Exelon

Benefits Reference Guide

Review this guide for more detailed information about your health and welfare, life insurance and other benefits and important terms to know.

2017

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ENROLLMENT HIGHLIGHTS

***Enroll by Web: exelonbenefits.com* (or via the My Benefits tab on *my*HR)**

***Enroll by phone:* 1-877-7EXELON (1-877-739-3566)**

*This guide includes some **key terms** you should know. These terms are highlighted in color throughout the guide the first time they appear and are defined beginning on page 22.*

This guide describes the Exelon health and welfare, life insurance and other benefit plans, and the descriptions are designed to help you select your coverages. The guide is not intended to be a summary plan description. If there is an inconsistency between this guide and the terms of the benefit plan documents or summary plan descriptions, the actual plan documents will govern in all cases.

This *Benefits Reference Guide* provides information to help you make decisions about your Exelon health and welfare, life insurance and other benefits. For more details about your Exelon benefits, refer to your summary plan description (SPD).

If you have any questions about the information in this guide, log on to ***exelonbenefits.com*** to access your benefits information via *my*HR *benefits*. You can also call *my*HR *benefits* at 1-877-7EXELON (1-877-739-3566) and speak with a representative. Representatives are available Monday – Friday from 7 a.m. to 6 p.m. Central Time/8 a.m. to 7 p.m. Eastern Time.

You may also call *my*HR *benefits* any time and listen to the prompts to be transferred to a benefits provider (for example, Blue Cross and Blue Shield of Illinois or Vision Service Plan).

ABOUT YOUR BENEFITS

COVERAGE

You can choose from the following coverage categories for the medical, dental and vision and hearing care plans:

- *Employee only*
- *Employee plus child(ren)*
- *Employee plus family.*

Note: **Dependents** *can include your* **domestic partner** *and his or her children for medical, dental and vision and hearing care plan coverage. For more information about domestic partner benefits, call* myHR benefits *at 1-877-7EXELON (1-877-739-3566).*

Medical Coverage and Working Spouses

Because the company's medical coverage is very generous, a higher percentage of employees cover their working spouses and domestic partners through the company's medical plans compared to other large companies. Because most of these working spouses and domestic partners have coverage available to them through their employers, many spouses are being covered under the company's medical plan out of choice rather than necessity.

If you cover your spouse or domestic partner under the company's medical coverage and he or she has coverage available through another employer, you will pay an additional $625 each year for company coverage. This $625 surcharge will be deducted from your paycheck in equal **pre-tax** installments of $24.04 during the year.

If you cover your spouse or domestic partner on the company's medical coverage, you will need to certify whether he or she has coverage available through another employer during open enrollment.

Transfers of Employment

If you transfer employment to another Exelon subsidiary (e.g., from ComEd to Exelon Generation) during the calendar year, your elections generally will continue in effect for the balance of the year, and you will be deemed to have consented to payroll deductions by your new employer, even if the amount of the deductions changes. The only reason you may have to re-enroll is if a benefit you elected with the prior subsidiary is not offered by the new employer (for example, HMO coverage is not available at your new assignment).

Part-Time Employees

If you are a **part-time employee**, you (and any eligible dependents) are eligible for the benefits under one of the following options:

Option 1	Option 2
• Medical • Health Care Flexible Spending Account • Dependent Care Flexible Spending Account • Commuter Spending Account • Long-Term Care Insurance • Legal Services	• Dental • Vision and Hearing Care • Basic Life Insurance • Supplemental Life Insurance • Disability Coverage (including MBA coverage) • Health Care Flexible Spending Account • Dependent Care Flexible Spending Account • Commuter Spending Account • Long-Term Care Insurance • Legal Services

If you are a part-time employee, you are not eligible for any excused paid absence (for example, for a doctor's appointment or a parent-teacher conference) or first-week disability benefits regardless of whether you elect Option 1 or Option 2. If you elect Option 2 and enroll in disability benefits, you will be eligible to receive disability benefits, but not first-week, company-paid benefits.

YOUR MEDICAL OPTIONS

- *PPO*
- *HMO*
- *Waive Coverage*

WHERE TO LOOK

Review the Comparing Your Health Care Options *brochure to compare the key features offered by the medical programs.*

MEDICAL

Exelon's medical options have been selected because they meet our high standards for employee satisfaction, care and cost management. You may select one of those options, or choose to **waive coverage**.

This guide summarizes the preferred provider organization (PPO) and health maintenance organization (HMO) options. Since eligibility is determined by your home ZIP code, the HMO may be unavailable to you. To learn which programs are available to you, see your personalized enrollment worksheet.

PPO

The PPO provides both in- and **out-of-network** coverage. To receive **in-network** benefits, you may seek care from any doctor participating in the PPO network. Because preventive care is vital to keeping you and your family healthy, in-network preventive care is covered at 100%. For most other in-network expenses, you meet a **deductible** each year, then the medical plan pays 90% of the cost of most eligible in-network expenses. There is also a limit on the amount of **out-of-pocket** expenses you pay toward eligible expenses each year.

For in-network office visits in the PPO, your **copayment** is $15 if your physician is a **primary care physician** (PCP) and $25 if you see a **specialty care physician** (a provider whose focus is a specific area of health care, such as a cardiologist or dermatologist).

If you see a health care provider who is not part of the PPO network, you still may receive a benefit. However, when you use out-of-network providers you pay higher **coinsurance** and deductibles than you do for in-network providers.

If you select the PPO, you must call to preauthorize hospital stays (including those for mental health/substance abuse treatments), certain surgical procedures, and to obtain out-of-network approval.

MEDICAL AND DENTAL NETWORK PARTICIPANTS

If you elect to participate in the HMO, you should make sure your current primary care physician (PCP) or dentist participates in the program you are electing. If you elect the PPO, you may see any qualified provider and receive out-of-network coverage, but it may be less costly to find a program in which your physician participates. However, please note that if your provider leaves the medical or dental PPO or HMO network during the year, it will not entitle you to change your coverage option.

