

**EP Energy
Health and Welfare Plan
Summary Plan Description**

January 1, 2021

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About This Summary Plan Description

This Summary Plan Description (“SPD”) provides information on health and welfare benefits under the EP Energy Health and Welfare Plan (the “Plan”) sponsored by EP Energy Global LLC (“EP Energy” or the “Company”). This SPD also provides information about the Health Savings Account Benefits, which are not provided under the Plan.

This SPD provides information on the following benefits:

- Health Care Program
 - Medical, including:
 - Prescription Drug Program
 - Mental Health and Chemical Dependency Program (including an EAP)
 - Health Savings Account Benefits
 - Dental
 - Vision
- Flexible Spending Account
 - Dependent Day Care
- Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance
- Long Term Disability (LTD)
- Short Term Disability Program
- Business Travel Accident Insurance

Keep in mind that, depending on where you live, you may have different coverage options available to you.

This SPD is effective January 1, 2021. This SPD and the Plan together comprise the plan document for all of the benefits offered under the Plan. The following additional documents also comprise the plan document for certain of the benefits offered under the Plan:

- the EP Energy Cafeteria Plan (“Cafeteria Plan”), which is a component plan of the Plan, and includes the Dependent Day Care Account Component Plan, Medical Opt-Out Credits and Health Savings Account Benefits;
- the applicable certificates of insurance coverage, with respect to each insured benefit (vision, life, accidental death & dismemberment, long term disability and business travel accident);
- the applicable health maintenance organization certificates of coverage, with respect to benefits provided by a DHMO.

In the event of any conflict between this SPD and other Plan documents, the other Plan documents will prevail. EP Energy (or its successors) reserves the right to modify, amend or terminate the Plan or any component plan or benefit at any time.

Accessing Your Benefits

Enrollment in EP Energy's health and welfare benefits is administered by Ultimate Managed Services ("UMS") through the UMS Benefits Center ("Benefits Center"). You can access benefits information by calling the Benefits Center toll-free at 1-844-232-4262 and speaking to a Benefits Center Representative. Representatives are available Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern Time.

You can also get benefit information and conduct transactions 24 hours a day by accessing UltiPro, <https://epenergy.ultipro.com>, and navigating to Menu > Myself > Manage My Benefits.

UltiPro is your primary resource for information about your Plan benefits, as well as conducting benefit transactions at any time that's convenient for you. Through UltiPro you can:

- Enroll in your benefits as a new hire (you must enroll in benefits within 31 days of your date of hire)
- Review your current benefit elections
- Make annual enrollment elections
- Verify your personal information, such as address or dependent information
- Make changes to your benefit elections as a result of qualifying changes in status such as marriage, divorce, birth or adoption of a child
- Designate or change beneficiaries for life and accidental death and dismemberment insurance
- Upload any and/or all dependent verification documents

You are required to enroll by calling the Benefits Center at 1-844-232-4262 or electronically through UltiPro, including when you are initially eligible for the Plan and when you are enrolling or changing your benefit options during open enrollment or special enrollment periods. To access UltiPro, you should have completed the single sign-on (SSO) verification process. If you are accessing UltiPro on a non-company computer outside the EP Energy network (from home on a personal computer), access the link <https://epenergy.ultipro.com>. You will be redirected to EP Energy's SSO portal where you will need to enter your EP Energy network credentials (user name is epenergy\xxxx (network ID) and your network password).

You may also contact UMS by mail at the following address:

Ultimate Benefits Service Center
11700 Great Oaks Way, Suite 600
Alpharetta, GA 30022

Frequently Used Telephone Numbers and Addresses

Source	Telephone Number	Address
Ultimate <i>For general information and enrollment</i>	1-844-232-4262	11700 Great Oaks Way, Suite 600 Alpharetta, GA 30022
BlueCross BlueShield of Texas <i>Medical program, mental health and chemical dependency program and non-network dental Claims Administrator</i> <i>Medical and Dental Customer Service</i> <i>Mental health and chemical dependency</i> <i>Locate network medical providers</i> <i>24/7 Nurseline</i> <i>Special Beginnings Maternity Program</i>	1-800-521-2227 1-800-528-7264 1-800-810-2583 1-800-581-0368 1-888-421-7781	Medical/Mental Health and Chemical Dependency claims: P. O. Box 660044 Dallas, TX 75266-0044 Dental Claims: P. O. Box 660247 Dallas, TX 75266-0247
Cigna Dental DHMO <i>Network Dental Insurer</i>	1-800-244-6224	P.O. Box 189062 Plantation, FL 33318-9062
Express Scripts <i>Prescription drug benefits Claims Administrator</i>	1-877-657-2491	P. O. Box 650322 Dallas, TX 75265-0322 Direct Claims: P. O. Box 14711 Lexington, KY 04512
Lincoln Life Assurance Company of Boston (Lincoln Financial Group) <i>Short Term Disability Claims Administrator and</i> <i>Long Term Disability Insurer</i>	1-800-713-7384 (report a claim) 1-800-291-0112 (claims mgmt)	P.O. Box 7210 London, KY 40742
Magellan Health Services <i>Employee Assistance Program</i>	1-800-327-1393	
Bank of New York Mellon (BNY Mellon) <i>Trustee of the Health Savings Accounts</i> <i>BenefitWallet Customer Service Center</i>	1-877-472-4200	
Voya Financial <i>Life and AD&D Insurer</i>	1-800-955-7736	P.O. Box 1548 Minneapolis, MN 55440
PayFlex <i>Dependent Day Care Flexible Spending</i> <i>Account Claims Administrator</i>	1-844-729-3539	P.O. Box 3039 Omaha, NE 68103-3039
VSP <i>Vision Plan Insurer</i>	1-800-877-7195	For Non-VSP claims: P.O. Box 997105 Sacramento, CA 95899-7105
PlanSource <i>COBRA administrator</i>	888-266-1732	P.O. Box 3850 Omaha, NE 68103

Eligibility and Enrollment

For new hires, some of your Plan benefits automatically begin on your first day of work at EP Energy.

Other benefits need your attention and enrollment before you are covered by those benefits.

This section of the SPD explains the eligibility and enrollment process for the Plan benefits. To the extent there are special eligibility or enrollment rules for a particular benefit, these exceptions will be described separately in each chapter that describes a particular benefit.

Please note, enrolling an ineligible dependent or failing to notify us of a dependent's loss of eligibility is a violation of EP Energy's Code of Business Conduct and could result in retroactive termination of the ineligible dependent's benefits and in disciplinary action up to and including termination of employment.

Eligibility Requirements

Employees

You are eligible to participate in the Plan if you are:

- A regular full-time (scheduled to work at least 40 hours per week) active employee of a participating employer;
- A regular reduced-schedule (scheduled to work at least 30 but less than 40 hours per week) active employee of a participating employer; or
- A part-time-schedule (scheduled to work at least 20 but less than 30 hours per week) active employee of a participating employer (**part-time employees are not eligible for all benefits; see exceptions in each benefit description**).

You are **not** eligible for the Plan if you are a (n):

- Member of a collective bargaining unit;
- Leased employee;
- Non-resident alien; or
- Employee working in a foreign country and not paid from the U.S. payroll.

Dependents

Your eligible dependents may also be covered under the Plan. Eligible dependents include:

- Your **Legal Spouse ("Spouse")**. Domestic partners are not eligible for the Plan.
- **Dependent children** include the following:
 - Children who have not attained the age of 26 and who are:
 - Your biological children;
 - Legally adopted children, children placed with you for adoption, step-children, or children for whom you act "in loco parentis" as determined by a court of competent jurisdiction. "In loco parentis as determined by a court of competent jurisdiction" means that a court has given you rights, duties and obligations similar to those of a parent. This may include, but is not limited to, an award of legal custody or guardianship. (You may be required to provide court orders or grants of legal guardianship to EP Energy in order to determine whether the rights you have been granted are similar to those of a parent.)

- Children for whom you are required by a Qualified Medical Child Support Order, judgment, decree or order issued by a court or administrative process established under state law to provide health coverage; or
- A child who is your tax dependent under Section 152 of the Internal Revenue Code (determined without regard to subsections 152(b)(1), 152(b)(2) and 152(d)(1)(B)). The child is treated as the dependent of both parents in the case of divorce;
- **Children with Disabilities** are eligible for Plan coverage if they are “dependent children” as described above and who are:
 - Incapable of self-support due to a physical or mental disability prior to attaining age 26; and
 - Claimed as a dependent on your federal income tax return. The child is treated as the dependent of both parents in the case of divorce.

If you wish to continue Health Care Program coverage for a disabled child, you must apply for coverage and provide proof of the child’s disability prior to the child attaining age 26. Continued proof of disability may be requested periodically. The Health Care Program Claims Administrators will determine whether a child is eligible for continued coverage.

For certain Plan benefits (such as life insurance and AD&D), there are different eligibility rules for children. These differences are explained later in this SPD.

Notification of Ineligible Dependents

For certain qualifying events such as divorce of the employee and spouse or a dependent child’s loss of eligibility for coverage as a dependent child, you or your dependents must notify the Benefits Center (not the insurance carriers) within 60 days from the date the qualified change in status occurs. To determine if your dependents are eligible for COBRA continuation coverage, please refer to the COBRA section in this SPD for more information.

Coverage End Date and Your Contributions

If you do notify the Benefits Center within 60 days of a dependent’s loss of eligibility for coverage, the effective date of the dependent’s loss of coverage is the last day of the month in which the qualified change in status occurred, unless your dependent timely elects and pays for COBRA continuation coverage. Please refer to the COBRA section in this SPD for more information about your dependent’s COBRA continuation coverage rights and responsibilities.

If you do not notify the Benefits Center within 60 days of the dependent’s loss of eligibility for coverage, your ineligible dependent’s coverage will be cancelled retroactively to the date coverage was lost and you will not be refunded any premiums paid for the ineligible dependent(s).

EP Energy reserves the right to recover any and all benefit payments made to or on behalf of an ineligible dependent. In addition, COBRA continuation coverage will not be available for that ineligible dependent and your current contributions for the ineligible dependent will continue until the earlier of annual enrollment or another qualified change in status.

In circumstances other than a failure to timely notify the Benefits Center, your contributions will be adjusted to reflect the change in coverage as soon as administratively possible. As a general rule, if the Benefits Center receives your election change by the payroll processing cut-off date for that pay period, it will be processed that pay period; otherwise, it will be processed the following pay period.

Enrollment

Initial Enrollment

For new hires, shortly after starting work at EP Energy, the Benefits Center will email your new hire enrollment information and instructions on how to enroll. **You have 31 days from your date of hire to enroll in your benefits.**

You'll enroll electronically through the UltiPro website (<https://epenergy.ultipro.com>). To access UltiPro, you should have completed the single sign-on (SSO) verification process. If you are accessing UltiPro on a non-company computer outside the EP Energy network (from home on a personal computer), access the link <https://epenergy.ultipro.com>. You will be redirected to EP Energy's SSO portal where you will need to enter your EP Energy network credentials (user name is epenergy\xxxx (network ID) and your network password).

Your health and welfare benefits will be effective as of your date of employment.

If You Do Not Enroll

If you do not enroll within 31 days from your date of employment you will receive core coverages (see below) offered by EP Energy through the end of the calendar year. You will not be able to make a change to your current coverage until the next annual enrollment or within 60 days of a qualified change in status.

Core Coverage

EP Energy provides the following core coverage to regular full-time and reduced-schedule employees:

Health Care (includes prescription drug and mental health and chemical dependency)	EPBasic Plan (Employee Only coverage –Tobacco User Rate) and Employee Assistance Program
Long Term Disability Insurance	60% of annual base pay
Basic Life Insurance	2 x annual base pay (maximum of \$1 million)
Basic Accidental Death & Dismemberment Insurance	2 x annual base pay (maximum of \$1 million)

EP Energy provides the following core coverage to part-time employees:

Health Care (includes prescription drug and mental health and chemical dependency)	EPBasic Plan (Employee Only coverage –Tobacco User Rate) and Employee Assistance Program
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Annual Enrollment

After your initial enrollment, you can make changes to your coverage only during annual enrollment each fall, or within 60 days of a qualified change in status. You'll enroll in your benefits each fall online or by calling the Benefits Center, and the elections will become effective on January 1 of the following calendar year.

HIPAA Special Enrollments

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and health coverage portability regulations require the Health Care Program to allow you to enroll in or change your Health Care Program coverage upon the occurrence of certain events called "special enrollment events." You may enroll in the Health Care Program or change coverage under the Health Care Program due to a special enrollment event so long as you request enrollment for yourself or your dependents within 60 days of the event. When you experience a HIPAA special enrollment event, you will be entitled to change coverage under all of the Health Care Program options that are available to you at annual open enrollment.

The following are HIPAA special enrollment events:

1. **Loss of Health Coverage.** You will be eligible to enroll yourself (and/or eligible dependents) in the Plan's Health Care Program benefits if you or your dependents had other group health plan or health insurance coverage as of the last opportunity you had to enroll you or your dependents in the Health Care Program and lost coverage under the other group health plan or health insurance for one of the following reasons:
 - a. You or your dependents became ineligible for coverage in the other coverage due to reasons other than failure to pay premiums on a timely basis or for cause (such as making a fraudulent claim or intentional misrepresentation), including termination of employment, loss of dependent status, divorce, death, moving out of an HMO's service area, or a reduction in hours of employment;
 - b. Employer contributions to the other coverage stopped;
 - c. The other coverage was terminated;
 - d. COBRA coverage under the other plan ended; or
 - e. The lifetime maximum for medical benefits was exceeded under the other coverage.
2. **Adding a Dependent.** Requesting to add a dependent due to marriage, birth, adoption or placement for adoption, of a dependent child.
3. **Loss of Eligibility for Medicaid or SCHIP Coverage.** If you and/or one of your dependents eligible for Health Care Program coverage loses eligibility for Medicaid coverage or coverage under a state Children's Health Insurance Program (SCHIP), you and your eligible dependents may enroll in the Health Care Program if you request enrollment within 60 days after the date of termination of the Medicare or SCHIP coverage due to loss of eligibility. You do not have this special enrollment right if you lose Medicaid or SCHIP coverage due to failure to pay required premiums for such coverage.
4. **Gaining Eligibility for State Premium Assistance under Medicaid or SCHIP.** If you and/or one of your dependents eligible for Health Care Program Coverage becomes eligible for a state program under which Medicaid or a state Children's Health Insurance Program (SCHIP) will provide assistance to pay a portion of the cost of your premium for Health Care Program Coverage, you and your eligible dependents may enroll in the Health Care Program if you request enrollment within 60 days after the date you or your dependent becomes eligible for such assistance. Please note that not all States have such a program.

Qualified Change in Status

In addition to the HIPAA special enrollment events described above, if you have a qualified change in status during the year, you may be able to change your Plan elections. However, in most instances your benefit change must be because of, and consistent with, your qualified change in status. Qualifying change in status changes include, but are not limited to:

- Gain or loss of coverage (for employee or other family members);
- Death of your spouse or child;
- Change in dependent eligibility;
- Receipt of a Qualified Medical Child Support Order (QMCSO);
- Relocation that affects the availability of your current health care options;

- Change in employment status that affects eligibility; or
- Unpaid leave of absence (if it affects eligibility).

You may be able to make one of the following benefit changes depending on the reason for your qualified change in status:

- Enroll, if your current election is “No Coverage”;
- Drop or change your current coverage; or
- Add or drop coverage for one or more dependents. (There are special rules for the Flexible Spending Account — please see “Flexible Spending Account” for more information).

Your election change is effective the first day of the month following your qualified change in status.

There are two important exceptions to this rule. The first exception applies when you add a dependent due to marriage, birth, adoption or placement for adoption. In this circumstance, the change is effective as of the date the dependent was acquired. The second exception applies when the qualifying change in status affects your dependent(s)’ eligibility (divorce of the employee and spouse or a dependent child’s loss of eligibility for coverage as a dependent child). In this situation, when your dependent loses eligibility, the effective date of the dependent’s loss of coverage is the last day of the month in which the qualified change in status occurred.

