-0368, 24 hours a day, seven days a week, to answer your health questions.

Cost Estimator is an online tool found on Blue Access for members under bcbstx.com that makes it simple to research a procedure prior to receiving care, get a cost estimate and quality comparison between facilities and providers.

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

BCBSTX Benefits Value Advisors

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

Where to Go for Care

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

	Nurse Line	Telemedicine ($)	Primary Care Center ($)
When to Use	You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.	You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).	You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.
Types of Care*	Answers to questions regarding: ▪ Symptoms ▪ Self-care/home treatments ▪ Medications and side effects ▪ When to seek care	▪ Cold & flu symptoms ▪ Bronchitis ▪ Urinary tract infection ▪ Sinus problems	▪ Routine checkups ▪ Immunizations ▪ Preventive services ▪ Managing your general health
Costs and Time Considerations**	▪ Usually available 24 hours a day, 7 days a week ▪ Typically free as part of your medical insurance	▪ Usually a first-time consultation fee and a flat fee or copay for any visit thereafter ▪ Typically immediate access to care ▪ Prescriptions through telemedicine or virtual visits not allowed in all states	▪ Often requires a copay and/or coinsurance ▪ Normally requires an appointment ▪ Short wait time with scheduled appointment

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

Do Your Homework

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

	Urgent Care Center ($$)	Emergency Room ($$$)
When to Use	You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.	You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.
Types of Care*	▪ Strains, sprains ▪ Minor broken bones (e.g., finger) ▪ Minor infections ▪ Minor burns	▪ Heavy bleeding ▪ Chest pain ▪ Major burns ▪ Severe head injury
Costs and Time Considerations**	▪ Copay and/or coinsurance usually higher than an office visit ▪ Walk-in patients welcome, but urgency determines order seen and wait time	▪ Often requires a much higher copay and/or coinsurance ▪ Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first ▪ Ambulance charges, if applicable, will be separate and may not be in-network

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

Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help?

Mental Health and Your Medical Plan

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

Other Mental Health Resources

No matter your problem, don't be afraid to ask for help. There are resources available 24/7.

988 Suicide & Crisis Lifeline

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

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

Crisis Text Line

Text "HOME" to 741741.

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

War Vet Call Center

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

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

Health Savings Account (Plan C)

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

Pre-65 retirees are eligible to participate in the HSA. Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependent(s), even if they are not covered by your plan.

HSA Bank will issue you a debit card, giving you direct access to your account balance. When you have a qualified medical expense, you can use your debit card to pay. You must have a balance to use your debit card. There are no receipts to submit for reimbursement.

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

Individually Owned Account

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

Eligibility

You are eligible to open and fund an HSA if:

- You are under the age of 65
- You are not covered by your spouse's non-HSA health plan
- Your spouse does not have a Healthcare FSA or HCA
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare or TRICARE
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration)

Tax-free Interest

Employer Pre-tax Contributions

HSA

Tax-free Payments
(for qualified medical expenses)

Unused Funds Roll Over Annually

How to Enroll

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

CPS Energy will establish an HSA account in your name and deposit contributions on a monthly basis once bank account information has been provided and verified.

Maximize Your Tax Savings

Your contributions to the HSA are tax-deductible, and the money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified expenses, they are withdrawn tax-free.

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

HSA Funding Limits

The IRS places a limit on the maximum amount that can be contributed to an HSA. For 2026, contributions (which include any CPS Energy contribution) are limited to the following:

HSA FUNDING LIMITS	
PARTICIPANT	$4,400
FAMILY	$8,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

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

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

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

Pharmacy Benefits

Prescription Drug Coverage

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

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

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

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

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

Maintenance Choice Pharmacy Benefit

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

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

Pharmacy Benefit Summary

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

Note: Out-of-Network coverage not available

Dental Benefits

CPS Energy offers affordable plan options from MetLife for routine care and beyond.

MetLife

Network Dentists

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

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

*After deductible

Note

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

Find a Provider on the MetLife Mobile App

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

You can:

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

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

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

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

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

Vision Benefits

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

MetLife

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

Note

You can mix and match and get two pairs of glasses, contacts, prescription sunglasses, or one pair of glasses and a set of contacts.

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Required Notices

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

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2026
Name of Entity/Sender:	CPS Energy
Contact—Position/Office:	Employee Benefits
Address:	500 McCullough Ave San Antonio, TX 78215
Phone Number:	210-353-2900, Option 1

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Employee Benefits at 210-353-2900, Option 1.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Employee Benefits at 210-353-2900, Option 1.

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

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

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

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

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

To request special enrollment or obtain more information, contact Employee Benefits at 210-353-2900, Option 1.