A FINANCIAL INCENTIVE TO PARTICIPATE IN THE HEALTHYROADS HEALTH COACHING PROGRAM

If you are enrolled in the PPO or Aetna HMO, certain preferred brand drugs related to a condition that the Healthyroads Health Coaching program is helping you manage will be covered at the generic coinsurance level, and generic prescriptions related to that condition will be filled at no cost to you. (Non-preferred brand prescriptions are not included in the incentive.)

For more information about the program and the incentive, see page 17 of this guide.

HMO

The Aetna HMO provides coverage for services received from a primary care physician (PCP) or through a PCP's referral. You select the PCP. Most eligible expenses are covered at 100% with a copayment and no deductible.

If you see a health care provider other than your PCP without the PCP's referral, your expenses will not be covered (except in certain emergency situations).

The Aetna HMO has one copayment for office visits with PCPs ($20) and a higher copayment ($30) for office visits with specialty care physicians (providers whose focus is a specific area of health care, such as a cardiologist or dermatologist). Also, a $250 copayment applies to each hospital admission.

Refer to your personalized enrollment worksheet to learn whether the Aetna HMO is available in your area. Then review the *Comparing Your Health Care Options* brochure for more information about the HMO.

Waive Coverage

You can choose to waive Exelon's medical coverage. This means that you choose to receive no medical coverage from Exelon. You might do this if you have medical coverage elsewhere.

FIND OPTUMRX NETWORK PHARMACIES, DRUG LISTS AND MORE

To see the OptumRx pharmacy networks, Premium Formulary or check the cost of your prescription, log on to ***mycatamaranrx.com/Exelon****.*

After you enroll, ***mycatamaranrx.com/Exelon*** *will be your one stop for all OptumRx information.*

If you have any questions, call OptumRx at 1-855-577-6548.

OptumRx Prescription Drug Program

Participants in the PPO automatically participate in the OptumRx (formerly Catamaran) prescription drug program. (The HMO has its own prescription drug program — refer to the *Comparing Your Health Care Options* brochure for more details.)

- The **retail drug program** covers a 30-day supply plus one refill at one of the thousands of pharmacies participating in the OptumRx network.
- Beginning with the second refill of a prescription, you may get refills through the **Home Delivery program** or at **certain retail pharmacies**.
  - — To use the **Home Delivery program**, you will need to obtain two prescriptions from your physician:
    1. A 30-day prescription with one refill that you can fill at a local participating pharmacy so you can get the medication under the retail program while your mail order is processed.
    2. A prescription for up to a 90-day supply with the number of refills specified by your doctor.

    You will then submit the second prescription (the one for only refills) to OptumRx by mail, by phone or on the Web, and OptumRx will fill the prescription and mail your medication to your home.
  - — You may also get refills at OptumRx's network of retail pharmacies.
    - – For any long-term or maintenance prescriptions that you fill through a retail pharmacy, the 90-day retail pharmacy minimum and maximum copayments apply beginning with the second refill of any prescription, regardless of whether you receive a 90-day supply (see the chart on page 6 for more details). This means it will generally be more cost-effective for you to get 90-day supplies, when appropriate.
    - – Please note however, that your out-of-pocket costs generally will be lower for 90-day supplies filled through the Home Delivery program rather than retail pharmacies, because drug costs and dispensing fees are typically higher at retail pharmacies.
    - – OptumRx's pharmacy network for 90-day prescriptions is slightly different from its standard network. See ***mycatamaranrx.com/Exelon*** for more information.

OptumRx Formulary

The OptumRx formulary is a list of drugs covered under the prescription drug program. The formulary identifies the drugs available for certain conditions and indicates which drugs are generic (tier 1), preferred brand (tier 2) and non-preferred brand (tier 3). Medications included on the formulary are preferred for their safety, cost and effectiveness. When choosing a medication, you and your doctor should consult the formulary. It will help you and your doctor choose the most cost-effective prescription drugs.

Since the formulary may change at any time, visit ***mycatamaranrx.com/Exelon*** for up-to-date information about all of the medications your pharmacy benefit covers, possible lower-cost options and cost comparisons.

2017 Retail Pharmacy and Home Delivery Prescription Drug Coverage for the PPO

Type of Medication	Plan Pays	You Pay	Retail (up to 30-day supply)		Home Delivery (up to 90-day supply)		Retail* (up to 90-day supply)	
			Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Generic	90%	10%	$5	$15	$10	$25	$15	$45
Preferred Brand	80%	20%	$15	$30	$25	$50	$45	$90
Non-Preferred Brand	70%	30%	$30	$50	$50	$85	$90	$150
Lifestyle Drugs and Non-Sedating Antihistamines	50%	50%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

* These copayments also apply beginning with the second refill (third total fill) of any 30-day prescription at retail pharmacies. For example, the second refill of a 30-day preferred brand prescription would have a $45 minimum copayment.

There is a separate $1,500 individual and $3,000 family annual prescription drug out-of-pocket limit in the PPO.

How You and the Company Share Prescription Costs

Under the OptumRx program, you pay coinsurance, or a percentage of the total cost of each prescription — the company pays the rest. The percentage you pay depends on whether the medication is **generic**, **preferred brand**, **non-preferred brand**, a **"lifestyle" drug** or a non-sedating antihistamine.

Non-Sedating Antihistamines

Non-sedating antihistamines that are available over the counter, without a prescription, are not covered under the OptumRx prescription drug program. Non-sedating antihistamines only available by prescription that are covered under the OptumRx program for the company include Xyzal®.

Lifestyle Drugs

Lifestyle drugs are those that treat the symptoms of chronic, non-life-threatening conditions, which are sometimes the by-products of natural aging. Lifestyle drugs under the OptumRx program for Exelon include the following:

Type of Medication	Examples
Acne medications	Retin-A®, Tretinoin®
Anabolic steroids	Oxandrin®
Depigmenting agents	Hydroquinone®, Lustra®
Erectile dysfunction	Cialis®, Levitra®, Viagra®
Weight management	Xenical®

WHERE TO LOOK

Review the Comparing Your Health Care Options *brochure to compare the key features offered by the dental programs.*

DENTAL

Exelon offers dental PPO and dental HMO options that emphasize preventive care, which can help keep small dental problems from becoming uncomfortable and expensive.