Important note: If you do not notify the Benefits Center within 60 days of the dependent’s ineligibility event date, your ineligible dependent’s coverage will be cancelled retroactively to the last day of the month of the ineligibility event date, and you will not be refunded any premiums paid for the ineligible dependent(s). EP Energy reserves the right to recover any and all benefit payments made to or on behalf of an ineligible dependent. In addition, COBRA continuation coverage will not be available for that ineligible dependent and your current contributions for the ineligible dependent will continue until the earlier of annual enrollment or another qualified change in status.

In circumstances other than a failure to timely notify the Benefits Center, your contributions will be adjusted to reflect the change in coverage as soon as administratively possible. As a general rule, if the Benefits Center receives your election change by the payroll processing cut-off date for that pay period, it will be processed that pay period; otherwise, it will be processed the following pay period.

Qualified Medical Child Support Order (QMCSO)

In divorce and other domestic relations proceedings, certain orders may require health care coverage for your child. This is known as a Qualified Medical Child Support Order (QMCSO) and it could affect the election and cost of your benefits. For a court order to qualify under the Plan, the Plan’s procedures must be followed. As soon as you become aware of any court proceedings that involve or affect your health care coverage, contact the Benefits Center at the following address and phone number for a copy of the administrative policy and the Plan requirements.

Ultimate Benefits Service Center
11700 Great Oaks Way, Suite 600
Alpharetta, GA 30022

If You Relocate

If you move, it’s possible that the in-network medical plan option and/or the DHMO in which you were enrolled prior to the relocation is not available in your new zip code. If that is the case, the Benefits Center will notify you of the change.

For example, if you relocate from a network area to a zip code that is not in a network area, your medical option will change to the out-of-network option for the medical plan in which you are enrolled. If you are participating in an out-of-network plan option and you relocate to a zip code where you have an in-network medical plan option, your medical option will change to the corresponding in-network plan option.

Please review the “Opting Into The BCBS Network” and “Out-of-Area Options” sections elsewhere in this SPD for more information.

Working Spouse Surcharge

If your spouse is employed and eligible for subsidized group medical coverage through his or her employer, he or she can be enrolled in the Plan’s medical benefits, but you will have to pay a working spouse surcharge in addition to your regular medical premium. The amount of the working spouse surcharge you will have to pay is \$100 per month, *in addition* to the regular premium you will pay for Employee and Spouse or Employee and Family coverage.

If You and Your Spouse Work at EP Energy

If you and your spouse work at EP Energy, you may both enroll for “Employee Only” coverage. Neither of you may be covered as both an employee and a dependent. One employee may not be covered as a dependent of the other employee. Only one parent may cover eligible children as dependents. The Working Spouse Surcharge does not apply to married EP Energy employees both working at EP Energy.

Cost of Coverage

Certain coverage requires an employee contribution. The contributions are made on either a before-tax or after-tax basis, depending on the type of coverage. Once you enroll in the Plan these contributions are deducted from your paycheck semi-monthly. By participating in this Plan, you agree to the payroll deductions necessary to make contributions for the coverage in which you are enrolled.

Tobacco Cessation Medical Premium Discount Wellness Program

EP Energy is committed to the health and wellbeing of our employees, and tobacco cessation is a key focus area towards achieving healthier lifestyles. New hires, as part of their initial Plan enrollment, and all employees during annual benefits enrollment will be asked to attest to tobacco use. Under the Tobacco Cessation Medical Premium Discount Wellness Program, the Plan provides a reward, in the form of a medical premium discount, if the employee qualifies under one of the following methods:

1. **Non-Tobacco Users.** If you and all of your family members covered by the Health Care Program do not use tobacco, you will receive the reduction in your premiums for the medical plan in which you are enrolled. In order to qualify for lower premiums for each Plan Year in this manner: (1) you must attest to the Plan that you and all of your family members covered by the Health Care Program are not tobacco users and have not been tobacco users for the past twelve months prior to the certification (“Tobacco-Free Certification”); and (2) you and your covered family members must not use tobacco during the Plan Year. You must make the Tobacco-Free Certification during the open enrollment period for the following Plan Year. If you enroll in the Health Care Program other than during open enrollment (such as new employees initially enrolling after January 1 or employees enrolling during a special enrollment period), you may make the Tobacco-Free Certification during your initial or special enrollment period, and if you do so, your premiums will be lowered for the remainder of the Plan Year.

If you or one of your covered family members starts using tobacco products after you have completed the Tobacco-Free Certification, you must immediately notify the Benefits Center at 1-844-232-4262 that you or one of your family members are tobacco users. You will be charged

a higher premium for the remainder of the Plan Year beginning in the month after you notify the Plan that you or one of your covered family members is using tobacco products.

2. Tobacco Users. If you cannot make the Tobacco-Free Certification for yourself or one or more of your family members covered by the Health Care Program, you may still qualify for the lower premiums for the Plan Year in one of two other ways:

- a. If you are enrolling in the Health Care Program during open enrollment for the upcoming Plan Year, and if all tobacco users in your family completed a smoking cessation program (“Cessation Program”) by a date designated by the Plan Administrator prior to the beginning of the upcoming Plan Year, your premiums will be lowered for the following Plan Year. In other words, all tobacco users in your family covered by the Health Care Program must complete the Cessation Program by a date designated by the Plan Administrator prior to December 31 to qualify for the lower premiums during the following calendar year. There is no charge for the Cessation Program: the entire cost is paid by the Plan. If you enroll in the Health Care Program other than during open enrollment (such as new employees initially enrolling after January 1 or employees enrolling during a special enrollment period), your premiums will be lowered for the Plan Year if you certify at your enrollment that all tobacco users in your family will complete the Cessation Program by a date designated by the Plan Administrator. If all tobacco users in the family do not complete the Cessation Program by this date, you will not receive lower premiums for the Health Care Program for the remainder of the Plan Year.

If the Cessation Program is completed on a timely basis, your premium will be lowered even if you and/or your family members do not stop using tobacco. In order to enroll in the Cessation Program, or if you wish to involve your personal physician in the Cessation Program, call the Benefits Center at 1-844-232-4262.

- b. You can qualify for the lower premium by submitting a statement by a physician, for you and/or each family member enrolled in the Health Care Program that uses tobacco (and that did not complete the Cessation Program discussed in the previous section), that the tobacco user(s) have a health condition that makes it unreasonably difficult or medically inadvisable for them to stop using tobacco products (“Qualifying Health Condition”), and the medical reason why the Qualifying Health Condition makes it unreasonably difficult or medically inadvisable to stop using tobacco. In order to qualify for the lower premiums for the upcoming Plan Year in this manner, please contact the Benefits Center at 1-844-232-4262. You will be required to submit a physician statement to the Plan for each such tobacco user for each Plan Year. A physician’s statement covers only the calendar year for which the statement is submitted. For example, a physician’s statement submitted during the open enrollment period in the fall covers only the following Plan Year. Each year during the open enrollment period you will need to submit a new statement from your physician. You must notify the Plan if you no longer have a Qualifying Health Condition within 30 days after the Qualifying Health Condition ceases. You will be charged a higher premium for the Health Care Program for the remainder of the Plan Year beginning in the month after you notify the Plan that you no longer have a Qualifying Health Condition.

Tobacco Cessation Medical Premium Discount Wellness Program: Notice Regarding Wellness Program

The Tobacco Cessation Medical Premium Discount Wellness Program is a voluntary wellness program available to all employees enrolled in one of the two Medical Program options of the Plan. The program is administered according to federal law that permits employer-sponsored wellness programs seeking to

improve employee health or prevent disease, including the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you or enrolled dependents use tobacco, you can qualify for the lower premium if the enrolled persons complete a Cessation Program as described in the section of this SPD entitled “Tobacco Cessation Medical Premium Discount Wellness Program.”

If you are unable to achieve any of the health outcomes required to earn an incentive due to your non-tobacco use, you might qualify for an opportunity to earn the same incentive reward by different means, such as qualifying for a reasonable accommodation or an alternative standard. You may request an accommodation or more information by contacting everythingHR@epenergy.com. We will work with you (and, if you wish, with your doctor) to find a wellness program with the same incentives that is right for you in light of your health status.

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Wellness Program and EP Energy may use aggregate information the Wellness Program collects to design wellness programs based on identified health risks in the workplace, this Plan will never disclose any of your personal information either publicly or to EP Energy, except as necessary to respond to a request from you for a reasonable accommodation or alternative standard under the Wellness Program or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Programs will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Programs, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellness Programs or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are (1) the medical professionals who conduct the annual physical exams; biometric screenings; (2) employees of third-party entities that operate the Wellness Program; and (3) certain EP Energy employees who administer the Wellness Program and only to the minimum extent necessary to administer the Wellness Program incentives (i.e., whether or not you qualify for a Wellness Program incentive, and not the underlying personal information collected by a third-party entity in determining whether you qualify for the incentive or for other purposes).

In addition, all medical information obtained through the Wellness Programs will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Wellness Programs will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellness Programs, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Programs, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact everythingHR@epenergy.com.

The Wellness Programs are also subject to the rules described in this SPD under the section entitled “Privacy.”

False Statements Regarding Tobacco Use

It is a requirement of the Plan that you are truthful in all matters concerning the Tobacco Cessation Medical Premium Discount Wellness Program and that you comply with all of the requirements of the Program.

You may lose coverage under this Plan or be subject to disciplinary action by the Company if:

- You falsely certified that you or your family members are non-tobacco users.
- You or any of your family members covered by the Plan used tobacco products within the past 12 months before your certification of non-tobacco use or started using tobacco products after the date of your certification as non-tobacco user(s), and you did not notify the Plan by submitting a new Certification Regarding Tobacco Use within 30 days.
- You submitted a false or misleading physician’s statement.
- You falsely certified that a Cessation Program had been completed.
- a• You failed to notify the Plan that you no longer have a Qualifying Health Condition.

Active Employee Medical Coverage Premiums

When or before you enroll in the Plan’s medical coverage, you will be informed of the premiums for your coverage, including the discounted premiums for non-tobacco users. Each year during open enrollment you will be informed of the premiums for the medical coverage. If you don’t attest to your tobacco use during the annual benefits enrollment, you will automatically default into the tobacco-user (standard rates) category.

Note: If it is unreasonably difficult due to a medical condition for you to achieve the standards for the discount under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the discount under this program, call the Benefits Center at 1-844-232-4262 and EP Energy will work with you to develop another way to qualify for this discount.

Before-Tax and After-Tax Payments

Following is a breakdown of whether the contributions you make towards the cost of benefits are on a before- or after-tax basis:

Cost of Coverage	Before-Tax	After-Tax
Medical	X	
Dental	X	
Vision	X	
Supplemental Life Insurance	X	
Spouse Life Insurance		X
Child Life Insurance		X
Supplemental Accidental Death & Dismemberment (AD&D)	X	
Spouse Accidental Death & Dismemberment (AD&D)	X	
Child Accidental Death & Dismemberment (AD&D)	X	
Flexible Spending Account	X	
Health Savings Accounts (HSAs)	X	
Hyatt Legal Plans, Inc. legal insurance		X
Allstate Identity Protection		X

Hyatt Legal Plans, Inc.

Although EP Energy allows you the convenience of purchasing legal services benefits through after-tax contributions deducted from your paycheck on a semi-monthly basis, legal services benefits are provided by Hyatt Legal Plans, Inc., and are not part of the EP Energy Health and Welfare Plan, are not sponsored by EP Energy and are not subject to ERISA. You have no rights under ERISA regarding legal insurance coverage. For more information about these services, contact Hyatt Legal at 1-800-821-6400 or log on to www.legalplans.com (access code 6940010).

Allstate Identity Protection

Although EP Energy allows you the convenience of purchasing identity protection services through after-tax contributions deducted from your paycheck on a semi-monthly basis, identity protection services are provided by Allstate Identity Protection, and are not part of the EP Energy Health and Welfare Plan, are not sponsored by EP Energy, and are not subject to ERISA. You have no rights under ERISA regarding these identity protection services. For more information about these services, contact Allstate Identity Protection at 1-800-789-2720.

Medical Opt-Out Credits

Regular full-time and reduced-schedule employees are eligible for medical opt-out credits. Part-time schedule employees are not eligible for medical opt-out credits. If you choose “no coverage” under the medical plan because you’re covered under another medical plan, you’ll receive \$50 per month in “Medical Opt-Out Credits.”

You may use your credits to purchase pre-tax benefits. Your leftover credits will be paid to you in taxable cash in your paycheck.

Eligibility and Enrollment Claims and Appeals

The Benefits Committee, under the Plan, or its delegate has the authority to interpret Plan provisions and render claim decisions based on the interpretation. Plan provisions include benefits payable under the Plan to any participant or beneficiary and the rights of any participant or beneficiary under the Plan. Such rights include the right to request Plan eligibility or enrollment as well as request review of eligibility and enrollment claims that are denied.

Any person who believes that he or she is entitled to eligibility for or enrollment in the Plan has the right to file a written claim with the Claims Administrator. The Claims Administrator for Plan eligibility and enrollment is one or more EP Energy Human Resources Department employees authorized by the Benefits Committee.

The written claim should be sent to:

Attn: Benefits Committee of the EP Energy Health and Welfare Plan
C/o EP Energy
P.O. Box 4660
Houston, Texas 77210-4660

Submission of a Claim for Plan or Benefit Eligibility or Enrollment

A claim for Plan eligibility or enrollment is considered filed when a written request is submitted to the Claims Administrator. The Claims Administrator shall respond to a claim in writing or electronically. An authorized representative may act on behalf of a participant or beneficiary (“Claimant”) who claims he or she is entitled to eligibility for or enrollment in the Plan or a Plan benefit.

Notice of Denial

Any time a Plan eligibility or enrollment claim is wholly or partially denied, the Claimant will be given written notice or electronic notice of such action within 30 days after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant will be notified of the extension and the reason for the extension within the initial 30-day period. The extension shall not exceed 45 days after the claim is filed.

The denial notice will indicate i) the reason for the denial, ii) the specific Plan provisions on which the denial is based, iii) an explanation of the claims appeal procedure including the time limits applicable to the procedure and a statement of the Claimant's right to bring a civil action under ERISA Section 502(a), and iv) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.

Appealing a Denied Claim for Plan Eligibility or Enrollment

Any Claimant who has had a claim for eligibility for or enrollment in the Plan or Plan benefit denied by the Claims Administrator, or who is otherwise adversely affected by the action of the Claims Administrator, shall have the right to request review by the Benefits Committee. The Benefits Committee shall provide a full and fair review that takes into account all comments, documents, records and other information submitted relating to the claim, without regard to whether the information was previously submitted or considered in the initial determination. Such request may be in writing, and must be made within 180 days after the Claimant is advised of the Claims Administrator's action.

The Claimant's written request for review should be sent to:

Attn: Benefits Committee of the EP Energy Health and Welfare Plan
c/o EP Energy
P.O. Box 4660
Houston, Texas 77210-4660

If written request for review is not made within such 180-day period, the Claimant shall forfeit his or her right to review. The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claims for benefits. The Claimant may submit written comments, documents, records and other information relating to the claim.

Review of Appeal

The Benefits Committee shall then review the claim. The Benefits Committee may hold a hearing if it is deemed necessary and shall issue a written decision reaffirming, modifying or setting aside the initial determination by the Claims Administrator within a reasonable time and not later than 60 days after receipt of the written request for review. The Benefits Committee may authorize one or more members of the Benefits Committee to act on behalf of the full committee to review and decide claims.

A copy of the decision will be furnished to the Claimant. The decision will set forth the specific reasons for the decision and specific Plan provisions on which it is based, a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, as well as a statement of the Claimant's right to bring suit under ERISA Section 501(a) within one year after the date of the final decision on the claim appeal. The Benefits Committee may authorize the Claims Administrator or one or more members of the Benefits Committee to act on behalf of the full committee to review and decide claims on appeal.

Health Care Program

For purposes of this section, the health care program includes medical, prescription drug, mental health and chemical dependency and Employee Assistance Program, dental and vision plans.

When Health Care Coverage Begins

Your health care coverage begins on the first day you meet eligibility requirements. For certain coverage, you must enroll before your coverage will begin.