Important Contacts

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

Nurse Line
800-581-0368

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

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

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

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

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

JPMorgan
888-719-8932

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

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

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2026 Non-Medicare Eligible Retiree Open Enrollment Form

Instructions:

- **Do NOT complete this form if:** You and your dependents are **all non-Medicare eligible**, and you have no changes. Your current coverage will continue.
- **Complete Sections 1 & 2 if:** You and your dependents are **all non-Medicare eligible**, and you want to make changes to your plan.
- **Complete Sections 1 & 3 if:** You are a **Split Family (some members are Medicare eligible; others are not).** *Medicare-eligible members must also complete the Amwins Enrollment Form (included in a separate mailing). If that form is not completed for those who are Medicare eligible, then those participants will automatically be enrolled in the Medicare Supplemental Base Plan.*

Section 1: Retiree Information

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

Section 2: Plan Changes (Non-Medicare eligible only)

I elect to change my plan to the following:

☐ PPO Plan A ☐ PPO Plan B ☐ PPO Plan C ☐ Waive Medical ☐ Waive Health Savings

Remove Dependents Below: (You cannot add dependents. Removed dependents cannot be re-enrolled later.)

Last Name, First Name, MI	**Gender** **M**	**F**	**Date of Birth**	**Social Security Number**
Retiree				
Spouse				
Child				
Child				

My signature below indicates my understanding that these elections remain in effect until I am eligible to make another election during an annual enrollment period or because of a qualified status change. I understand that I must report and submit in writing any requests for plan changes due to a status change within 31 days of the event.

Authorized Participant Signature:_____ **Date:**_____

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

Section 3: Split Family

- Are you (the retiree), Medicare eligible? ☐ Yes ☐ No
- Do you have dependents on your plan who are Medicare eligible? ☐ Yes ☐ No
  (If "Yes" to either question, *please remember to also fill out the Amwins Enrollment form for those individuals who are Medicare eligible.*

List all who are non-Medicare eligible staying on PPO Plan A, B or C

Last Name, First Name, MI	Gender M	Gender F	Date of Birth	Social Security Number
Retiree				
Spouse				
Child				
Child				

Health Plan Election: ☐ PPO Plan A ☐ PPO Plan B ☐ PPO Plan C ☐ Waive Medical ☐ Waive Health Savings Account

Health Savings Account (Plan C only)

Coverage	Annual Funding Limit[1]	-	CPS Energy Contribution	=	Retiree Contribution
Retiree	$4,400		$250		
Retiree + Spouse	$8,750		$500		
Retiree + Children	$8,750		$500		
Retiree + Family	$8,750		$750		

[1]*Individuals who are age 55-64 by the end of the tax year can make an additional catch-up contribution of $1,000*

☐ **I acknowledge that I have read and understand the Health Savings Account Authorized Agent Agreement** (Plan C Only).

My signature below indicates my understanding that these elections remain in effect until I am eligible to make another election during an annual enrollment period or because of a qualified status change. I understand that I must report and submit in writing any requests for plan changes due to a status change within 31 days of the event.

Authorized Participant Signature:_____ **Date:**_____

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

Authorized Agent Agreement for Plan C

I appoint CPS Energy as the Agent for the purpose of opening and administering a health savings account (HSA) on my behalf. I also acknowledge and certify that:

- I wish to establish an HSA with HSA Bank as custodian.
- I understand the eligibility requirement for deposits made to my HSA and state that I qualify to make deposits to this account. I understand and agree that my HSA will be opened and governed by HSA Bank.
- I authorize HSA Bank to provide information about my HSA, including my account number, to CPS Energy and those acting on behalf of CPS Energy or HSA Bank, in connection with the establishment and maintenance of my HSA.
- I acknowledge that CPS Energy, and all others acting on behalf of CPS Energy, may provide information on my behalf to establish and maintain my HSA and authorize CPS Energy and its designee to take such action deemed necessary and appropriate by CPS Energy to administer my HSA, including, but not limited to, making deposits and correcting errors where necessary.
- I understand my monthly account statements will be made available to me electronically. I agree to notify HSA Bank if I wish to have statements mailed to my home address.
- I understand that I have requested a Mastercard Debit Card.
- I certify that the information provided in this application is true and complete.

I agree that CPS Energy will remain my agent unless and until CPS Energy and the Bank receive notice that the appointment of CPS Energy as my agent has been terminated, that I am no longer employed by CPS Energy, or that I am no longer an HSA eligible individual, or I receive a notice from the Bank that my application for an HSA has been declined.

CPS ENERGY