You should determine the level of network coverage in your area before making a coverage decision. Some areas may not have dental HMO coverage or only a limited HMO provider network. To check for providers in your area, call the benefit providers at the phone numbers listed in the *Comparing Your Health Care Options* brochure to request provider directories for the Aetna dental PPO network or the BlueCare dental HMO, or use the provider search tool on ***exelonbenefits.com***.

Aetna Dental PPO

If you elect the Aetna Dental PPO option, you can use any provider you choose. However, you will receive a higher level of benefit if you use a dentist in the dental PPO network. If you use an out-of-network provider, the program limits what it pays to a specific percentage of what is determined to be **reasonable and customary** for a certain service. If your provider charges more than the reasonable and customary rate, you pay the difference.

BlueCare Dental HMO

BlueCare offers a network of providers you can use to receive dental services. When you remain within the network, the program doesn't require you to pay a deductible and generally covers 100% of your costs after a copayment. The network providers and the program have already reached an agreement about the costs of dental services. **If you receive care outside of the network, you will not receive a benefit.**

Waive Coverage

You also can waive dental coverage if, for example, you have dental coverage elsewhere.

YOUR VISION AND HEARING CARE OPTIONS

- *Vision and Hearing Care Coverage*
- *Waive Coverage*

VISION AND HEARING CARE

Exelon's Vision and Hearing Care Plan can help you pay for preventive exams as well as for basic vision and hearing care expenses. The tables below highlight benefits provided by the program.

For more information, call Vision Service Plan (VSP) at 1-800-877-7195, or HearUSA at 1-800-333-3389.

Vision Benefits	In-Network Coverage	Out-of-Network Coverage
Eye exams (comprehensive) — once every calendar year	100%	Up to $30
Frames — once every calendar year*	Up to $150 retail allowance and 20% discount on amounts over allowance	Up to $50
Lenses* • Single vision • Bifocal • Trifocal • Lenticular	100% for standard glass or plastic prescription lenses or preapproved medically necessary contact lenses	 Up to $25 Up to $35 Up to $45 Up to $105
Contact lenses* (elective) — includes eye exam, evaluation and fitting	Up to $150	Up to $125

* The plan provides eyeglass lenses (or medically necessary contacts) every year, and you can get elective contacts or a pair of frames every year.
  — If you get contacts during a calendar year, you will be eligible to get two pairs of frames or a pair of frames and a set of elective contact lenses the following calendar year.
  — If you get a pair of frames during a calendar year, you will be eligible to get elective contact lenses and a pair of frames or two pairs of frames the following calendar year.

Please refer to the chart above for coverage details.

Lasik discounts are available if you use a VSP contracted Laser Vision Center. Go to ***vsp.com*** for details.

Hearing Care Benefits	HearUSA
Diagnostic hearing tests — one every 12 months	100% covered
Hearing aids, hearing aid repairs or earmolds	Up to the *lesser* of: • $1,000 per ear (every 36 months for adults and every 24 months for children), or • The amount allowed by HearUSA.
Hearing aid evaluation	100% covered

There are no out-of-network hearing care benefits. The program will pay benefits only if you go to a provider in the HearUSA network.

YOUR SPENDING ACCOUNT OPTIONS

- *Health Care FSA*
- *Dependent Care FSA*
- *Commuter Spending Account*
  - *— Parking Reimbursement Account*
  - *— Mass Transit Reimbursement Account*
- *Opt Out of Any or All Spending Accounts*

SPENDING ACCOUNTS

Spending accounts help you save tax dollars on a variety of health care and dependent care expenses. **You make spending account contributions pre-tax, so your money goes further!**

How the Spending Accounts Work

You enroll by deciding how much money, if any, you want to contribute to each account for the calendar year. Once you enroll, you cannot change your contributions outside of open enrollment unless you experience a qualified **change in status**.

The money is deducted from your paycheck before federal and state income and Social Security taxes are taken. Generally, when you have an eligible expense, you pay for it. You can then be reimbursed for the expense from the applicable spending account. Certain health care expenses and mass transit expenses are handled differently, as explained on pages 10 and 13.

If you transfer employment to another Exelon subsidiary, your year-to-date balance transfers with you — you cannot start another account.

If you enroll in a spending account, you will receive more information from WageWorks, the spending account administrator. You can log on now to ***wageworks.com*** to use helpful contribution calculators and view lists of eligible expenses.

Health Care FSA

The health care FSA enables you to use your pre-tax contributions to pay for a variety of eligible health care expenses for you and your eligible dependents. The maximum you can contribute to a health care FSA is $2,550. An eligible dependent for health care FSA purposes includes your spouse, your eligible children through age 25 and your qualifying relatives. Eligible children include both your legally adopted children and children lawfully placed with you for adoption. Your qualifying relatives include the individuals listed as qualifying relatives beginning on page 11. These individuals, however, need not be physically or mentally incapable of caring for themselves, nor are these individuals required to share your principal place of abode for more than one-half the year. An individual other than your spouse, for example, your domestic partner, is however required to share your same principal place of abode to qualify as a qualifying relative for health care FSA purposes.

IMPORTANT CONSIDERATIONS

Additional things to keep in mind about the health care and dependent care FSAs:

- *If you contribute to the health care FSA in 2017, you will have until March 15, 2018 to incur expenses against your 2017 contributions, and until May 31, 2018 to file claims for those health care expenses. You will forfeit amounts you do not use by March 15, 2018 and submit claims for by May 31, 2018. Please note that no expenses for an eligible child can be reimbursed under the health care FSA for any expenses incurred on or after the 26th birthday. All claims for expenses for such child must also be submitted no later than May 31, 2018.*
- *If you contribute to the dependent care FSA in 2017, you will forfeit amounts you do not use by December 31, 2017 and submit claims for by March 31, 2018.*
- *You cannot transfer funds from one spending account to another — from the health care FSA to the dependent care FSA, for example.*
- *If you leave the company, you can be reimbursed only for dependent care expenses incurred while you were actively employed. Health care expenses incurred after termination can be reimbursed only if you elect to continue* **after-tax contributions** *through COBRA.*

Eligible Expenses

Eligible health care expenses include but are not limited to:

- Medical and prescription drug coinsurance, insulin, certain over-the-counter medical items (not drugs), and dental, vision and hearing care expenses only partially covered or not covered under the company's plans, and
- Copayments and deductibles.