If you enroll eligible dependents, their coverage begins on the same day your coverage begins, or the date you gain a new dependent (whichever is later), as long as you contact the Benefits Center (through the UltiPro website or by phone) within 31 days of being hired or within 60 days from a qualified change in status event. Otherwise, you cannot enroll them until the next annual enrollment period or until you have another qualified change in status. Please refer to the “Eligibility Requirements” section of this SPD for more information regarding coverage for your dependents.

When Health Care Coverage Ends

Coverage for you and your dependents ends on the last day of the month in which the events listed below occur, unless otherwise noted. Coverage for an individual will also end upon the individual’s death or upon the date the Plan is terminated.

Employee

- You are no longer eligible for coverage (review Eligibility and Enrollment section for more information);
- You fail to make a required contribution for coverage;
- You are required during an open enrollment period to elect coverage and you do not elect coverage (coverage ends as of December 31 after the close of the open enrollment period);
- You begin receiving long-term disability benefits from the Plan; or
- Your coverage is terminated for cause, such as enrolling an ineligible dependent or failing to notify us of a dependent’s loss of eligibility.

Spouse

- Your coverage ends for reasons other than death;
- The marriage is legally dissolved;
- Your spouse is no longer enrolled for coverage; or
- In the event you die while you and your spouse are covered by the Health Care Program, your spouse’s current coverage will continue for three months, at no cost, following the date of your death. After this three-month period, coverage terminates and your surviving spouse may elect COBRA coverage.

Child

- Your coverage ends for reasons other than death;
- Your child is no longer enrolled for coverage;
- Your child is no longer an eligible dependent (Review the Eligibility and Enrollment section for more information); or
- In the event you die while you and your children are covered by the Health Care Program, your eligible dependent children’s current coverage will continue for three months, at no cost, following

the date of your death. After this three-month period, coverage terminates and your surviving eligible dependent children may elect COBRA coverage.

Notwithstanding the rules above, if you terminate employment and you are covered under a severance arrangement, you and your dependents may be entitled to continuation of your current coverage according to the terms of your severance arrangement.

In some instances in which coverage terminates, you and/or your dependents may be eligible to elect COBRA continuation coverage. See the COBRA section of this SPD for more details.

Hospitalization

If a covered person is hospitalized the day coverage ends or is reduced, full benefits for the hospitalized patient will continue until he or she is released.

Qualified Change in Status

If you elect to drop or change coverage voluntarily due to a qualified change in status (as described in the “Qualified Change in Status” section under “Eligibility and Enrollment”), and you notify the Benefits Center within 60 days of the event date, the effective date of loss or change of coverage is the last day of the month in which the qualified change in status occurred.

Your contributions will be adjusted to reflect the change in coverage as soon as administratively possible. As a general rule, if the Benefits Center receives your election change by the payroll processing cut-off date for that pay period, it will be processed that pay period; otherwise, it will be processed the following pay period. Premiums will not be refunded retroactively.

If coverage for you or your dependents ends, you may be able to continue coverage through COBRA for a specified period of time. See the “COBRA” section for more details.

Important note: If you do not notify the Benefits Center within 60 days of the dependent’s ineligibility event date, your ineligible dependent’s coverage will be cancelled retroactively to the last day of the month of the ineligibility event date, and you will not be refunded any premiums paid for the ineligible dependent(s). EP Energy reserves the right to recover any and all benefit payments made to or on behalf of an ineligible dependent. In addition, COBRA continuation coverage will not be available for that ineligible dependent and your current contributions for the ineligible dependent will continue until the earlier of annual enrollment or another qualified change in status.

Coverage Categories

Deciding whom you want to cover is an important decision and affects what your benefit choices will cost. You can make separate coverage category elections under the medical, dental, and vision programs. There are four “coverage categories” to choose from:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

When electing Employee + Child(ren) or Employee + Family, all eligible children will be covered.

Medical Program

Medical Options

Each individual has different health care needs. EP Energy offers two medical options and you can select the one which best meets the needs of you and your family. You can also choose No Coverage, but please remember that you may be subject to a federal tax penalty if you and/or your tax dependents do not have minimum essential health coverage.

Following are the medical options available:

- EPChoice Plan with Health Savings Account (HSA) (High Deductible Medical Option with HSA)
- EPBasic Plan with Health Savings Account (HSA) (High Deductible Medical Option with HSA)

The claims administrator of the EPChoice Plan and EPBasic Plan is BlueCross BlueShield of Texas (“BCBS”). You will be in either a network option or an out-of-area option depending on the zip code where you live. If you live in an area that is served by the BCBS network, called the BCBS Network, your medical option will be a network option. If you live outside the service area of the BCBS network, you will be in an out-of-area option unless you affirmatively opt into the network option as described below.

No Coverage (Medical Opt-Out Credit)

If you elect “No Coverage,” you will receive a \$50 per-month Medical Opt-Out Credit to spend on other pre-tax benefits or receive as taxable cash in your paycheck. If both you and your spouse work at EP Energy, neither of you will be eligible for the Medical Opt-Out Credit.

If You Relocate Into or Out of a Network Service Area

If you move, your medical plan option will change if you move into or out of the network service area. If you are in a network option and a network is not available in your new location, you will be enrolled in the corresponding out-of-area plan in the new location. If you are currently in an out-of-area plan and you move where a network plan is available, you will be enrolled in the corresponding network plan.

For example, if you live in Houston, Texas, and are enrolled in the EPChoice Plan BCBS Network option and you move to an area outside the BCBS Network area, you will be enrolled in the EPChoice BCBS Out-of-Area option. Please review the “Opting Into The BCBS Network” and “Out-of-Area Options” sections elsewhere in this SPD for more information.

Opting Into The BCBS Network

Employees who do not live in a BCBS Network area will be allowed to opt into this network during initial enrollment, annual enrollment, or within 60 days of your relocation.

However, if this network does not appear on the UltiPro website as a medical option during enrollment, it is because there are not a sufficient number of network providers to support the area. Before deciding to opt into the BCBS Network, you should visit BCBS’s website at (www.bcbstx.com/epenergy) to find providers and where they are located so that you can determine whether you are willing to travel the distance necessary to use their services. Once you enroll in the network option you cannot change your election until the next annual enrollment period even if your doctor drops out of the network.

If, after careful consideration, you decide you want to opt into this network option, you must call the Benefits Center and request this election by speaking to a Benefits Center Representative. You cannot make this election online.

Network Medical Options

Highlights

If you live in an area that is served by the BCBS Network, your medical option will be a network option.

In-Network Care

With a network option, you have a choice each time you receive care. You can choose “in-network” providers or you may choose to receive your care from “out-of-network” providers. The network options have a network of physicians, hospitals, and other health care providers who provide services at negotiated rates to members who utilize the network. When you receive care from a network provider, you’ll receive the highest level of benefits available and you won’t need to submit claim forms for payment. **It is your responsibility to ensure that you receive all services, either directly or indirectly, from a network provider in order to receive the network level of benefits. This includes services during an inpatient or outpatient hospital stay.**

Out-Of-Network Care

If you are in a network medical option and you use a doctor, laboratory, hospital, or other provider that is not part of the network, you will receive a lower level of benefits. You’ll pay a higher annual deductible, the co-insurance (the percentage of the expenses that the plan pays) will be lower, and preventive care will not be covered at all. For hospitalizations, use of out-of-network hospitals will require pre-certification. Failure to pre-certify will result in a 10% reduction in benefits. Expenses are also subject to reasonable and customary limits.

Out-Of-Network Specialists and Providers

If you are in a network plan and require the care of a specialist and a network specialist is not available in your network area (as determined by the Claims Administrator), exceptions may be made which would allow the services of out-of-network specialists to be covered at a higher rate than the out-of-network coverage level. **You must contact your Claims Administrator and request and be approved for this exception prior to the start of any services.** If you are not approved for this exception in advance of services, then the services of out-of-network providers will be covered at the out-of-network level. If you are approved for this exception, then the medically necessary services of the out-of-network providers will be covered at 80% of reasonable and customary expenses after the deductible. In addition to co-insurance, you are responsible for any difference between the payment allowance and the provider’s actual charges.

If you are in a network plan and use a specialist (e.g., physician, anesthesiologist, radiologist or pathologist) who is not in your network but this service resulted from your office visit to a network physician, admission to a network hospital or treatment at a network outpatient facility, the plan will cover the medically necessary expenses of the out-of-network providers at the network level of coverage, after the deductible.

Access to Network Providers

You can locate BCBS network medical providers by calling BCBS at 1-800-521-2227 or visiting their website (www.bcbstx.com/epenergy) to find if a doctor, hospital or other health care provider is in the BCBS network.

While an online provider directory is a convenient tool, changes can occur which may not be immediately reflected on the directory of providers. Therefore, to be sure your doctor or facility is a member of a particular network, you should call the provider directly to verify that they are still part of the network.

EPChoice Plan Network Option Coverage Chart
 (High Deductible Option with Health Savings Account)
 For employees who live in a BCBS Network area

Plan Provisions	In Network	Out of Network
Deductible	Employee only: \$1,400 Family: \$2,800*	Employee only: \$2,800 Family: \$5,600*
Contribution EP Energy makes to your Health Savings Account (HSA)	Employee only: \$400 Family: \$800	
Out-of-Pocket Maximums	Employee only: \$3,050 Family: \$6,100	Employee only: \$6,100 Family: \$12,200
Co-insurance (Plan pays)	After deductible, 85%	After deductible, 60% of R&C
Lifetime Maximum	Unlimited per person \$25,000 maximum on infertility treatments [†]	
Emergency Room	After deductible, 85%	After deductible, 85% of R&C if a qualifying emergency; if not a qualifying emergency, after deductible, 60% of R&C
Hospital Expenses (Inpatient)	After deductible, 85%	Pre-certified: After deductible, 60% of R&C Not pre-certified: After deductible, 50% of R&C
Hospital Expenses (Outpatient)	After deductible, 85%	After deductible, 60% of R&C
Diagnostic X-Ray & Laboratory Services	After deductible, 85%	After deductible, 60% of R&C
Primary Care Physician Office Visit	After deductible, 85%	After deductible, 60% of R&C
Specialist Physician Office Visit	After deductible, 85%	After deductible, 60% of R&C
Preventive Care (age and gender appropriate)	100%, no deductible	Not covered
Chiropractic	After deductible, 85% up to a maximum of 35 visits per year	After deductible, 60% of R&C up to a maximum of 35 visits per year

* The family deductible will be met if the employee and/or his or her dependents—collectively or individually—incur this amount in covered health care expenses.

[†] Calculation of the lifetime maximum began on May 25, 2012.

R&C means the expense is subject to Reasonable & Customary limits.

EP Basic Plan Network Option Coverage Chart
 (High Deductible Option with Health Savings Account)
 For employees who live in a BCBS Network area.

Plan Provisions	In Network	Out of Network
Deductible	Employee only: \$2,550 Family: \$5,100*	Employee only: \$5,100 Family: \$10,200 (\$8,100 embedded individual limit)**
Contribution EP Energy makes to your Health Savings Account (HSA)	Employee only: \$800 Family: \$1,200	
Out-of-Pocket Maximums	Employee only: \$4,550 Family: \$9,100 (\$8,100 embedded individual limit)**	Employee only: \$9,100 Family: \$18,200
Co-insurance (Plan pays)	After deductible, 75%	After deductible, 50% of R&C
Lifetime Maximum	Unlimited per person \$25,000 maximum on infertility treatments [†]	
Emergency Room	After deductible, 75%	After deductible, 75% of R&C if a qualifying emergency; if not a qualifying emergency, after deductible, 50% of R&C
Hospital Expenses (Inpatient)	After deductible, 75%	Pre-certified: After deductible, 50% of R&C Not pre-certified: After deductible, 40% of R&C
Hospital Expenses (Outpatient)	After deductible, 75%	After deductible, 50% of R&C
Diagnostic X-Ray & Laboratory Services	After deductible, 75%	After deductible, 50% of R&C
Primary Care Physician Office Visit	After deductible, 75%	After deductible, 50% of R&C
Specialist Physician Office Visit	After deductible, 75%	After deductible, 50% of R&C
Preventive Care (age and gender appropriate)	100%, no deductible	Not covered
Chiropractic	After deductible, 75% up to a maximum of 35 visits per year	After deductible, 50% of R&C up to a maximum of 35 visits per year

* The family deductible will be met if the employee and/or his or her dependents—collectively or individually—incur this amount in covered health care expenses.

** Once an individual's out-of-pocket expenses reach \$8,100, the plan will cover 100% of that individual's eligible expenses for the rest of the year. Other covered family members will continue to pay out of pocket until the family out-of-pocket maximum is reached (\$9,100).

[†] Calculation of the lifetime maximum began on May 25, 2012.

R&C means the expense is subject to Reasonable & Customary limits.

Out-of-Area Options

If you live in an area that is not served by the BCBS Network, you will be in an out-of-area medical plan.

The out-of-area options allow you to receive care from the doctor, specialist, or hospital of your choice without affecting the level of benefit coverage you receive. All services, except for preventive care, remain subject to the deductible in an out-of-area medical plan. For preventive care under an out-of-area medical plan, the Plan will pay 100% of reasonable and customary charges, and the deductible does not apply. Participant cost-sharing could differ for out-of-area medical plans. Specific information about coverage and cost-sharing provisions in an out-of-area medical plan are available free of charge upon request.

If you live in an area not covered by the BCBS Network because there are not sufficient network providers available, you can opt into the network during open enrollment or within 60 days of your relocation by contacting the Benefits Center and making this election. Once you enroll in the network option you cannot change your election until the next open enrollment period or unless you have a qualified change in status. Please review the “Opting Into The BCBS Network” section in this SPD for more information.

If you believe you live in an area not covered by the BCBS Network, or if you have questions about the coverage or cost-sharing provisions for out-of-area medical benefits, please contact the Benefits Center.

Annual Deductible

The annual deductible is the amount each calendar year you are responsible for paying before the plan will pay benefits on services that are subject to the deductible.

The deductible for employee only coverage under the EPChoice Plan is \$1,400. The deductible for the family categories under the EPChoice Plan (employee + spouse, employee + children, and employee + family coverage) is \$2,800.

The deductible for employee only coverage under the EPBasic Plan is \$2,550. The deductible for the family categories under the EPBasic Plan (employee + spouse, employee + children, and employee + family coverage) is \$5,100.

The family deductible will be considered met when the employee and/or his or her dependents—collectively or individually—incur the family deductible amount in covered healthcare expenses. The annual deductible applies to all services (including mental health and chemical dependency and prescription drugs) except preventive care.

Annual Out-of-Pocket Maximum

In order to protect you against very large medical bills, an out-of-pocket maximum limits the amount you pay in covered medical expenses during the calendar year. Once you reach the annual out-of-pocket maximum, the Plan will cover your eligible expenses at 100% for the remainder of the Plan Year.

The out-of-pocket maximum for employee only coverage under the EPChoice Plan is \$3,050. The out-of-pocket maximum for the family categories (employee + spouse, employee + children, and employee + family coverage) is \$6,100. Under the EPChoice Plan, the family out-of-pocket maximum will be considered met when the employee and/or his or her dependents—collectively or individually—incur the family maximum amount.

The out-of-pocket maximum for employee only coverage under the EPBasic Plan is \$4,550. The out-of-pocket maximum for the family categories (employee + spouse, employee + children, and employee + family coverage) is \$9,100.

Note: The Affordable Care Act imposes an “**embedded out-of-pocket maximum**” for individuals with family coverage under the EPBasic Plan. The embedded out-of-pocket maximum limits the amount that one individual will pay out-of-pocket under family coverage to \$8,100. Here is how it works:

Once an individual’s out-of-pocket expenses reach \$8,100, the Plan will cover 100% of that individual’s eligible expenses for the rest of the year. Other family members will continue to pay expenses out-of-pocket until the family out-of-pocket maximum of \$9,100 is met. At that time, the Plan will pay 100% of the family’s eligible expenses for the remainder of the Plan Year.