If you contribute to the health care FSA, you will receive a prepaid card that works like a credit card. You can use this card to pay for certain eligible health care expenses, and it automatically deducts from your account. (Be sure to keep your receipts and other records each time you use the card as you may need to submit these to verify that your expenses are eligible.)

If a health care expense is insured or reimbursed through another plan, you cannot be reimbursed for that expense through this account.

Dependent Care FSA

The dependent care FSA permits you to be reimbursed for expenses for children and other dependents. The dependent care FSA lets you save tax dollars for eligible child and elder day care services. It is designed to help you pay for dependent care services that make it possible for you and your spouse (if applicable) to be gainfully employed or for your spouse to attend school full-time. **It does not cover medical expenses incurred by a dependent, or expenses incurred while you or your spouse are not working (or your spouse is not attending school).**

Each calendar year you can contribute a maximum of $5,000 to your dependent care FSA. However, if you are married, other limits apply (see below). There is no minimum contribution limit.

If you are married and…	Then your maximum contribution is…
You or your spouse earns less than $5,000	The amount the lower-paid spouse earns
Your spouse also participates in a similar dependent care reimbursement account	$5,000 combined for both accounts
You file separate federal income tax returns	$2,500
You file a joint tax return	$5,000 (for you and your spouse's child care FSA whether at Exelon or another company)
Your spouse is a full-time student for at least five months of the year or is disabled	$250 per month if you have one dependent, $500 per month, subject to the $5,000 annual limit, if you have two or more dependents These limits apply to the months your spouse is in school.
Note: The total amount you can contribute to the dependent care FSA in a calendar year also includes any contributions made to a prior employer's FSA. This includes contributions to your and your spouse's plan(s).	

Eligible Dependents

As mentioned above, to be considered an eligible dependent under the dependent care FSA, a dependent must require care while you and your spouse (if applicable) are at work or your spouse attends school full time.

To comply with applicable IRS regulations, a dependent must be your spouse who is physically incapable of caring for himself or herself and has the same principal place of abode as you for more than half the year or one of the following:

Qualifying Child

To be a qualifying child, a child must:

- Be under age 13, **and**
- Have the same principal place of abode as you for more than half the year*, **and**
- Not have provided over one-half of his or her own support for the year, **and**
- Be your son, daughter, stepchild, brother, sister or stepsibling or a descendant of such relative (for example, your grandchild).

* Please note that generally an individual may only be claimed as a qualifying child by one taxpayer and specific rules apply to determine which taxpayer will be treated as having a qualifying child.

Qualifying Relative

If your dependent is not a qualifying child, he or she may be an eligible dependent if he or she is a qualifying relative. To be a qualifying relative, the dependent must:

- Be physically or mentally incapable of caring for himself or herself, **and**
- Have the same principal place of abode as you for more than half the year**, **and**
- Receive more than half of his or her support from you.**

Qualifying relatives may include:

- A child who doesn't satisfy the "qualifying child" definition or a descendant of such child (for example, your grandchild),
- A son- or daughter-in-law,
- A brother, sister or stepsibling,
- A brother- or sister-in-law,
- A parent or the ancestor of a parent (for example, your great-grandparent),
- A stepparent or parent-in-law,
- A niece or nephew,
- An aunt or uncle, or
- An individual (other than your spouse) who has the same principal place of abode as you for the year and is a member of your household.

** In the case of children of divorced parents, legally separated parents or parents who live apart during the last six months of the calendar year, special rules apply; see Section 152 of the Internal Revenue Code or contact *my*HR *benefits*.

Eligible Expenses

You can use your dependent care account to pay for a variety of services, including:

- A licensed day care center or child care center
- Nursery school or preschool
- A caregiver who provides child care in your home
- Summer day camp expenses
- A practical nurse for a dependent who is physically or mentally unable to care for himself or herself
- A housekeeper who cares for a dependent.

Note: Your caregiver cannot be your dependent child under age 19 or your spouse, and you must provide the caregiver's tax identification number or Social Security number when you file your income taxes.

For a full list of eligible dependent care expenses, log on to ***wageworks.com***.

Federal Tax Credit

Under current tax law, you may claim dependent care expenses as a credit on your federal income tax return. The amount of the tax credit varies depending on your income.

You *can* use both the tax credit and the dependent care FSA for your dependent care expenses. However, if you plan to use both, your tax credit will be reduced — dollar for dollar — by any reimbursements you receive from the FSA. In some cases, it may be more advantageous to claim the dependent care tax credit than to use the dependent care FSA. Consult your tax advisor to determine which option is better for you.

IMPORTANT CONSIDERATIONS

Additional things to keep in mind about the Commuter Spending Account:

- *Your deductions are taken monthly, not per pay period, for this account.*
- *If the cost of your mass transit pass or voucher exceeds the monthly maximum contribution, the difference will be deducted after-tax. For example, if your pass costs $275, then $255 will be deducted pre-tax and $20 will be deducted after-tax.*
- *If you leave the company, you can be reimbursed only for commuting expenses incurred while you were actively employed.*

Commuter Spending Account

The Commuter Spending Account enables you to contribute pre-tax dollars for certain transportation costs. You can contribute to two separate accounts within the Commuter Spending Account: the Parking Reimbursement Account and the Mass Transit Reimbursement Account. **You may enroll in the Commuter Spending Account at any time during the year for any reason.** Enrollment is subject to certain monthly deadlines. Please contact WageWorks for more information.

Eligible Expenses

You can use your account to pay for a variety of expenses, including:

- Mass transit passes, such as for subways, commuter trains or buses
- Commercial van or bus services
- Parking near the company or at a location from which you commute to work.

The account does not cover EZ Pass, IPass, tolls, gas, mileage or your spouse's commuting expenses.

The current maximum amounts you can contribute are:

- $255 per month to the parking account for parking costs while working
- $255 per month to the mass transit account for mass transit and commercial van service.