Your deductible and co-insurance count toward meeting the out-of-pocket maximum. The following charges do not count toward the out-of-pocket maximum:

- Charges that exceed reasonable and customary limits;
- Penalty for not following pre-certification guidelines; and
- Charges that exceed plan limits or charges that are not covered by the Plan.

Co-insurance

Co-insurance is the percentage of expenses the Plan pays after the deductible is met, on services that are subject to co-insurance. For example, on services subject to co-insurance for the EPChoice Plan, the co-insurance is 85% for in-network services. This means that you pay 15% of the remaining charges. The co-insurance applies to all services (including mental health and chemical dependency and prescription drugs) except preventive care (when the preventive care is given by network providers).

Preventive Care

Preventive care is available under all plans and must be age and gender appropriate. Preventive services include annual physicals; well woman, man and baby exams; and immunizations. You should check with your Claims Administrator for information on specific services covered under the preventive provision of your health plan. If you are enrolled in a network option, you must receive all preventive care from network providers. Preventive care is paid at 100% before the deductible is met under both plans. Preventive care provided by out-of-network providers will not be covered. If and when COVID-19 vaccines, immunizations and other preventive services are recommended by the Center for Disease Control’s United States Preventive Services Task Force, the Plan will pay for 100% of the cost for such services and immunizations before the deductible is met, beginning 15 business days after the recommendations are made.

Emergency Care

If you need emergency treatment, you should go to the nearest emergency facility. However, you must contact the Claims Administrator (BCBS) at 800-521-2227 within 48 hours of emergency treatment, if you are admitted to an out-of-network facility. Keep in mind that the emergency room should be used only for true emergencies. An emergency is defined as a serious medical condition or symptom resulting from injury, sickness or mental illness, or chemical dependency which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health. If you become ill or injured and the condition does not require immediate hospital attention, your first step should be to call your doctor.

EP Energized Wellness Program

The EP Energized Wellness Program is discontinued effective January 1, 2021. However, incentives earned by EP Energized Participants for wellness activities undertaken in 2020 will be provided during 2021.

Health Savings Account (HSA)

Highlights

If you are covered under the EPChoice Plan or EPBasic Plan and you are an “eligible individual,” EP Energy will make a contribution to a Health Savings Account (HSA) on your behalf. If you have not yet opened your HSA, go to <https://mybenefitwallet.com/HSA/BCBSTX.adv> to activate your account. To ensure that you will receive your current year employer contribution, open your account by November 30 of the current year.

An HSA is a separate special bank account you can use to pay on a pre-tax basis for certain health care expenses not covered by the EPChoice Plan, EPBasic Plan, or any other health care plan, that are incurred after your HSA is established (review the “Establishing Your HSA” section below). This summary provides you with some basic information about HSAs and how they operate. **Please Note: Neither EP Energy’s arrangement for making contributions to the HSAs of eligible employees nor the HSAs themselves are ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).**

General Information about HSAs

An HSA is an IRS approved special type of personal account that an individual must establish with a qualified trustee. An HSA allows “eligible individuals” (described below) to pay for certain medical, dental and vision expenses on a tax-free basis. HSA contributions can be made by an eligible employee’s employer, the employee, or both. Under federal law, employer contributions are nontaxable and contributions made by an eligible employee will qualify for “above-the-line” tax deduction (up to the maximum annual contribution allowed under federal law). Please note, individual income tax treatment may vary from state to state. HSA account balances are nonforfeitable and automatically carry forward from year to year for future health care expenses. Earnings on HSA account balances are generally not taxed while held in the HSA, which means the accounts grow on a tax-free basis. In addition, you are responsible for reporting contributions made to your HSA and for reporting distributions from your HSA. To learn more about HSAs, see the IRS Publication #969, “Health Savings Accounts and Other Tax-Favored Health Plans,” available at www.irs.gov (“Publication 969”).

HSA Eligibility Requirements

To be an “eligible individual” and qualify for an HSA, you must meet the following requirements:

- Be covered under a qualifying high deductible health plan. The EPChoice Plan and the EPBasic Plan are qualifying plans.
- Have no other health coverage except certain types of permitted insurance or permitted coverage, such as a specific disease or illness insurance policy. (For more information about these and other types of coverages, see Publication #969.)
- Not be enrolled in Medicare or TriCare.
- Not be claimed as a dependent on someone else’s tax return.

If you meet these requirements, you are an “eligible individual” even if your spouse has non-qualifying coverage, provided your spouse’s plan does not cover you.

Establishing Your HSA

For administrative convenience, EP Energy has chosen to make HSA contributions for employees enrolled in the EPChoice Plan or the EPBasic Plan by direct deposit to HSAs established at Bank of New York Mellon (BNY Mellon) only. BNY Mellon is an authorized HSA trustee and its HSA services are provided through BenefitWallet. You will be provided with the forms necessary to establish an HSA at BNY Mellon or you can enroll online at <https://mybenefitwallet.com/HSA/BCBSTX.adv>. BenefitWallet

will provide you with a welcome kit that describes the bank account and includes a list of applicable bank fees. You will be responsible for managing your HSA, including choosing how your HSA funds are invested (if applicable) and following the rules that BNY Mellon—and the IRS—impose.

After you complete the account application and EP Energy is notified that your account is open, EP Energy will then make a company contribution as soon as administratively possible (normally on the next applicable pay period end date). Your personal pre-tax contributions to your HSA, if any, will also normally begin at the same time that EP Energy makes its annual contribution. Please note, you must be an eligible active employee on the date EP Energy’s contribution will be deposited to your account. If you terminate employment prior to that date, EP Energy’s contribution will not be made to your HSA. To ensure that you will receive your employer contribution for the upcoming year, open your account by November 30 of the current year. For example, to ensure you receive your employer contribution for 2021, open your HSA before November 30, 2020.

EP Energy will make the following company contributions:

Plan option	Company Contribution
EPBasic	Employee-only: \$800 Family: \$1,200
EPChoice	Employee-only: \$400 Family: \$800

According to current IRS guidance, an HSA is “established” once dollars are deposited into your HSA. Once your HSA is established, you can start using your HSA dollars to pay for health care expenses that are incurred after the HSA is established and that are not covered by the EPChoice Plan or any other health care plan.

Example: If you became eligible for an HSA on January 1, 2021, but your HSA company or personal contributions are not deposited into your HSA until January 31, 2021, then according to current IRS guidance, your HSA is not “established” until January 31, 2021, and, therefore, only eligible medical expenses incurred on or after January 31, 2021, can be reimbursed tax-free through your HSA.

HSA Contributions

HSA contributions may be made by an HSA account holder or (on his or her behalf) by any other person, including an employer or family member. EP Energy is making it possible for contributions to be made to your HSA in the following ways: (1) by EP Energy as a result of your election to become covered under the EPChoice Plan or EPBasic Plan; and (2) by you, in the form of pre-tax contributions.

EP Energy will deposit its company contribution into your HSA as soon as administratively possible after it confirms that your account is open. The EP Energy contribution is only available to employees who are in an active pay status on the date the company contribution is to be made to your HSA. You must be enrolled in the EPChoice Plan or EPBasic Plan by December 1st of any Plan Year, and your account must be open (as per BNY Mellon) by December 31st of any Plan Year to receive that same Plan Year’s company contribution. If you have not yet opened your HSA, go to <https://mybenefitwallet.com/HSA/BCBSTX.adv> to activate your account. To ensure that you will receive your 2021 employer contribution, open your account by November 30, 2020.

You can also make pre-tax contributions to your HSA through payroll deductions. As long as you are covered by the EPChoice Plan or EPBasic Plan, you can start, stop or change your contribution to your HSA at any time during the calendar year by contacting the Benefits Center. The amount of your HSA pre-tax election does not automatically carry over to future years. You must make the election each year during annual enrollment for the following calendar year. IRS guidelines limit contributions to an HSA.

Combined annual limits (EP Energy's contribution plus your contribution) for 2021 are \$3,600 for single coverage and \$7,200 for family coverage. If you're 55 or older, you can also make an additional "catch-up" contribution of up to \$1,000 into your HSA for 2021 on a pre-tax basis.

Full Contribution Rule

There is a special rule that allows individuals who are HSA-eligible on December 1 to make a full year's contribution (as if the EPChoice Plan or EPBasic Plan had been in effect all year). The IRS refers to this rule as the "full contribution rule." In other words, if you are covered under the EPChoice Plan or EPBasic Plan on December 1st, you are eligible to contribute up to the IRS limit (the statutory maximum for 2021 is \$3,600 for self-only coverage and \$7,200 for family coverage, plus a full annual catch-up contribution, if applicable). In order to take advantage of this rule, your HSA must be established (as discussed above) on or before December 31 and any expenses that you incur before the HSA is established cannot be reimbursed on a tax-free basis by the HSA. You should also be aware that contributions made in reliance on this rule will result in adverse tax consequences for individuals who fail to remain HSA-eligible throughout a "13-month testing period." Please consult with a tax advisor if you have any questions regarding your HSA contributions and/or distributions.

The 13-Month Testing Period

Individuals who make HSA contributions in reliance on the full contribution rule described above **MUST** remain eligible for the HSA throughout a 13-month testing period, which is generally measured from December 1 of the year for which HSA contributions are being made (year 1) through December 31 of the following year to avoid adverse tax consequences. Please consult with a tax advisor if you have any questions regarding your HSA contributions and/or distribution.

Example: Bob was hired by EP Energy on November 15, 2020. Bob is 35 years old and elects the EPChoice Plan (employee only coverage). He then establishes his HSA, and it is effective before December 1, 2020. EP Energy deposits its contribution (\$400) in December 2020 and Bob elects to make a pre-tax contribution in the amount of \$3,150 in December 2020. Bob remains in the EPChoice Plan for all of 2021. In this scenario, Bob has no adverse tax consequences associated with the 2020 HSA contribution because he remained in the EPChoice Plan for all of 2021. If, however, Bob were to drop coverage under the EPChoice Plan in July of 2021, for example, because he gained coverage under a spouse's plan, Bob will have to include a portion of the 2020 HSA contribution (Bob's and EP Energy's) in his income and also pay an additional 10% penalty on that amount.

If You are Hired After December 1

If you are hired and become covered under the EPChoice Plan or EPBasic Plan between December 2nd and December 31st, you **CAN** be covered under the plan option, but you **CANNOT** receive an HSA contribution from EP Energy for that year and you cannot make personal pre-tax contributions to the HSA for that year either.

HSA Distributions

Distributions from your HSA will be tax-free if they are for expenses incurred for you or your tax dependents' medical care as defined in Internal Revenue Code Section 231(d) or the medical care of your legal spouse or tax dependents (as reported on your federal income tax return). Beginning on January 1, 2020, eligible medical expenses include non-prescription drugs and medical supplies and menstrual care products.

Unlike benefit payments under the EPChoice Plan or EPBasic Plan, **HSA distributions for the qualified medical expenses of children under 27 are not tax-free unless your child is a tax dependent.**

Example: Employee Bob covers his 25-year married daughter Mary under the Plan. Bob does not pay federal income tax on the cost of coverage for Mary under the Plan. However, Mary is

not Bob's tax dependent. Bob cannot pay for Mary's medical expenses with HSA funds on a tax-free basis.

HSA distributions to pay insurance premiums will not be tax-free unless they are used, for example, for COBRA coverage, qualified long term care insurance, health insurance maintained while you are receiving unemployment compensation under federal or state law or health insurance for an individual age 65 or over (other than a Medicare supplemental policy). For a complete list of eligible health care expenses, see the IRS website <http://www.irs.gov/pub/irs-pdf/p502.pdf> (Publication #502, "Medical and Dental Expenses"). *Please note, expenses for qualified medical care must be incurred after your HSA is established in order to be reimbursable on a tax-free basis. In this instance, "established" means that the account must be open and funded (with contributions from EP Energy or with your pre-tax contributions).*

Distributions from your HSA will not be tax-free if the funds are withdrawn for non-health care related reasons or to pay for medical expenses of persons who are not your tax dependents. Such distributions must be included in your taxable income and generally will be subject to an additional 20% excise tax. The excise tax will not apply to certain distributions made after death, disability or attainment of age 65.

Please consult with a tax advisor if you have any questions regarding your HSA contributions and/or distributions.

HSA Investments

The money in your HSA earns tax-free interest and your funds may be eligible for investments. Any money left in your HSA at the end of the year rolls over into the next year and remains in your account (no "use it or lose it" rule with an HSA). The dollars stay in the HSA until you withdraw them. If you leave EP Energy, the HSA stays with you.

BNY Mellon or other trustee or custodian may offer investment options for your HSA account balance. Neither EP Energy nor the Plan has reviewed these options, if any, and does not endorse or recommend any options. You should consult a tax advisor or financial consultant to determine what, if any, investments are appropriate for you. Neither the Plan, the Plan Administrator, EP Energy nor any official or employee of EP Energy is a Plan fiduciary with respect to the investment designation or direction you make. You are solely responsible for your actions concerning HSA investment decisions.

Reporting is Your Responsibility

You are responsible for reporting contributions made to your HSA (whether made by you or on your behalf by EP Energy or others) and for reporting distributions from your HSA. Employees with HSAs must file IRS Form 8889 when filing their IRS Form 1040. To complete this form, you will need to know the contributions that were made to the HSA and the distributions received from the HSA. You must determine whether your HSA distributions are taxable or whether they are used for qualified medical expenses (and thus are not taxed by the federal government). You should maintain records sufficient to show that any distributions that you do not report as taxable were made exclusively for qualified medical expenses. See IRS Publication 969, available at www.irs.gov for more information.

When HSA Participation Ends

If you become ineligible to fund an HSA (such as becoming eligible for Medicare), no further contributions can be made to the HSA, either by you or by EP Energy. However, the account balance always belongs to you, and you may continue to take distributions from your HSA. If you die when you still have a balance in your HSA, your beneficiary will receive a payout of the funds. Subject to certain special rules, the value of your HSA at death will be taxable to your beneficiary. You may make beneficiary designations by contacting BNY Mellon.

Certain Administrative Errors

If EP Energy makes an administrative or other error under which it contributes funds to your HSA in excess of the HSA Benefits provided under the Plan (“Excess Contribution”), and EP Energy is unable to obtain a refund of the Excess Contribution from the HSA custodian or trustee, you are required to repay EP Energy the Excess Contribution. As a condition of participating in the Plan and receiving HSA contributions from EP Energy, you agree to repay EP Energy any such Excess Contributions. EP Energy may require you to repay the Excess Contribution via payroll deduction or may allow you to repay the Excess Contribution in another manner agreed to by you and EP Energy. If your employment with EP Energy ends before you have repaid the Excess Contribution, EP Energy may deduct the remaining repayment amount of the Excess Contribution from your last payroll check.

Prenatal Wellness Program

This program is designed to help ensure that expectant mothers and their babies receive the best possible care during pregnancy. Every child deserves to have a healthy start. Early thorough care is the most effective way to make sure a child has the best chance to come into the world healthy and stay that way. If you find out you or an eligible dependent is expecting a baby, you should call the BCBS Claims Administrator to request the materials you’ll need to enroll in the prenatal wellness program:

BCBS — Special Beginnings® Maternity Program at 888-421-7781.

The program is administered by registered nurses with years of experience in prenatal care, labor and delivery, and newborn care. Once the patient is enrolled, her nurse will follow her throughout her pregnancy to identify problems and facilitate appropriate care and follow up.

Additional Medical Provisions

Pre-certification

Pre-certification of all inpatient hospital admissions and skilled nursing facility admissions is required to receive the highest level of benefits if you are enrolled in an out-of-area medical option or if you are in a network medical option and you use a non-network hospital or facility. The purpose of pre-certifying is to assure that hospitalization or skilled nursing is appropriate and medically necessary. To help accomplish this, the Plan has contracted with the Claims Administrator, BCBS, to pre-certify in-patient hospitalization and skilled nursing facility admissions when it is needed.

Penalty for Not Pre-certifying

You are ultimately responsible for pre-certifying care for you and any dependents covered under the Plan, though your provider may handle the pre-certification process. Please verify that your provider is taking care of pre-certifying your in-patient hospital stay. If your in-patient stay is not pre-certified your benefits will be reduced by 10%. Call the Claims Administrator (BCBS at 1-800-441-9188) to pre-certify your hospital care.

You and your dependents do not need to pre-certify care under these circumstances:

- If you or your dependents are in a network medical plan and use an in-network facility.
- If you or your dependents have primary medical coverage through another plan.
- If you or your dependents are eligible for Medicare.

When You Need to Pre-certify Care

The timing of when you notify the Claims Administrator of your admission will depend on whether you are admitted on an emergency basis or whether you enter a hospital for a procedure scheduled in advance:

- *If you or a covered dependent is admitted to the hospital on an emergency basis*, you, a family member, or your doctor must call the Claims Administrator within 48 hours of being admitted so that you will receive the highest level of benefits.
- *If you schedule a procedure to be performed in advance*, you must call the Claims Administrator to pre-certify your admission before you or your covered dependent are admitted.

If your in-patient stay is not pre-certified your benefits will be reduced by 10%. Call the Claims Administrator (BCBS at 1-800-441-9188) to pre-certify your hospital care or verify that your provider has handled the process.

Maternity Stays

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Reasonable and Customary

The charge is “reasonable” when the fee for a specific service or supply falls within the range of usual charges in the same geographical area, and “customary” when the fee is that which is most frequently charged for a similar medical service, procedure, or supply. The Plan will take into consideration any complication or unusual aspect of a particular claim when determining the reasonable and customary charge.

Medically Necessary

The Plan covers expenses “medically necessary” for the diagnosis or treatment of an illness or injury that are commonly recognized as appropriate treatment by the medical profession. Also, to be covered, medical care must be recommended or approved by your physician. Treatment that is educational, experimental, or done primarily for research is not considered medically necessary.

Lifetime Benefit Maximum

Except for infertility treatments, there is no lifetime maximum for benefits you or your covered dependents receive from the Plan.

Infertility treatments have a \$25,000 lifetime benefit maximum. Calculation of the lifetime maximum began on May 25, 2012.

Home Health Care

You may be eligible to receive benefits for part-time or intermittent nursing care in your home through the Home Health Care Program. This program is for continued care and treatment of an individual, normally within seven days following hospitalization for the same or related conditions for which hospitalized. The necessity of the program must be certified by the attending physician and approved in advance by the Claims Administrator. Services rendered under the program are skilled nursing care, home health services, paraprofessional nursing care, therapeutic services (physical or speech therapy), medical supplies, drugs, and laboratory and X-ray services. The care must be provided under a registered nurse’s supervision.

The care will not be covered if it is:

- Not included in the Claims Administrator-approved Home Health Care Program;
- Provided by a person who ordinarily resides in your home, or by an immediate family member;
- Provided by a Social worker;

- Considered transportation services; or
- Custodial.

Hospice Care

The Health Care Program covers hospice care, which is a centrally administered program of palliative and supportive services that provides physical, psychological, social, and spiritual care for dying persons (who have six months or less to live as diagnosed and certified by the attending physician) and their families. Services are provided by a physician-supervised interdisciplinary team of professionals and volunteers through licensed hospice agencies. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock, on-call basis. Bereavement services are available to the family.

Benefit approval for a hospice program is based on patient and family need. Contact the Claims Administrator (BCBS) for coordination of this service.

Reconstruction Benefits in Connection with a Mastectomy

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 co-insurance applicable to other medical and surgical benefits provided under your medical plan.

Treatment of Temporomandibular Joint (TMJ) Dysfunction

This Plan covers the conservative or palliative treatment of pain, including injections of muscle relaxants, cortisone, or other necessary therapeutic drugs or agents; and oral surgical treatment, provided the treatment is determined to be medically necessary and functional in nature. Benefits are not payable for application of appliances (splints, etc.), orthodontics, equilibration, repositioning, altering, implanting, or replacement of teeth.

BCBS Wellbeing Management Program

Wellbeing Management is an umbrella of programs administered by BCBS that is designed to help achieve a higher level of wellness for you and your covered dependents. As of the publication date of this Summary Plan Description, the Wellbeing Management program includes:

Holistic Health Management — Multidisciplinary clinical team of health advisors (registered nurses and other health care professionals) work with you and your family to coordinate health concerns, provide education, and help you address complex health challenges.

24/7 Nurseline — This program provides around the clock access to experienced registered nurses who understand and can help with your health care concerns.

Special Beginnings — A maternity program offering expectant mothers ongoing support and education from prenatal to postpartum care.

Wellbeing Management is available to employees enrolled in a medical plan through EP Energy. For more information, please call 1-866-412-8795 or go to www.bcbstx.com/epenergy.

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions, you may receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. Some of the chronic medical condition programs include coronary artery disease, chronic obstructive pulmonary disease, diabetes, and asthma programs.

Participation is completely voluntary and without extra charge. If you think you may be eligible or would like additional information regarding the program, please contact the number on your ID card.

MDLIVE

You and your family can consult with U.S. board-certified doctors by phone any time of the day or night, even if you are not enrolled in one of the Plan's Medical Options. MDLIVE is a convenient and inexpensive way for you and your family to get non-emergency medical care during and after normal business hours, and on weekends and even holidays. You will pay \$44.00 for each consultation. And EP Energy has made arrangements for MDLIVE to file claims with BCBS if you are enrolled in one of the Plan's Medical Options. To speak with a MDLIVE representative, call (888) 680-8646 any time day or night. Or, go to www.mdlive.com/epenergy to set up your account, view general health information, or request a call-back from a physician. This service is secure and confidential.

Covered Medical Expenses

Following are examples of reasonable and customary expenses the Health Care Program will cover if medically necessary:

- Hospital daily room and board, general nursing care, and intensive care.
- All other medically necessary miscellaneous services and supplies furnished by a hospital during covered inpatient hospital confinement, but not for private-duty nursing care.
- Pre-admission testing prior to a scheduled inpatient hospital confinement.
- Outpatient hospital charges for medical care and supplies used on the premises of a hospital.
- Medically necessary services and supplies furnished in a licensed ambulatory surgical center.
- Medically necessary services and supplies furnished in a lawfully operating birthing center.
- Medically necessary treatment for dental care that results from accidental injury.
- Preventive care (must be age and gender appropriate).
- Skilled nursing facility charges (60 days per Plan Year) for:
 - Daily room and board;
 - A confinement that begins from an inpatient hospital confinement; or
 - A confinement that begins within three days of a prior skilled nursing facility confinement. The confinement must be for the same illness or injury that caused the prior confinement.
 - Skilled nursing care must be pre-certified by the Plan.
- Professional service charges by a doctor (other than psychiatric/psychological service charges, which are covered under the Mental Health and Chemical Dependency Program).
- Professional service charges by a doctor for surgery.

- Professional service charges by a doctor for the giving of anesthesia.
- Professional service charges made by a doctor, or by a laboratory, for diagnostic laboratory and X-ray exams.
- Chiropractic care up to 35 visits per covered individual per Plan Year.
- Physiotherapy services by a physiotherapist.
- Charges for services of a qualified speech therapist to correct speech loss or damage which:
 - Follows surgery to correct a birth defect;
 - Follows surgery due to illness; or
 - Is due to illness, except a functional nervous disorder, congenital defect, delayed speech, or other learning development conditions.
- Charges for anesthesia as given by a doctor.
- Durable medical equipment that is ordered or provided by a physician for outpatient use, used for medical purposes, not consumable or disposable, not of use to a person in the absence of a sickness, injury or disability, durable enough to withstand repeated use and is appropriate for use in the home.
- Travel:
 - By commercial airline in the continental U.S. and Canada to, but not from, a hospital for needed special care.
 - By professional ambulance used locally to and from a hospital.
- Expenses for pregnancy will be payable on the same basis as any illness.
- Infertility diagnosis and treatment up to a \$25,000 lifetime benefit maximum. Calculation of the lifetime benefit maximum began on May 25, 2012.
- Sterilization, including tubal ligation and vasectomy.
- Second surgical opinion.
- Allergy tests and treatment.
- Hearing aids and their fitting up to \$1,000 every 36 months. Calculation of the Plan maximum began on May 25, 2012.
- Home health care.
- Hospice care.
- Reconstructive procedures to address a physical impairment where the expected outcome is restored and improved function.
- Organ transplants.

If any of the preceding covered expenses are incurred during a covered inpatient hospital confinement or as a covered outpatient hospital charge, and are reasonable and customary, they will be paid as covered hospital charges or outpatient hospital charges, as the Plan determines appropriate, and not as a separate benefit.

Expenses Not Covered

Examples of expenses that will not be covered as medical care benefits are:

- Charges not included as covered expenses.
- Blood or plasma when a refund or credit is made for those items.
- Cosmetic or plastic surgery and related charges, unless (1) reconstruction benefits in connection with a mastectomy; or (2) medically necessary due to:
 - An accidental injury; or
 - A birth defect;and which interferes with a normal function of the body or causes physical pain.
- Eyeglasses or contact lenses and the fitting of such (except the first pair after cataract surgery, which is performed while covered).
- Eye refractions.
- Expenses for care or supplies which are furnished by a facility operated for or by the U.S. Government (or its agency) or by a doctor employed by that place unless:
 - For emergency treatment when you or your dependent must pay for those services;
 - For non-service connected disabilities in a Veterans Administration hospital;
 - Incurred by a U.S. military retiree (covered by this Plan) and his or her covered dependents, while confined in a military medical facility;
 - Otherwise required by law.
- Expenses for care and services to the extent furnished or payable under:
 - A plan or program operated by a National Government or one of its agencies;
 - A state cash sickness or similar law.
- Care and supplies for which:
 - No charge is made;
 - You or your dependent would not have to pay if you did not have this coverage.
- Expenses for injury or illness resulting from taking part in the commission of an assault or felony.
- Expenses for injury or illness arising out of employment, whether or not you or your dependent is covered by Workers' Compensation or similar laws.
- Exercise for the eyes (orthoptics).
- Psychological testing, counseling, or group therapy.
- Services or supplies for obesity, weight reduction, or dietary control, except for certain preventive care or when provided for treatment of morbid obesity.
- Custodial care.
- Charges incurred by other than the diagnosed patient except for organ transplants, except as provided in the organ transplant benefit.

- Orthodontic treatment, or other non-surgical procedure, care, or supply to correct a malocclusion of the teeth.
- Treatment of teeth or nerves connected to teeth except:
 - Treatment of an accidental injury (sustained while covered) to natural teeth; or
 - Covered hospital charges (as defined) when needed for dental care.
- Any service rendered by a close relative or someone having the same legal residence as the patient.
- Infertility diagnosis and treatment which exceeds the \$25,000 lifetime benefit maximum.
- Reversal of an elective sterilization procedure.
- Surgical correction of eye refraction which can be corrected by eyeglasses or lenses (radial keratotomy, keratectomy, keroplasty).
- Purchase or rental of luxury medical equipment when standard equipment is appropriate for the patient's condition (e.g., motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).
- Acupuncture.
- Elective abortion.
- Experimental, investigational, or unproven procedures or treatment.
- Education or training of any type for the treatment of learning disabilities and attention deficit disorders; I.Q. testing.
- Thermograms or temperature gradient studies.
- Any care or supplies received prior to the effective date or after the termination date of this coverage (unless coverage is continued according to some Plan provision).
- Any service rendered by a person who is not legally qualified to perform that service.
- Sex transformations and hormones related to such.
- Charges for services not rendered.

No coverage (or reduced coverage) will be provided for expenses determined by the Medical Claims Administrator to be for services or supplies that could have been provided in a more cost-effective manner.

Medical and Dental Program Claims Procedures and Claims

General Information

Benefits under the Plan will be paid only if the Plan Administrator or its delegate decides, in its discretion, that you or your covered dependents are entitled to them. Where a third-party administrator is in place with respect to a certain medical or dental benefit, such third party has been delegated the responsibility for administering and determining claims and appeals. The third party responsible for determining medical and dental claims (other than claims under the DHMO) is BCBS. If you are enrolled in the DHMO, you must follow the claims and appeals procedures and external review procedures outlined in the certificates of insurance coverage that you receive from the DHMO.

For any claim for benefits, you may be asked to submit additional information so that the Claims Administrator can determine whether the claim is covered and the amount of the claim.

An authorized representative may pursue the claim on your behalf. For example, this can be a doctor, lawyer, friend or relative. You may be asked to notify the Claims Administrator in writing and give the Claims Administrator the name, address, and telephone number where your personal representative can be reached.

Making a Medical Benefit Claim

Claims for medical benefits fall into four categories: claims for urgent care, claims requiring pre-certification, claims following approval of an on-going course of treatment, and claims for the payment of medical services after they have been received (referred to as “Post-Service Claims”). The time frame within which you are notified of a claim decision depends on what kind of a claim has been made.

If you have a claim for in-network medical benefits, your claim is submitted for you by the provider. If you have a claim for non-network medical benefits, you must file a claim with BlueCross BlueShield of Texas (the “Claims Administrator”). In many cases, a non-network provider will file a claim on your behalf, but it is your responsibility to ensure that the claim has been filed with the Claims Administrator.

Non-Network Medical Benefit Claims

If you have a claim for non-network medical benefits, you must file a claim form. You may obtain claim forms by calling BCBS at 1-800-521-2227 or downloading the form from their website: www.bcbstx.com/epenergy. You must complete all sections of the claim form (including the section about coverage under another insurance plan). Send the completed form to:

BlueCross BlueShield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

Your claim must be submitted within 12 months from the date on which you incur the expense that gives rise to the claim. If the Plan is secondary, you must first submit your claim to the primary plan.

Medical Benefit Denials

As described above, claims for benefits fall into four categories: claims for urgent care, claims requiring pre-certification, claims following approval of an ongoing course of treatment, and Post-Service Claims. If you make a request for benefits, the time frame within which you receive notice of a benefit denial depends on what kind of claim has been made.

Urgent Care Claims

If a claim is urgent, you will be notified of BCBS’s decision, adverse or not, as soon as possible, taking into account the medical circumstances. Notice will not be later than 24 hours after BCBS received the claim, unless the claim does not contain sufficient information on which to base a decision.

If the claim is incomplete and additional information is required, you will be notified as soon as possible, but not later than 24 hours after BCBS received the claim. You will be advised of the information required and will be given at least 48 hours to provide it.

You will then be notified of BCBS’s decision as soon as possible, but not later than 48 hours after the earlier of:

- BCBS’s receipt of the specified information, or
- The end of the 48 hours given to you to provide additional information.

A claim is “urgent” in the following cases:

- Where application of the 30-day time period for non-urgent care claims could reasonably be expected to seriously jeopardize your life or health or ability to regain maximum function;
- Where application of the 30-day time period for non-urgent care claims would subject you to severe pain that could not be adequately managed without the care that is the subject of the claim; or
- If a physician with knowledge of your medical condition determines that a claim is urgent, such determination shall be accepted.

Claim Requiring Pre-certification

If a claim is for a benefit requiring pre-certification by BCBS, for example pre-certification of a hospital stay (see “Pre-certification” under “Additional Medical Provisions”), you will be notified of BCBS’s decision, adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after BCBS received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond BCBS’s control.

If an extension is required, you will be notified before the end of the original 15-day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, BCBS will specifically describe it in the notice and give you a period of at least 45 days to provide it.

Approval of an Ongoing Course of Treatment

If BCBS has approved an ongoing course of treatment to be provided to you over a period of time or has approved a number of treatments, the following will apply:

- Unless the Plan is amended or terminated, any reduction or termination in the course of treatment will be treated as a claim denial or “Adverse Benefit Determination,” which is defined below.
- BCBS will notify you sufficiently in advance to allow you to appeal and obtain a decision on appeal before the reduction or termination in the course of treatment.

Post-Service Claim

If your claim is for the payment of medical or dental services after they have been received, BCBS will decide the claim within a reasonable time, but not longer than 30 days after BCBS received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond BCBS’s control.

If an extension is required, you will be notified before the end of the original 30-day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, BCBS will specifically describe it in the notice and give you a period of at least 45 days to provide it.