If these limits increase during the year, you may adjust your election by contacting WageWorks.

Using the Account

To be reimbursed for parking and van pool expenses, you fill out a claim form and submit it to the spending account administrator. You will need to submit claims for reimbursement of these types of expenses incurred within six months. Otherwise, your election amount will be converted to a credit that you can use to offset future pre-tax elections.

You can use your contributions to the Mass Transit Reimbursement Account to buy mass transit vouchers and passes online at ***wageworks.com*** or by calling WageWorks at 1-877-WAGEWORKS (1-877-924-3967). (The IRS does not permit cash reimbursements for most mass transit expenses.)

YOUR DISABILITY OPTIONS

- *MBA Disability Coverage (includes Supplemental Disability Plan)*
- *Core Disability Coverage*

DISABILITY

Your disability program provides you with income protection if you are unable to work due to a non-occupational illness or injury. The program has three parts:

- **"First-Week" Benefits.** If you are a full-time employee, become **disabled** and cannot work, your employer will provide disability benefits equal to your **basic wages** for up to one week (seven calendar days).
- **Extended Disability Coverage.** Your disability coverage after the first week of disability benefits depends on the type of extended coverage you choose.
  - — **Mutual Benefit Association (MBA) Disability Coverage.** The MBA is an organization that provides additional disability benefits to its members. As a member, if you are disabled for more than one week, you will receive a percentage of your basic wages starting with the eighth day of disability and continuing for up to a total of 65 weeks. The percentage of your basic wages paid by the MBA depends on your length of service at the time of your disability.

    You automatically will be enrolled in the MBA after you complete three months of continuous service as a regular, full-time employee. You may opt out of MBA coverage within 30 days of your benefits eligibility by calling *my*HR *benefits*.

    If you elect to remain in the MBA, you will be required to pay membership dues.

    Your employer shares in the cost of MBA disability benefits by contributing an amount equal to the dues paid by members.
  - — **Core Disability Coverage.** If you are eligible for MBA membership but elect not to remain enrolled, you may still receive benefits beyond the first week of disability. However, you will receive only half of the benefits you would have received if you were an MBA member. You do not need to enroll for Core disability coverage.
- **Supplemental Disability Plan.** If you are an MBA member and you exhaust your 65 weeks of MBA disability benefits, you may continue to receive supplemental disability benefits for up to 36 months if:
  - — Exelon's Occupational Health Services (OHS) department certifies that you are **totally disabled** (as defined under the Supplemental Plan) throughout the period that you receive supplemental benefits, and
  - — You continue to satisfy the other applicable eligibility rules, and
  - — You are not eligible to begin receiving pension benefits, and
  - — You qualify for Social Security Administration disability benefits, or if you fail to apply for such benefits, a physician selected by OHS determines that you satisfy the requirements for Social Security Administration disability benefits.

Supplemental disability benefits are entirely employer-paid, and the percentage of basic wages you receive is the same as the percentage you received as an MBA benefit.

You are only eligible for the Supplemental Disability Plan if you participated in the MBA. No separate enrollment is required.

The following table allows you to compare your disability benefit options:

Years of Continuous Service at Date of Disability	Percentage of Basic Wages Paid After the "First Week"		
	First-Week Benefits	MBA Benefits	Non-MBA Member Benefits
Less than two years	100%	75%	37.5%
Two years or more	100%	86%	43%

You will need to provide **evidence of insurability (EOI)** if you enroll in MBA coverage after your initial eligibility period, and your eligibility for MBA coverage may depend on the results of a medical evaluation.

After your initial enrollment period, you may only enroll in the MBA during open enrollment, with coverage effective on the later of January 1 or the date your application is approved, or within 30 days after a qualified change in status, with coverage effective on the date the change in status occurred.

Your contributions for coverage will be deducted from your paycheck after tax.

YOUR LIFE INSURANCE OPTIONS:

- *Elect Supplemental Coverage*
- *Waive Supplemental Coverage*

LIFE INSURANCE

Exelon also sponsors a life insurance plan. Through basic and supplemental life insurance, you can provide income for your family in the event of your death.

- **Basic Life Insurance.** You automatically receive employer-paid basic life insurance equal to one times your annual base **pay**. Part-time employees working at least 20 hours per week receive basic life insurance if they elect Option 2.

- **Supplemental Life Insurance.** You may elect supplemental coverage equal to an additional one, two or three times your base pay. You pay the total cost of supplemental coverage, which is based on your age, with after-tax contributions. (Premiums generally increase the year you reach age 30 and every five years thereafter.) **Imputed income** will be calculated on any amounts of basic and supplemental life insurance that, combined, exceed $50,000. For information about how imputed income is calculated, see the "imputed income" definition on page 24.

Life insurance coverage also includes accidental death insurance and a permanent and total disability benefit. For more information, see your summary plan description (SPD).

Note: You must be actively at work on the day any coverage or increase in coverage will be effective. If you are not actively at work, the coverage or increase in coverage will be effective when you return to work for one full day.

Important Life Insurance Decisions

- **When to Enroll.** Evidence of insurability (EOI) is required if you elect supplemental life insurance or increase coverage amounts after your initial eligibility. You can complete a Personal Health Application online, using the link on ***exelonbenefits.com***, or by calling *my*HR *benefits* and requesting that a form be mailed to you.

- **Naming Your Beneficiary.** You must designate a beneficiary (or beneficiaries) who will receive your life insurance benefit should you die. **Make sure you have completed a life insurance beneficiary form or designated your beneficiary online at *exelonbenefits.com***. If you have any questions or if you need a beneficiary form, call *my*HR *benefits* at 1-877-7EXELON (1-877-739-3566).

Conversion Privilege

Regardless of your health, you have the right to convert your life insurance coverage to individual policies if you terminate your employment at Exelon. You **cannot** convert your accidental death coverage. For more information, see your SPD.

Portability

Your life insurance is portable — you may be able to continue coverage even if you terminate your employment. For more information, see your SPD.

For more information, including information about weight management programs, visit the Wellness page on ***exelonbenefits.com.***

OTHER BENEFITS

These benefits can be accessed at any time throughout the year.