BCBS may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

Notice of Denial

If BCBS issues an Adverse Benefit Determination, you will be notified of the Adverse Benefit Determination in writing. An “Adverse Benefit Determination” includes:

- Coverage denial;

- The Plan's failure to provide or make payment for a benefit, including a denial, reduction, termination or failure to provide or make payment based on an eligibility determination;
- Denial because the service is determined to be experimental, investigational, or not medically necessary;
- Reduction or termination in an ongoing course of treatment (except due to Plan amendment or termination); or
- Cancellation or discontinuance of coverage that has a retroactive effect, regardless of whether there is an adverse effect on any particular benefit at that time.

Written notice of the Adverse Benefit Determination, or denial, will include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- The specific reason(s) for the denial;
- A reference to the Plan provision on which the denial is based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If BCBS relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge to you upon request; and
- An explanation of (i) the Plan's claim appeal procedures and the time limits applicable to those procedures; (ii) the external review process; (iii) how to initiate and follow those procedures and the external review process; (iv) the right to submit written comments, documents, records and other information relating to the claim to have them considered; (v) the right to have reasonable access to, and copies of (on request at no charge), relevant documents and other information; and (vi) a statement of your right to bring a civil action under ERISA section 502(a) within one year after the date of the final decision on the claim appeal. Such statement will include the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793 to assist individuals with internal claims and appeal procedures and external review process.

Appealing a Denied Medical Benefit Claim

You or your authorized representative may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 180 days of BCBS's initial notice of an Adverse Benefit Determination, or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should be sent to:

BlueCross BlueShield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You will have the opportunity to submit written comments, documents, records, and other information in support of your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations.

All written comments and documents you submit with your appeal, whether or not considered in the initial claim determination, will be reviewed and considered on appeal, regardless of whether such information was submitted and considered in the initial benefit determination.

Review of Appeal

BCBS will review and render a decision on your appeal within the time frames outlined below and will notify you of its decision in writing. The individual who reviews and renders a decision on your appeal will not be someone who participated in or decided your original claim, nor will he or she be subordinate to the original decision maker. No deference shall be given to the initial decision. BCBS may consult with a physician or other licensed health care professional with appropriate training and experience to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in your initial claim and will not be a subordinate of that expert. The identity of a medical expert consulted in connection with your appeal will be provided upon request.

You will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim. The evidence will be provided to you as soon as possible and in advance of the notice of the final determination so that you will have an opportunity to respond prior to that date.

BCBS may hold a hearing if it is deemed necessary, and shall issue a written decision reaffirming, modifying or setting aside the initial determination not later than 30 days after BCBS received the appeal. If there is a hearing, you will be allowed to present evidence as part of the process. If there is no hearing, BCBS will notify you of its decision on appeal, adverse or not, but not later than 30 days after BCBS received the appeal.

The time frame for review of your appeal, like your initial claim for medical or dental benefits, depends on whether it is an urgent care claim, a claim requiring pre-certification, a claim following approval of an ongoing course of treatment or a Post-Service Claim.

Urgent Care Claims

If your appeal is in connection with a complete urgent care claim, BCBS will notify you of its decision on appeal as soon as possible, taking into account medical circumstances, but not later than 72 hours after BCBS received the appeal.

Claim Requiring Pre-certification

If your appeal is in connection with a claim for benefits requiring pre-certification by BCBS, you will be notified of its decision on appeal, adverse or not, within a reasonable period of time

appropriate to the medical circumstances, but not later than 30 days after BCBS received your appeal.

Approval of an Ongoing Course of Treatment

If your appeal is in connection with a claim for an ongoing course of treatment, BCBS will notify you of its decision on appeal as soon as possible, but not later than the date your treatment ends or is reduced.

Post-Service Claim

If your appeal is in connection with a claim for payment of medical services after they have been received, BCBS will notify you of its decision on appeal, adverse or not, but not later than 60 days after BCBS received the appeal.

Notice of Appeal Denial

If the decision on appeal affirms the initial denial of your claim, you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- The specific reason(s) for the denial;
- The Plan provisions on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents and other information;
- A description of the external review process, including how to initiate external review;
- If BCBS relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge to you upon request;
- A statement of your right to bring suit under ERISA section 502(a) within one year after the date of the final decision on the claim appeal, and the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available to you is to contact your local U.S. Department of Labor Office and your State regulatory agency.”; and
- Information regarding the availability of, and the contact information for, any applicable office of health insurance commissioner assistance or ombudsman established under Public Health Service Act Section 2793 to assist individuals with internal claims and appeals and external review process.

External Review

You will be informed if you have the right to request external review of an Adverse Benefit Determination upheld on appeal. The request for external review must be made in writing and must be

made within four months of the date you are advised that the Adverse Benefit Determination following your appeal was upheld. Your request for external review should be sent to:

BlueCross BlueShield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

Within five business days following receipt of the external review request, BCBS will complete a preliminary review of the request for external review to determine whether the request is complete and eligible for external review; and within one business day after completion of the preliminary review, you will be furnished with a written notification. If the request is complete but ineligible for external review, the notification will include the reason for ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and you will be allowed to complete the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

You or your authorized representative may be allowed to request an expedited external review if you receive an Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of an external review would seriously jeopardize your life or health or your ability to regain maximum function, or that concerns admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility. BCBS will review your request for expedited external review in the same manner in which it reviews your request for external review, and will immediately send you a notice regarding your eligibility for the expedited external review.

BCBS will assign an “Independent Review Organization” (IRO) that is accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally recognized accrediting organization to conduct the external review.

The IRO will issue a notice of the final external review decision. Such notice will meet the requirements of 29 C.F.R. 2590.715-2719 and any subsequent regulatory and subregulatory guidance regarding the content and timing of the notice of the final external review decision. If BCBS receives notice from the IRO that the final Adverse Benefit Determination following appeal was reversed, it will immediately pay the claim.

For information about filing a Medical or Dental benefit eligibility or enrollment claim, see “Eligibility and Enrollment Claims and Appeals” under the Eligibility and Enrollment section of this SPD.

Prescription Drug Program

Highlights

If you are covered under an EP Energy Medical Program option, the information in this section describes the prescription drug coverage you have under your medical plan. While the prescription drug program is administered separately, it is a component of your medical plan.

Express Scripts is the administrator of the prescription drug benefits for the Health Care Program. You will receive a separate prescription drug ID card from Express Scripts to present when filling your prescription at retail pharmacies.

Formulary Drugs

A formulary is a list of preferred drugs that can assist in patient care while helping to lower the cost of prescription drugs for the Health Care Program. An independent Pharmacy and Therapeutic Committee, brought together by Express Scripts, reviews each drug on the list for safety and effectiveness.

Retail Prescriptions

When you need a prescription for a 30-day supply of medication or less, take your prescription and your prescription drug ID card to a participating Express Scripts pharmacy. No benefit is available if you use a non-participating pharmacy. You can locate Express Scripts pharmacies by going through Express Scripts' website (www.express-scripts.com) or by phone at 1-877-657-2491.

If a generic drug is available you will receive the generic drug unless you or your physician indicates otherwise. If you or your physician chooses to get a brand-name drug instead of the generic drug, you will pay the difference in actual cost between the generic and the brand name drug plus 20% of the generic drug cost. Any cost difference you pay between the generic and brand name drug does not go toward meeting your medical deductible or out-of-pocket maximum.

A prescription may be refilled *two times* at retail after the original prescription. After the prescription is refilled twice at retail, you will be required to use Express Scripts' mail-order pharmacy service or pay 100% of the cost of the medication refilled at retail.

Mail Order Prescriptions

To obtain prescriptions for greater than a 30-day but up to a 90-day supply, use the mail order pharmacy. You will save money on medication for periodic maintenance or long-term treatments by ordering prescriptions through the mail.

If a generic is available you will receive the generic drug unless you or your physician indicates otherwise. If you or your physician chooses a brand-name drug instead of the generic drug, you will pay the co-insurance plus the difference in cost between the generic and the brand name drug. Any cost difference you pay between the generic and the brand name drug does not go toward meeting your medical deductible or out-of-pocket maximum.

Prescription Drug Coverage Chart

Except for prescription drugs which constitute preventive care under federal law, prescription drugs are subject to the medical deductible and co-insurance. When you use an Express Scripts network pharmacy, after the applicable deductible (combined medical, mental health/chemical dependency and prescription drug benefits) is met, the Plan will pay for a certain percentage of your prescription drugs as follows:

Plan Option	Retail (30-day supply or less)*†	Mail-Order (31- to 90-day supply)*
EPChoice Plan	After you reach the deductible, the Plan pays 85% co-insurance and you pay 15%, subject to your out-of-pocket maximum.	
EPBasic Plan	After you reach the deductible, the Plan pays 75% co-insurance and you pay 25%, subject to your out-of-pocket maximum.	

Non-Participating Pharmacy No benefit.

* Penalties may apply if a generic is available and a brand name is ordered.

† A prescription may be refilled two times at retail after the original prescription. After the prescription is filled twice at retail, you will be required to use Express Scripts' mail order pharmacy or pay 100% of the cost of the medication filled at retail.

The Plan pays for the entire cost of prescription drugs which constitute preventive care under federal law, such as contraceptive drugs and devices for women. You do not pay any deductible or co-insurance for these drugs.

Prescription Drugs Requiring Prior Authorization for Benefits

Some prescriptions may require prior authorization before they can be paid by the Plan, depending on your medical plan. Prior authorization is required by the Plan to determine whether the products will be approved for coverage for medically necessary treatment of a covered health condition. Some examples of drugs that require prior authorization are:

- Fertility agents
- Growth hormones
- Interferons
- Opioids (see following section for information on opioid management program)

If the medication prescribed for you requires this approval, your participating retail pharmacist or Express Scripts will initiate the process on your behalf. Express Scripts will contact your physician to review the therapy and determine whether the drug can be covered by the Plan. Typically, this process will take two business days, although in some cases it can be completed the same day. You and your physician will be notified when the process is complete. If your medication is not approved under the Plan and you elect to fill your prescription, you will be responsible for paying the full cost of the medication.

Opioid Management Program

The Plan has adopted the Express Scripts opioid management program that is aimed at the prevention of opioid addiction. As part of this program, the following rules apply to prescriptions for opioids:

- There is a seven-day supply limit for adults initiating opioid therapy, which applies to the first 4 fills (supply limit of 28 days in a 60-day period).

- There is a three-day supply limit for children initiating opioid therapy, which applies to the first 4 fills (supply limit of 12 days in a 60-day period).
- Prior authorization required for opioid prescriptions for patients starting opioids whose accumulated opioid prescriptions total more than 90 morphine milligram equivalents.
- Prior authorization required for opioid prescriptions for all patients whose accumulated opioid prescriptions total more than 200 morphine milligram equivalents.
- Prior authorization required on the first prescription for a long-acting opioid.

Step Therapy Program

Express Scripts' Step Therapy program provides an opportunity to save on prescription drug costs, particularly for individuals with conditions that require taking medications regularly, such as arthritis, high blood pressure, or high cholesterol. Under this program, prescription medications are grouped into three categories, based on cost:

- Step 1: Generic medications, known as “front-line medications,” fall in the lowest cost category.
- Step 2: Lower-cost brand-name medications, known as “back-up medications,” are higher in cost.
- Step 3: Higher-cost brand-name medications, also known as “back-up medications,” fall in the highest cost category.

If the medication prescribed for you is a back-up medication, Express Scripts will contact your physician to review the therapy and determine whether a front-line medication can be prescribed instead. If there will be a delay in getting a new prescription from your physician and you need the medication immediately, you can ask Express Scripts for a partial fill of the original prescription, but you will be responsible for the full price for this quantity. If your physician decides that a front-line medication or a lower-cost brand-name medication is not appropriate for you, you can fill a prescription for a higher-cost brand-name medication at a higher copayment.

For more information on how Step Therapy works, visit <http://www.steptherapyfacts.com> or contact Express Scripts at 1-877-657-2491.

Drug Quantity Management Program

Express Scripts' Drug Quantity Management program provides another opportunity to save on prescription drug costs, by dispensing your prescription medications according to industry standards and recommendations on the maximum quantities considered safe for you, especially for drugs that are difficult to take in the proper dose. For more information about this program, visit www.express-scripts.com.

Specialty Drugs Requiring Medical Channel Management (MCM)

Specialty medications are drugs that are used to treat complex conditions and illnesses, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. These drugs usually require special handling, special administration, or intensive patient monitoring. Medications used to treat diabetes are not considered specialty medications. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service. These specialty medications are not covered under your medical benefit but are only covered when ordered through Accredo Health Group, Inc. (“Accredo”), Express Scripts' specialty pharmacy, which is a part of the prescription drug benefit.

If you are using specialty medications you will be required to transfer those prescriptions to Accredo. If you continue to purchase the medications from your doctor or from another pharmacy, you will be responsible for the full cost of the drug. When you order a covered specialty medication through

Accredo, your out-of-pocket cost will be limited to the applicable copayment or co-insurance. (See the next section regarding drug manufacturer copay assistance.) The list of medications subject to this specialty drug program may change, and you should check the list before you fill a prescription for a specialty medication. For a list of conditions and specialty medications, visit Accredo's website at www.accredo.com. If you need to contact Accredo about a specialty medication, call 800-922-8279 Monday through Friday between 8 a.m. and 8 p.m. Eastern Time.

Specialty Drugs and Copay Assistance from Drug Manufacturers

If you purchase a specialty drug for which the drug manufacturer provides copay assistance of any type (such as a drug manufacturer coupon or other similar arrangement), the amount of the copay assistance will not be credited towards the Plan's deductibles or out-of-pocket maximums. In these situations, only the amount, if any, that you are out-of-pocket after the copay assistance and the Plan benefits are considered will be credited towards the Plan's deductibles and out-of-pocket maximums. Here is an example:

- You have met the EPChoice Plan deductible.
- Your purchase a specialty drug that costs \$2,000.00.
- The Plan pays \$1,700 in benefits (85%) for the drug.
- The drug manufacturer provides \$200 in copay assistance for the drug.
- You pay \$100 out-of-pocket for the drug.
- The Plan will credit \$100 towards your out-of-pocket maximum under the Plan.

Compound Management Solution

Under the new Compound Management Solution, Express Scripts aims to cover prescription medications that are clinically acceptable and reasonably priced for you. Express Scripts will monitor compound ingredient prices on your behalf and, if any ingredients increase outside of market-acceptable ranges, those ingredients will be excluded as soon as reasonably possible. If any ingredient in the prescribed compound is on the list of excluded ingredients, the compound will not be covered. For more information about this new program, visit www.express-scripts.com.

Prescription Expenses Covered

The following are covered benefits (unless listed in the "Prescription Expenses Not Covered" section):

- federal legend drugs;
- State restricted drugs;
- Compounded medications of which at least one ingredient is a legend drug;
- Insulin;
- Insulin needles and syringes;
- Smoking deterrents, including those requiring a prescription;
- Over-the-counter diabetic supplies; and
- Oral or injectable antineoplastic agents.

Prescription Expenses Not Covered

- Drugs not classified as federal legend drugs;

- Over-the-counter medicines and drugs, other than insulin, not prescribed by a physician;
- Topical fluoride preparations;
- Therapeutic devices or appliances;
- Drugs whose sole purpose is to promote or stimulate hair growth (Rogaine®) or are for cosmetic purposes only (e.g., Renova®);
- Allergy sera;
- Biologicals and blood or blood plasma products;
- Drugs labeled “Caution—limited by federal law to investigational use,” or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers’ Compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member;
- Medication which is dispensed and to be taken or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals which is supplying the medications;
- Any prescription refilled at a retail pharmacy following the second refill;
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order; and
- Charges for the administration or injection of any drug.

Prescription Drug Program Claims Procedures

Claims for reimbursement of prescription drugs purchased at retail can be sent to the following address:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

Claims for prescription drugs to be filled through the mail order pharmacy can be mailed to the following address:

Express Scripts
P.O. Box 650322
Dallas, TX 75265-0322

Your claim for Prescription Drug Program benefits must be submitted within 12 months from the date in which you incur the expense that gives rise to the claim. If the Plan is secondary, you must first submit your claim to the primary plan.