Healthyroads Wellness Programs

Exelon encourages you to take advantage of the voluntary Healthyroads® program, provided at no cost to you.

Healthyroads Health Coaching

This comprehensive health improvement program offers telephone, video and online coaching to help you understand and deal with a variety of complicated health conditions, including diabetes, metabolic syndrome, congestive heart failure, back/spine pain conditions, asthma, COPD, hypertension and heart disease.

If you are enrolled in the PPO or Aetna HMO, have one of these conditions and choose to participate in the program, certain preferred brand prescriptions related to your condition will be paid at the generic coinsurance level, and certain generic prescriptions related to your condition will be filled at no cost to you. The list of medications eligible for this incentive is available on ***mycatamaranrx.com/Exelon***.

There is no additional contribution required for this program, and you can also save money because copayments for physician and chiropractor office visits related to your condition are reimbursed by the program. For more information or to see if you're eligible to enroll, call 1-888-385-2746.

Healthyroads Lifestyle Coaching

This personal health coaching program helps you address lifestyle health risks related to tobacco, activity, nutrition, weight and stress through one-on-one telephone-based and online coaching. You work with your own personal Healthyroads health coach to develop a customized program and set goals based on your needs, personality and lifestyle. In addition to motivation and support from your coach, you can also use online tools to make healthier choices.

Biometric Screenings

By attending either an onsite screening or a screening at a local contracted facility, you can learn vital health statistics, including:

- Blood pressure
- Lipid panel (total cholesterol, HDL, LDL and triglycerides)
- BMI and/or waist circumference
- Glucose/blood sugar

Your results will automatically populate your Personal Health Assessment so that you can generate a plan customized to you and your health needs.

Healthyroads.com

The website features a variety of tools to help you be your healthiest, including:

- **Personal Health Assessment (PHA):** The Personal Health Assessment is an online, private* questionnaire about your health and lifestyle. Your answers will generate suggestions for achieving health improvement.
- **Personal Scorecard:** View a complete, easy-to-read summary of the results from your initial Personal Health Assessment (PHA) and/or biometric screening, along with a tailored action plan based on your results.

For more information about programs available to you through Healthyroads, call 1-888-385-2746.

* While the company will receive information about the data collected to help identify the current and future health risks in our employee population, it will not be provided with any individually identifiable medical information. Healthyroads may use your participation information to provide you with other services on behalf of the company. Your participation serves as your consent for Healthyroads to use and/or provide this information as stated above.

Employee Assistance Program and Work/Life Benefits

OptumHealth administers the Employee Assistance Program (EAP), including Work/Life Benefits.

Employee Assistance Program (EAP)

The company provides confidential assistance to guide you and your family members to people, programs or services that will help with:

- Family or marital problems
- Job-related issues
- Legal or financial concerns
- Drug or alcohol abuse
- Stress, anxiety or other emotional problems.

You can reach the EAP at 1-866-872-1666.

Work/Life Benefits

Work/life benefits can help you find and maintain a balance between your work and your personal life. Consultants will answer your questions and find resources for grocery shopping, referral services for child care, elder care and camps, household services and more. You can visit ***liveandworkwell-exelon.com*** for information about these benefits.

Best Doctors

For employees and dependents who are enrolled in company medical coverage, Best Doctors can help you make the best decisions about your health. Whether you're facing minor surgery or an illness like cancer or heart disease, Best Doctors can guide you with the following services:

- In-depth reviews by specialists to confirm the diagnosis and treatment plan that your personal physician has provided
- Ask-the-expert services to help you get answers to questions about a medical condition and its treatment options
- Physician referral services
- Support to help you understand treatment options, including drugs and medical procedures, before making a medical decision.

To learn more, visit ***exelonbenefits.com*** or call Best Doctors at 1-866-904-0910.

24/7 Nurseline

The 24-hour nurse phone line administered by Blue Cross and Blue Shield of Illinois is a way to get quick, accurate information about health-related issues. If you are enrolled in Exelon medical coverage, you and your immediate family members may call for answers to your health-related questions 24 hours a day, seven days a week at 1-800-299-0274.

Staffed by registered nurses, the 24/7 Nurseline can help when you or a family member has a question about a health problem, such as:

- Dizziness or severe headaches
- High fever
- Constant crying (infants)
- Cuts or burns
- Sore throat.

Legal and Identity Theft Protection Services

Protect your family, finances and future year-round with legal and identity theft protection services offered through ARAG, a provider of insurance and legal services. As an ARAG member, you will receive access to professional attorneys, financial counselors, certified identity theft case managers plus other valuable resources that can help you prevent and resolve common legal issues.

Signing up for coverage gives you access to a network of attorneys, similar to how a PPO works for medical and dental plans. These attorneys will be available to advise you on legal issues at discounted rates. You are also eligible for unlimited free telephone consultations with network attorneys for many matters.

To learn more about Legal and Identity Theft Protection Services, call 1-800-247-4184 or visit ***ARAGLegalCenter.com***, access code 16301exe.

For terms, benefits and exclusions, call ARAG's toll-free number, 1-800-247-4184. Exelon is not responsible for Legal and Identity Theft Protection Services provided through ARAG.

GlobalFit

GlobalFit lets you choose from thousands of fitness centers nationwide, including well-known national chains and local facilities. You can join at low rates and with flexible membership options. For more information, log on to ***GlobalFit.com/beneplace***.

Note: Some non-metropolitan areas currently have limited or no GlobalFit network fitness centers. However, GlobalFit currently offers most Anytime Fitness, 24 Hour Fitness and Curves locations and is continually adding new providers to its network.

Exelon Extras (Employee Discounts)

Exelon Corporate Relations, Corporate Benefits and Strategic Supply have teamed up to compile and promote all of the savings opportunities available to employees as a result of Exelon's business relationships with suppliers and local organizations, including museums, auto, homeowners' and pet insurance and computer and phone companies. There's a link to Exelon Extras on the intranet home page. You may also log on to ***www2.beneplace.com/exelon***.