For any claims for benefits, you may be asked to submit additional information so that Express Scripts can determine whether the claim is covered and the amount of the claim.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer, friend or relative. You may be asked to notify Express Scripts in writing and give Express Scripts the name, address and telephone number where your authorized representative can be reached.

Prescription Drug Program benefits will be paid only if Express Scripts (the Plan Administrator's delegate) decides, in its discretion, that you or your covered dependents are entitled to them. Claims for Prescription Drug Program Benefits fall into four categories: claims for urgent care, claims requiring advance approval, claims following approval of an on-going course of treatment, and claims for the payment of medical services after they have been received (referred to as "Post Service Claims"). If you request Prescription Drug Program benefits, the time frame within which you receive notice of a benefit denial will depend on what kind of claim has been made.

Urgent Care Claims

If a claim is urgent, you will be notified of Express Scripts' decision, adverse or not, as soon as possible, taking into account the medical circumstances. Notice will not be later than 24 hours after Express Scripts received the claim, unless the claim does not contain sufficient information on which to base a decision.

If the claim is incomplete and additional information is required, you will be notified as soon as possible, but not later than 24 hours after Express Scripts received the claim. You will be advised of the information required and will be given at least 48 hours to provide it.

You will then be notified of Express Scripts' decision as soon as possible, but not later than 48 hours after the earlier of:

- Express Scripts' receipt of the specified information, or
- The end of the 48 hours given to you to provide additional information.

A claim is "urgent" in the following cases:

- Where application of the 30-day time period for non-urgent care claims could reasonably be expected to seriously jeopardize your life or health or ability to regain maximum function;
- If, after discussion between your physician and a physician acting on behalf of the Prescription Drug Program, it is determined that the application of the 30-day time period for non-urgent care claims would subject you to severe pain that could not be adequately managed without the care that is the subject of the claim; or
- If a physician with knowledge of your medical condition determines that a claim is urgent, such determination shall be accepted.

Claim Requiring Advance Approval or Preauthorization

If a claim is for a benefit requiring advance approval by Express Scripts, for example, preauthorization for growth hormones (see "Prescription Drugs Requiring Prior Authorization for Benefits"), you will be notified of Express Scripts' decision, adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after Express Scripts received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond Express Scripts' control.

If an extension is required, you will be notified before the end of the original 15-day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, Express Scripts will specifically describe it in the notice and give you a period of at least 45 days to provide it.

Approval of an Ongoing Course of Treatment

If Express Scripts has approved an ongoing course of treatment to be provided to you over a period of time or has approved a number of treatments, the following will apply:

- Unless the Plan is amended or terminated, any reduction or termination in the course of treatment will be treated as a claim denial or “Adverse Benefit Determination,” which is defined below.
- Express Scripts will notify you sufficiently in advance to allow you to appeal and obtain a decision on appeal before the reduction or termination in the course of treatment.

Post-Service Claim

If your claim is for the payment of Prescription Drug Program benefits after they have been received, Express Scripts will decide the claim within a reasonable time, but not longer than 30 days after Express Scripts received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond Express Scripts’ control.

If an extension is required, you will be notified before the end of the original 30-day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, Express Scripts will specifically describe it in the notice and give you a period of at least 45 days to provide it.

Express Scripts may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

Notice of Denial

If Express Scripts issues an Adverse Benefit Determination, you will be notified of the Adverse Benefit Determination in writing. An “Adverse Benefit Determination” includes:

- Coverage denial;
- The Plan’s failure to provide or make payment for a benefit, including a denial, reduction, termination or failure to provide or make payment based on an eligibility determination;
- Denial because the service is determined to be experimental, investigational, or not medically appropriate;
- Reduction or termination in an ongoing course of treatment (except due to Plan amendment or termination); or
- Cancellation or discontinuance of coverage that has a retroactive effect, regardless of whether there is an adverse effect on any particular benefit at that time.

Written notice of the Adverse Benefit Determination, or denial, will include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- The specific reason or reasons for the denial;
- A reference to the Prescription Drug Program provision on which the denial is based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;

- If Express Scripts relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge to you upon request; and
- An explanation of (i) the Prescription Drug Program's claim appeal procedures and the time limits applicable to those procedures; (ii) the external review process; (iii) how to initiate and follow those procedures and the external review process; (iv) the right to submit written comments, documents, records and other information relating to the claim to have them considered; (v) the right to have reasonable access to, and copies of (on request at no charge), relevant documents and other information; and (vi) a statement of your right to bring a civil action under ERISA section 502(a) within one year after the date of the final decision on the claim appeal. Such statement will include the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793 to assist individuals with internal claims and appeal procedures and external review process.

Appealing a Denied Prescription Drug Program Claim for Benefits

You or your authorized representative may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 180 days of Express Scripts' initial notice of an Adverse Benefit Determination, or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should be sent to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

You may file an urgent care claims appeal to Express Scripts by fax to 1-888-235-8551.

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You will have the opportunity to submit written comments, documents, records, and other information in support of your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse determination will take into account all comments, documents, records and other information submitted by you relating to the claims, regardless of whether such information was submitted and considered in the initial benefit determination.

Review of Appeal

Express Scripts will review and render a decision on your appeal within the time frames outlined below and will notify you of its decision in writing. The individual who reviews and renders a decision on your appeal will not be an individual who participated in or decided your original claim, nor will he/she be a

subordinate to the original decision maker. No deference shall be given to the initial decision. Express Scripts may consult with a physician or other licensed health care professional with appropriate training and experience to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in your initial claim and will not be a subordinate of that expert. The identity of a medical expert consulted in connection with your appeal will be provided upon request.

You will be provided with any new or additional evidence considered, relied upon, or generated the Plan in connection with your claim. The evidence will be provided to you as soon as possible and in advance of the notice of the final determination so that you will have an opportunity to respond prior to that date.

Express Scripts may hold a hearing if it is deemed necessary, and shall issue a written decision reaffirming, modifying or setting aside the initial determination not later than 30 days after Express Scripts received the appeal. If there is a hearing, you will be allowed to present evidence as part of the process. If there is no hearing, Express Scripts will notify you of its decision on appeal, adverse or not, but not later than 30 days after Express Scripts received the appeal.

The time frame for review of your appeal, like your initial claim for Prescription Drug Program benefits, depends on whether it is an urgent care claim, a claim requiring advance approval, a claim following approval of an ongoing course of treatment or a Post-Service Claim.

Urgent Care Claims

If your appeal is in connection with an urgent care claim, the independent fiduciary will notify you of its decision on appeal as soon as possible, taking into account the medical circumstances, but not later than 72 hours after Express Scripts received the appeal.

Claim Requiring Advance Approval or Preauthorization

If your appeal is in connection with a claim for benefits requiring advance approval by the independent fiduciary, you will be notified of its decision on appeal, adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after Express Scripts received your appeal.

Approval of an Ongoing Course of Treatment

If your appeal is in connection with a claim for an ongoing course of treatment, the independent fiduciary will notify you of its decision on appeal as soon as possible, but not later than the date your treatment ends or is reduced.

Post-Service Claim — Level 1 Appeal

If your appeal is in connection with a claim for payment of Prescription Drug Program benefits after they have been received, the independent fiduciary will notify you of its decision on appeal, adverse or not, but not later than 30 days after Express Scripts or received the appeal. There are two levels of appeal for post-service claims.

Notice of Appeal Denial

If the decision on appeal affirms the initial denial of your claim, you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- The specific reason(s) for the denial;
- The Prescription Drug Program provision(s) on which the decision is based;

- A statement of your right to review (on request and at no charge) relevant documents and other information;
- If Express Scripts relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- A description of the external review process, including how to initiate external review;
- If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge to you upon request;
- If the notice of denial is a Post-Service Claim Level 1 appeal denial, an explanation of Level 2 Appeal procedures;
- A statement of your right to bring suit under ERISA section 502(a) within in one year after the date of the final decision on appeal, and the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available to you is to contact your local U.S. Department of Labor Office and your State regulatory agency.”, unless the notice of denial is a Post-Service Claim Level 1 appeal denial. In which case, this statement will be included in the notice of a Level 2 appeal denial, if any; and
- Information regarding the availability of, and the contact information for, any applicable office of health insurance commissioner assistance or ombudsman established under Public Health Service Act Section 2793 to assist individuals with internal claims and appeals and external review process.

Post-Service Claim — Level 2 Appeal

You or your authorized representative may request a review of the Level 1 appeal denial. If you choose to request a Level 2 review, you must submit your appeal in writing within 180 days of Express Scripts’ notice of Level 1 Appeal Denial, or else you will lose the right to a Level 2 review. If you do not request a Level 2 review on time, you will also lose your right to file suit in federal court as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your Level 2 Appeal should be sent to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

Your written Level 2 Appeal should include the reasons you feel your claim should not have been denied and any additional facts or documentation that you feel supports your claim.

Notice of Level 2 Post-Service Claim Appeal Denial

If the decision on the Level 2 review upholds the Level 1 appeal denial, you will be furnished with a notice of Adverse Benefit Determination on review, setting forth all of the items included in the notice of the Appeal Denial described above, as well as a statement of your right to bring suit under ERISA Section 502(a) within one year after the date of the final decision on the claim appeal.

External Review

You will be informed if you have the right to request external review of an Adverse Benefit Determination upheld on appeal. The request for external review must be made in writing and must be made within four months of the date you are advised that the Adverse Benefit Determination following your appeal was upheld. Your request for external review should be sent to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

Within five business days following receipt of the external review request, Express Scripts will complete a preliminary review of the request for external review to determine whether the request is complete and eligible for external review; and within one business day after completion of the preliminary review, Express Scripts will furnish you with a written notification. If the request is complete but ineligible for external review, the notification will include the reason for ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and you will be allowed to complete the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

You or your authorized representative may be allowed to request an expedited external review if you receive an Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of an external review would seriously jeopardize your life or health or your ability to regain maximum function, or that concerns admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility. Express Scripts will review your request for expedited external review in the same manner in which it reviews your request for external review, and will immediately send notice regarding your eligibility for the expedited external review.

Express Scripts will assign an “Independent Review Organization” (IRO) that is accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally recognized accrediting organization to conduct the external review.

The IRO will issue a notice of the final external review decision. Such notice will meet the requirements of 29 C.F.R. 2590.715-2719 and any subsequent regulatory and subregulatory guidance regarding the content and timing of the notice of the final external review decision. If Express Scripts receives notice from the IRO that the final Adverse Benefit Determination following appeal was reversed, it will immediately pay the claim.

For information about filing a prescription drug benefit eligibility or enrollment claim, see “Eligibility and Enrollment Claims and Appeals” under the Eligibility and Enrollment section of this SPD.

Mental Health and Chemical Dependency Program

Highlights

If you are covered under an EP Energy Medical Program option, the information in this section describes the coverage you have under the Mental Health and Chemical Dependency Program. The mental health and chemical dependency services are provided through BlueCross BlueShield of Texas (“BCBS”) and their network of service providers.

Network and Non-Network Care

You may choose to have your treatment from either a network provider or a provider outside the network, but to receive the highest level of benefits you must receive treatment from a provider within the BCBS network of service providers.

All mental health and chemical dependency care must be rendered by a practitioner who is independently licensed. There are no benefits available for practitioners who do not meet minimum licensing requirements.

All mental health and chemical dependency care, whether in- or out-of-network, must be medically necessary as determined by BCBS.

Contact Information

Use BCBS to help arrange your care. Contact BCBS if you have questions about your care or about network and non-network providers at 1-800-528-7264.

Claim Payments for Covered Services

Claim payments for covered services received by a participant will be made as follows:

- **Network Providers.** When a participant receives covered services from a practitioner or facility that is a network provider, any payment due under this Plan will be made directly to the network provider.
- **Non-Network Providers.** When a participant receives covered services from a facility or practitioner that is not a network provider, payment due under this Plan will be made to the member or practitioner/facility as directed on the claim form.

If you are enrolled in either the EPChoice Plan or EPBasic Plan medical option, expenses you have for mental health and chemical dependency treatment, whether in- or out-of-network, count toward your medical plan annual deductible and medical plan annual out-of-pocket maximum.

Mental Health and Chemical Dependency Coverage Charts

EPChoice Plan Option

	Network Provider	Non-Network Provider
Deductible (combined medical, prescription drug and mental health/chemical dependency benefit)	Employee only: \$1,400 Family: \$2,800	Employee-only: \$2,800 Family: \$5,600
Outpatient Treatment Outpatient treatment does not require pre-certification	Plan pays 85% after deductible	After deductible, Plan pays 60% of reasonable and customary charges
Inpatient Treatment Inpatient treatment from non-network providers requires pre-certification	Plan pays 85% after deductible	Pre-certified: After deductible, Plan pays 60% of reasonable and customary charges Not Pre-Certified: Plan pays 50% of reasonable customary charges
Out-of-Pocket Maximum (combined medical, prescription drug and mental health/chemical dependency benefit)	Employee-only: \$3,050 Family: \$6,100	Employee-only: \$6,100 Family: \$12,200

EPBasic Plan Option

	Network Provider	Non-Network Provider
Deductible (combined medical, prescription drug and mental health/chemical dependency benefit)	Employee-only: \$2,550 Family: \$5,100	Employee-only: \$5,100 Family: \$10,200
Outpatient Treatment Outpatient treatment does not require pre-certification	Plan pays 75% after deductible	After deductible, Plan pays 50% of reasonable and customary charges
Inpatient Treatment Inpatient treatment from non-network providers requires pre-certification	Plan pays 75% after deductible	Pre-certified: After deductible, Plan pays 50% of reasonable and customary charges Not Pre-Certified: Plan pays 40% of reasonable customary charges
Out-of-Pocket Maximum (combined medical, prescription drug and mental health/chemical dependency benefit)	Employee-only: \$4,550 Family: \$9,100 (\$8,100 embedded individual limit)*	Employee-only: \$9,100 Family: \$18,200

* Once an individual's out-of-pocket expenses reach \$8,100, the plan will cover 100% of that individual's eligible expenses for the rest of the year. Other covered family members will continue to pay out of pocket until the family out-of-pocket maximum is reached (\$9,100).

Exclusions and Limitations

Some expenses are specifically excluded from coverage. Expenses not covered include:

- Treatment for caffeine intoxication, withdrawal, or dependence.
- Custodial care, educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided.
- Treatment for personal or professional growth, development, or training or professional certification.
- Evaluation, consultation, or therapy for educational or professional training or for investigational purposes relating to employment.
- Counseling/therapy related to change of sex.
- Therapies that do not meet national standards for mental health professional practice (e.g., Erhard/The Forum, primal therapy, bioenergetic therapy, crystal healing therapy, sensitivity training, or rolfing).
- Experimental or investigational therapies.
- Court-ordered psychiatric or chemical dependency treatment, unless service provider determines that such services are medically necessary for the treatment of a condition included in the *Diagnostic and Statistical Manual of Mental Disorder*, Fourth edition, revised, as amended (“DSM-IV R”).
- Psychological testing, except where pre-certified as medically necessary by the service provider.
- Charges for services, supplies, or treatments that are covered charges under the medical portion of this Plan or other employer-sponsored health care plan.
- Prescription drugs, except where dispensed by a hospital or residential or day treatment program to a covered individual who, at the time of dispensing, is receiving treatment at the appropriate facility or program.
- Private-duty nursing, except when pre-certified by the service provider as medically necessary.
- Services to treat conditions that are identified by the DSM-IV R as not being attributable to a mental disorder (such as V codes).
- Treatment of congenital or organic disorders, except for associated treatment and acute behavioral manifestations.
- Marriage counseling.
- Couples therapy, except when certified as a medically necessary part of the treatment plan of a spouse covered by the Plan, who has a DSM-IV R mental disorder.
- Aversion therapy.
- Non-abstinence based or nutritionally based treatment for chemical dependency.
- Sexual therapy programs.
- Treatment or consultations provided via telephone.
- Services, treatment, or supplies provided as a result of any Workers’ Compensation law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state, or of any subdivision thereof (exclusive of Med-Cal/Medicaid); or caused by the conduct or omission of a third party for which the participant has a claim for damages or relief, unless the participant provides the service provider with a lien against such claim for damages or relief in a form and manner satisfactory to the service provider.