Adoption Assistance

The company will reimburse you up to $5,000 for eligible expenses you may incur while adopting a child under age 18. Adoption assistance benefits cover expenses such as legal and court fees and private and public adoption agency fees. For more information, call *my*HR *benefits* at 1-877-7EXELON (1-877-739-3566) to speak with a benefits representative.

Tuition and Education Reimbursement

All regular full-time employees of Exelon are eligible for the Tuition and Education Reimbursement benefit, which is designed to assist employees in their educational development and maintain the leading edge of knowledge in their area of responsibility. Employees may be reimbursed for courses at regionally or nationally accredited institutions and any mandatory fees.

You are eligible to participate after completing three months of continuous full-time service. Advance approval and satisfactory completion are necessary to be reimbursed for courses taken.

For additional information, call *my*HR.

Employee Savings Plan (ESP)

The Exelon Corporation Employee Savings Plan (ESP) is a 401(k) plan that enables you to save for your future and reduce your taxable income today.

You can contribute on a pre-tax basis, an after-tax basis or a combination of both. Exelon will match your contributions dollar for dollar up to 5% of your base pay each pay period.

You have a choice of investment funds, each with different objectives and expected risk and return. Please log on to ***exelonbenefits.com*** for more information.

Employee Stock Purchase Plan (ESPP)

The Exelon Corporation Employee Stock Purchase Plan (ESPP) enables eligible employees to share in the value we create as a business by providing an opportunity to purchase Exelon common stock at a discount from the market price.

The purchase price will be 90% of the closing price of the stock on the first business day of the quarter or the last business day of the quarter, whichever is lower. For more information, log on to *my*HR *benefits*.

KEY TERMS

AFTER-TAX CONTRIBUTIONS:
Contributions made after federal and state income and Social Security taxes are deducted from your pay.

BASIC WAGES:
Your annual base salary plus meter reader bonus, if applicable. Basic wages do not include other bonuses, incentive pay, overtime pay, shift premiums, fringe benefits and other extraordinary payments.

CHANGE IN STATUS:
According to IRS rules, once you enroll for coverage under Exelon benefits, those benefits, including coverage categories selected, remain in effect through the end of the plan year unless you have a qualified change in status. **Coverage changes must be made within 30 days of the change in status.** Qualified changes in status include the following:

- You, your spouse or your dependent experiences a change in employment status that affects benefits (for example, going from full-time to part-time or vice versa),
- Your legal marital status changes due to legal separation, marriage, divorce or annulment,
- A child is born, legally adopted or placed for adoption; you are appointed as a legal guardian to a child; or you are legally determined to be the parent of a child,
- A spouse or child loses eligibility or dies,
- Your, your spouse's or your dependent's hours of employment are reduced or increased,
- An event occurs that causes your dependent to satisfy or stop satisfying the eligibility requirements for the benefits program, such as reaching the age limit or adding a stepchild,
- Your spouse experiences a change in status that affects coverage under another employer's plan,
- Your, your spouse's or your dependent's place of residence changes,
- You, your spouse or your dependent becomes entitled to a **special enrollment** (see "Special Enrollment Period" on page 24),
- You are required to provide health coverage to your dependent child pursuant to a qualified medical child support order,
- You, your spouse or your dependent enrolls in or ends coverage in Medicare or Medicaid, or
- You experience a significant reduction or elimination of health benefits or a significant increase in the cost of coverage under another employer's plan.

If you have a domestic partner whom you can claim as your income tax dependent, the changes in status described above that apply to your dependents also will apply to your domestic partner. If you have a domestic partner whom you cannot claim as your income tax dependent, you may change coverage for your domestic partner (premiums for which are essentially paid on an after-tax basis) if your domestic partner experiences any of the following changes in status:

- Your domestic partner experiences a change in employment status that affects health care benefits,
- Your domestic partner loses health care eligibility or dies,
- Your domestic partner's hours of employment are reduced or increased,
- Your domestic partner experiences a change in status that affects health care coverage under another employer's plan,
- Your domestic partner's place of residence changes, or
- Your domestic partner enrolls in or ends coverage under Medicare or Medicaid.

The changes described above will not permit you to change your coverage or your dependent's coverage under a plan if you cannot claim your domestic partner as your income tax dependent. However, there is one exception: if your domestic partner experiences a change in status that affects health care coverage under another employer's plan (for example, your domestic partner's health plan has a different enrollment period than an Exelon plan), you may be permitted to change your coverage and your dependent's coverage under an Exelon plan.

Your change in coverage must be consistent with your change in status. For example, if you have a baby, adding the baby to your coverage would be consistent, but dropping coverage for your spouse would not be consistent.

To change your coverage as the result of a qualified change in status, you must request enrollment from *my*HR *benefits* within 30 days after the change in status — notifying the administrative service provider is not sufficient. Otherwise, you will not be able to make any changes until the next open enrollment period, with the change generally effective the following January 1.

COINSURANCE:
The percentage of a medical or dental expense that you or a plan pays after the deductible is met.

COPAYMENT:
The flat dollar amount you pay for certain medical or dental expenses.

DEDUCTIBLE:
The amount you pay each year for out-of-network medical services or dental care services before the plan starts to pay benefits.

DEPENDENT(S):
Dependents can include your:

- Spouse
- Domestic partner
- Children through age 25*
- Children of any age who are incapable of self-support because of a mental or physical disability, provided disabled status is determined prior to the child's 26th birthday, and the child is dependent on you or your spouse for support
- Children for whom there is a valid qualified medical child support order requiring health care coverage.

*Your dependents may be covered after age 26 if you participate in a fully-insured plan in Illinois. Under a state law, insured medical, dental and vision plan options that offer dependent child coverage must offer such coverage up to age 30 for unmarried military veteran dependents. This law affects fully-insured Exelon health care coverage options in Illinois (Blue Care Dental HMO).

For more information, including the cost of coverage, please call *my*HR *benefits* at 1-877-7EXELON (1-877-739-3566).

Children can include:

- Your biological children
- Legally adopted children who live with you
- Stepchildren and children for whom you are the permanent legal guardian, provided they live with you
- Children of your domestic partner, provided they live with you (see definition of "Domestic Partner" on this page for more information)
- Any children for whom a court of law has determined that you are the parent
- Children who are placed with you while formal adoption proceedings are pending and for whom you have a legal obligation for total or partial support.

DISABLED:
For Exelon's Core and MBA disability benefits, you are considered disabled if you are unable to perform in the regular employment of the company due to a non-occupational illness or injury and are under the regular care of a doctor.

DOMESTIC PARTNER:
As part of an ongoing commitment to diversity, Exelon provides coverage under the medical, dental and vision and hearing care plans for domestic partners and their children. An eligible domestic partner must be an adult of the same or opposite sex who is at least 19 years of age and who:

- Shares a residence with you,
- Is in a committed personal relationship with you and has no such relationship with any other person,
- Is not related to you by blood to a degree that would prevent marriage, and
- Is not legally married to any other person.

Children of a domestic partner (who may be covered under the plans that cover the domestic partner) include any children of a domestic partner who meet the requirements for coverage as a dependent child under the medical, dental and vision and hearing care plans.

If you cover a domestic partner whom you cannot claim as an income tax dependent, you will be taxed on the fair market value of the coverage for your domestic partner and his or her children. Payment for domestic partner coverage (non-income tax dependent) will appear on your paycheck stub as after-tax contributions and/or imputed income.

For more information about enrolling a domestic partner and his or her children, please call *my*HR *benefits*.

EVIDENCE OF INSURABILITY (EOI):
If you apply for MBA membership or long-term care insurance after your initial eligibility, you will be required to provide evidence of insurability (EOI) at the time of your application.

For supplemental life insurance, EOI may be required to show good health. Typically, you provide evidence of good health by completing an EOI form.

An insurance company (or for disability, OHS) reviews the EOI and approves or declines coverage; the insurance company (or for disability, OHS) may also request additional information, such as:

- A statement from an attending doctor,
- A medical exam,
- Additional information relating to a specific health condition, or
- Laboratory tests.

GENERIC DRUG:
A prescription drug with the same active ingredients as a brand-name drug, and one identical in dose, form and administrative method, but offered under a different name.

IMPUTED INCOME:
Life Insurance
If you have more than $50,000 in life insurance coverage for yourself, the federal government taxes you on the value of coverage over $50,000. This value is called "imputed income." If you have imputed income, usually the impact on your taxes is small.

Here's how imputed income is calculated:

Value of coverage over $50,000 x IRS rate divided by $1,000 less annual supplemental life contributions = your adjusted imputed income for the year.

Here are the IRS rates for life insurance imputed income:

Your Age as of December 31, 2017	Annual IRS Rate
Under 25	$.60
25 – 29	$.72
30 – 34	$.96
35 – 39	$1.08
40 – 44	$1.20
45 – 49	$1.80
50 – 54	$2.76
55 – 59	$5.16
60 – 64	$7.92
65 – 69	$15.24
70 and over	$24.72

Medical, Dental and Vision
If you cover a domestic partner whom you cannot claim as an income tax dependent, you will be taxed on the fair market value of the coverage for your domestic partner and his or her children. Payment for domestic partner coverage (non-income tax dependent) will appear on your paycheck stub as after-tax contributions and/or imputed income. For more information, call *my*HR *benefits*.

IN-NETWORK:
Care that is received from or coordinated by providers who are part of the program's network.

LIFESTYLE DRUGS:
Drugs that treat the symptoms of chronic non-life-threatening conditions, which are sometimes the by-products of natural aging.

NON-PREFERRED BRAND PRESCRIPTION DRUG:
A brand-name prescription drug that generally has higher copayments than preferred brand-name drugs.

OUT-OF-NETWORK:
Care that is received outside of the network or is not coordinated by a primary care physician.

OUT-OF-POCKET MAXIMUM:
The maximum amount you will pay toward eligible expenses in a calendar year.

PART-TIME EMPLOYEE:
You are considered a regular part-time employee if you are regularly scheduled to work at least 20 but fewer than 40 hours per week.

PAY:
For life insurance and the Core, MBA and Supplemental Disability programs, the definition of pay is annual base pay plus meter reader bonus, if applicable. For more information, refer to your summary plan description (SPD).

PREFERRED BRAND PRESCRIPTION DRUG:
A brand-name prescription drug that generally has lower copayments than non-preferred brand-name drugs.

PRE-TAX CONTRIBUTIONS:
Contributions made before federal and state income and Social Security taxes are deducted from your pay. You save money by contributing on a pre-tax basis, since this reduces the amount of income on which you are taxed.

PRIMARY CARE PHYSICIAN (PCP):
In the PPO, a non-specialty care physician such as a general practitioner, pediatrician or obstetrician/gynecologist. In the HMO, the health care provider responsible for managing your medical treatment and specialist referrals.

REASONABLE AND CUSTOMARY:
Charges determined by the insurance carrier, based on what is usually charged by dentists of similar professional standing in the same geographical area where services are performed.

SPECIAL ENROLLMENT PERIOD:
If you elect to waive coverage under Exelon's medical or dental plans because you have other coverage, you may be able to enroll yourself or your dependents within 30 days of the date your coverage under the other plan ends. In addition, if you have new dependents as a result of marriage, birth, adoption or placement of a child for adoption, you may be able to enroll yourself and your new dependents. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

SPECIALTY CARE PHYSICIAN:
In the PPO and HMO, a provider whose focus is a specific area of health care, such as a cardiologist or dermatologist.

TOTALLY DISABLED:
Under the Supplemental Disability Plan, you are considered totally disabled if you are unable, as certified by a physician selected by OHS, to perform material duties of any occupation for which you are reasonably qualified by reason of education, training or experience and are not reasonably expected to be able to do so during the 12-month period that begins on the date your 65 weeks of MBA disability payments end.

WAIVE (WAIVING) COVERAGE:
To decline coverage through Exelon.

1-877-7EXELON
(1-877-739-3566)

exelonbenefits.com

EBU 9/2016 180397
PrinteAd on Mohawk Via, 100% PC Cool White, which contains 100% postconsumer waste and process-chlorine-free fiber and is manufactured with wind power.