- Treatment or consultations provided by you or your dependent’s parents, siblings, children, current or former spouse or domiciliary partner.
- Remedial education beyond evaluation and diagnosis of learning disabilities, education rehabilitation, academic education, and educational therapy for learning disabilities.

Mental Health and Chemical Dependency Services Claims Procedures

Filing a Claim

If you have a claim for out-of-network mental health or chemical dependency treatment, you must file a claim with BCBS. You may obtain claim forms by calling BCBS at 1-800-521-2227.

Mail claims to:

BlueCross BlueShield of Texas
 Claims Division
 P.O. Box 660044
 Dallas, TX 75266-0044

Your claim must be submitted within 12 months from the date in which you incur the expense that gives rise to the claim. If the Plan is secondary, you must first submit your claim to the primary plan.

For any claim for benefits, you may be asked to submit additional information so that BCBS can determine whether the claim is covered and the amount of the claim.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer, friend or relative. You may be asked to notify BCBS in writing and give BCBS the name, address and telephone number where your authorized representative can be reached.

Mental health and chemical dependency benefits will be paid only if BCBS (the Plan Administrator’s delegate) decides, in its discretion, that you or your covered dependents are entitled to them. Claims for mental health and chemical dependency services fall into four categories: a claim for urgent care, a claim requiring pre-certification, a claim following approval of an ongoing course of treatment, and a claim for services after they have been received (“Post-Service Claim”). The time frame within in which you receive notification will depend on what kind of a claim has been made.

Urgent Care Claims

If a claim is urgent, you will be notified of the decision, adverse or not, as soon as possible, taking into account the medical circumstances. Notification will not be later than 24 hours after BCBS received the claim, unless the claim does not contain sufficient information on which to base a decision.

If the claim is incomplete and additional information is required, you will be notified as soon as possible, but not later than 24 hours after BCBS received the claim. You will be advised of the information required and will be given at least 48 hours to provide it.

You will then be notified of BCBS’s decision as soon as possible, but not later than 48 hours after the earlier of:

- The receipt of any additional information by BCBS, or
- The end of the 48 hours given to you to provide additional information.

A claim is “urgent” in the following cases:

- Where application of the 30-day time period for non-urgent care claims could reasonably be expected to seriously jeopardize your life or health or ability to regain maximum function;

- After discussion between the patient’s physician and the BCBS physician, it will be determined if the application of the 30-day time period for non-urgent care claims would subject you to severe pain that could not be adequately managed without the care that is the subject of the claim; or
- If a physician with knowledge of your medical condition determines that a claim is urgent, such determination shall be accepted.

Claim Requiring Pre-Certification

If a claim is for a benefit requiring pre-certification by BCBS, you will be notified of the decision, adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after BCBS received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond BCBS’s control.

If an extension is required, you will be notified before the end of the original 15-day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, BCBS will specifically describe it in the notice and give you a period of at least 45 days to provide it.

Approval of an Ongoing Course of Treatment

If BCBS has approved an ongoing course of treatment to be provided over a period of time or approved a number of treatments, the following will apply:

- Unless the Plan is amended or terminated, any reduction or termination in the course of treatment will be treated as a claim denial or “Adverse Benefit Determination,” which is defined below.
- BCBS will notify you sufficiently in advance to allow you to appeal and obtain a decision on appeal before the reduction or termination in the course of treatment.

Post-Service Claim

If your claim is for the payment of medical services after they have been received, BCBS will decide the claim within a reasonable time, but not longer than 30 days after it received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond BCBS’s control.

If an extension is required, you will be notified before the end of the original 30-day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, BCBS will specifically describe it in the notice and give you a period of at least 45 days to provide it.

BCBS may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

Notification of Denial

If BCBS issues an Adverse Benefit Determination, you can request to have your claim reviewed and reconsidered. An “Adverse Benefit Determination” includes:

- Coverage denial;
- The Plan’s failure to provide or make payment for a benefit, including a denial, reduction, termination or failure to provide or make payment based on an eligibility determination;
- Denial because the service is experimental, investigational or not medically necessary;
- Reduction or termination in an ongoing course of treatment (except due to Plan amendment or termination); or

- Cancellation or discontinuance of coverage that has a retroactive effect, regardless of whether there is an adverse effect on any particular benefit at that time.

The written explanation of the denial will include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;
- The specific reason(s) for the denial;
- A reference to the provision on which the denial is based;
- If BCBS relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline or protocol, or other criterion will be provided free of charge to you upon request;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If the Adverse Benefit Determination was based on a medical necessity or experimental or investigational limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge to you upon request; and
- An explanation of (i) the mental health and chemical dependency claim appeal procedures and the time limits applicable to those procedures; (ii) the external review process; (iii) how to initiate and follow those procedures and the external review process; (iv) the right to submit written comments, documents, records and other information relating to the claim to have them considered; (v) the right to have reasonable access to, and copies of (on request at no charge), relevant documents and other information; and (vi) a statement of your right to bring a civil action under ERISA section 502(a) within one year after the date of the final decision on the claim appeal. Such statement will include the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793 to assist individuals with internal claims and appeal procedures and external review process.

Appealing Denied Claims

You or your authorized representative may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 180 days of the initial notice of an Adverse Benefit Determination (or claim denial), or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should be sent to:

Claim Review Section
 BlueCross BlueShield of Texas
 P. O. Box 660044
 Dallas, Texas 75266-0044

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied
- Any additional facts and/or documentation that you feel support your claim.

You will have the opportunity to submit written comments, documents, records, and other information in support of your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations.

All written comments and documents you submit with your appeal, whether or not considered in the initial claim determination, will be reviewed and considered on appeal.

Review of Appeal

BCBS will review and render a decision on your appeal within the time frames outlined below and will notify you of its decision in writing. The individual who reviews and renders a decision on your appeal will not be an individual who participated in or decided your original claim, nor will he/she be a subordinate to the original decision maker. No deference shall be given to the initial decision. BCBS may consult with a physician or other licensed health care professional with appropriate training and experience to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in your initial claim and will not be a subordinate of that expert. The identity of a medical expert consulted in connection with your appeal will be provided upon request.

You will be provided with any new or additional evidence considered, relied upon, or generated the Plan in connection with your claim. The evidence will be provided to you as soon as possible and in advance of the notice of the final determination so that you will have an opportunity to respond prior to that date.

BCBS may hold a hearing if it is deemed necessary, and shall issue a written decision reaffirming, modifying or setting aside the initial determination not later than 30 days after BCBS received the appeal. If there is a hearing, you will be allowed to present evidence as part of the process. If there is no hearing, BCBS will notify you of its decision on appeal, adverse or not, but not later than 30 days after BCBS received the appeal.

The time frame for review of your appeal, like your initial claim for mental health and chemical dependency benefits, depends on whether it is an urgent care claim, a claim requiring pre-certification, a claim following approval of an ongoing course of treatment or a Post-Service Claim.

Urgent Care Claims

If your appeal is in connection with an urgent care claim, the independent fiduciary will notify you of its decision on appeal as soon as possible, taking into account medical circumstances, but not later than 72 hours after BCBS received the appeal.

Claim Requiring Pre-certification

If your appeal is in connection with a claim for benefits requiring pre-certification approval by the independent fiduciary, you will be notified of its decision on appeal, adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after BCBS received your appeal.

Approval of an Ongoing Course of Treatment

If your appeal is in connection with a claim for an ongoing course of treatment, the independent fiduciary will notify you of its decision on appeal as soon as possible, but not later than the date your treatment ends or is reduced.

Post-Service Claim

If your appeal is in connection with a claim for payment of medical services after they have been received, the independent fiduciary will notify you of its decision on appeal, adverse or not, but not later than 60 days after BCBS received the appeal.

Notification of Appeal Denial

If the decision on appeal affirms the denial of your claim, you will be furnished with a notice of Adverse Benefit Determination in writing. This notice of denial will include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;
- The specific reason(s) for the denial;
- The Plan provisions on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents and other information;
- If BCBS relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- A description of the external review process, including how to initiate external review;
- A statement of your right to bring suit under ERISA section 502(a) within one year after the date of the final decision on the claim appeal, and the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available to you is to contact your local U.S. Department of Labor Office and your State regulatory agency.”; and
- Information regarding the availability of, and the contact information for, any applicable office of health insurance commissioner assistance or ombudsman established under Public Health Service Act Section 2793 to assist individuals with internal claims and appeals and external review process.

External Review

You will be informed if you have the right to request external review of an Adverse Benefit Determination upheld on appeal. The request for external review must be made in writing and must be made within four months of the date you are advised that the Adverse Benefit Determination following your appeal was upheld. Your request for external review should be sent to:

Claims Review Section
BlueCross BlueShield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

Within five business days following receipt of the external review request, BCBS will complete a preliminary review of the request for external review to determine whether the request is complete and eligible for external review; and within one business day after completion of the preliminary review, you will be furnished with a written notification. If the request is complete but ineligible for external review, the notification will include the reason for ineligibility and contact information for the Employee Benefits

Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and you will be allowed to complete the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

You or your authorized representative may be allowed to request an expedited external review if you receive an Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of an external review would seriously jeopardize your life or health or your ability to regain maximum function, or that concerns admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility. BCBS will review your request for expedited external review in the same manner in which it reviews your request for external review, and will immediately send notice regarding your eligibility for the expedited external review.

BCBS will assign an “Independent Review Organization” (IRO) that is accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally recognized accrediting organization to conduct the external review.

The IRO will issue a notice of the final external review decision. Such notice will meet the requirements of 29 C.F.R. 2590.715-2719 and any subsequent regulatory and subregulatory guidance regarding the content and timing of the notice of the final external review decision. If BCBS receives notice from the IRO that the final Adverse Benefit Determination following appeal was reversed, it will immediately pay the claim.

For information about filing a mental health and chemical dependency benefit eligibility or enrollment claim, see “Eligibility and Enrollment Claims and Appeals” under the Eligibility and Enrollment section of this SPD.

Employee Assistance Program (EAP)

Highlights and Eligibility

As an employee of EP Energy, your family's health and wellbeing are important. In a time where meeting the demands of home and work can be challenging, EP Energy's Employee Assistance Program (EAP) goes the extra mile to help meet your needs. From the birth of a child to personal stress issues, the EAP offers services that can help you face a variety of challenges.

The EAP is provided through Magellan Health Services ("Magellan"). EAP offers you access to experienced and highly qualified counselors, who will help develop a personalized plan including referrals to an appropriate provider or resource.

These services are available to all regular full-time, reduced-schedule and part-time employees without regard to what medical plan they have selected, including those with no medical coverage. Your EAP coverage begins the first day you meet eligibility requirements, which is normally your date of hire.

EAP Contact Information

As soon as you or a family member realizes that the EAP may be of help to you, call Magellan at 1-800-327-1393. Once you have made an initial call to Magellan, they will put you in touch with an EAP counselor. If appropriate, you may also receive a packet of information in the mail or via email. This will provide helpful information about your situation. Not only will counselors be able to assist you at your initial time of need, they will also be available 24 hours a day.

EAP Online Resources

Log on to www.magellanascend.com to find articles, self-assessments, tools and calculators on a wide range of topics that include: stress management, work-life balance, relationships, depression, chemical dependency, communication, and many more. On the medicine tracker, learn about the medicine you're taking, the benefits and potential side effects.

Cost of EAP Services

Telephone consultation services and EAP visits with your counselor(s) are generally free. Additional resources may incur costs. Magellan counselors will research the most appropriate and affordable resources to help meet your and your family's needs. Your counselor can help determine if extended services are covered under your plan and what the approximate cost would be.

EAP Services

The EAP provides confidential assessment and counseling services to help with issues or problems that could potentially affect your health, relationships and job performance. You and each of your eligible household members are eligible to participate in up to 3 sessions per problem each year (as considered clinically necessary by the EAP). Below are some of the services offered by the EAP:

Child and Parenting Support Services

Extensive services for children from birth to age 18 are available, including information and consultation on all kinds of parenting questions, and resources for day care, summer camps, adoption and sick-child care.

Personal Stress Issues/Mental Health

Depression, stress and anxiety can impact your ability to perform well at work and at home. Trained counselors will listen to your concerns and assess the problem to determine the needed resources and/or referrals.

Chronic Condition Support

Manage chronic conditions like diabetes, arthritis and asthma with researched links to professional organizations and expert resources—as well as qualified referrals on transportation services, support groups, remodeling for accessibility, dealing with stress and anxiety and more.

Family Issues

Balancing work and personal life is a big issue that affects a large portion of today's workforce. The counselors will listen to your concerns and provide assistance regarding relationship, dual career, health, child care and adult care issues.

Chemical Dependency

If you or a family member is struggling with chemical dependency, Magellan can help. Counselors will recommend a course of treatment and assist you in finding the most appropriate care provider or program.

Work/Life Services

Life resource counselors work with you to identify and address your work/life issues and needs. You can receive counseling, education and referrals in a wide range of areas: prenatal care, child care (including summer and emergency care), adoption, schools, special needs, colleges, personal services and adult care. The team refers providers and programs that meet your service and location requirements to help you better balance your personal and professional life. You will also have access to comprehensive educational materials that present the detailed practical information you need to manage your work and life responsibilities.

Life Learning

Educational resources are provided for all ages and abilities, including help with locating and evaluating schools, finding classes for special-needs children and arranging tutoring services.

Adult/Elder Support Services

Reduce stress and eliminate the guesswork of caring for adult and elder dependents. We will help you find the right resources you need, including care giving and housing options, transportation and meal services, senior activity groups and more.

Relocation Resources

Make moving to a new city or state a little easier with practical detailed information on your new location—from grade schools to piano teachers, gyms to drugstores.

Dental Program

Highlights

Regular full-time and reduced-schedule employees are eligible for the Dental Program. Part-time employees are not eligible for Dental Program coverage.

The Dental Program is designed to help you and your family cover many dental expenses, including preventive services. The Dental Program is a separate option under the Plan, so you have the option of choosing “No Coverage,” or you may elect coverage for you and your dependents.

The non-network Dental Program’s Claims Administrator is BlueCross BlueShield of Texas (“BCBS”). Depending on where you live, you may have a Cigna Dental HMO option available to you. Your dental coverage options are:

- No Coverage;
- Non-Network Option (BCBS); and
- Network Option (Cigna Dental HMO), only where available.

Your enrollment materials will indicate which options are available to you. You may review the provisions of the Cigna Dental HMO on EP Energy’s intranet. Under Everything HR, select the My Health site, then Cigna Network Dental HMO Summary Plan Description. If you enroll in the Cigna Dental HMO, you must receive all your care from a Cigna Dental HMO provider, and you will receive information about your benefits from Cigna Dental.

If you are enrolled in both medical and dental with BCBS, you will receive only one BCBS card that you will use to receive both medical and dental services. If you elect dental coverage and no medical coverage, you will receive a dental identification card from either BCBS or Cigna, depending on which dental option you choose. If you have medical coverage and the Cigna dental coverage, you will receive a medical identification card for BCBS for your medical coverage and a Cigna identification card for your dental coverage.

When or before you enroll in the Plan’s dental coverage, you will be informed of the premiums for your coverage. Each year during open enrollment you also will be informed of the premiums for the dental coverage.

Non-Network Dental Option

The non-network option is a fee-for-service plan administered by BCBS. You can choose to receive care from the provider of your choice and you are responsible for paying an individual annual deductible for services other than preventive. Once you have met the individual annual deductible, the plan pays a percentage of reasonable and customary charges, and you are responsible for the remaining amount.

Non-Network Dental Coverage Chart

Plan Provision	Non-Network Coverage
Annual Deductible	For Preventive and Diagnostic Care: None For Basic and Major Care: \$75 individual (when three individuals meet their individual deductibles, the family deductible is met).
Preventive and Diagnostic Care (Routine exams, X-rays, fluoride treatment, sealants)	Plan pays 100% of reasonable and customary charges

Basic Care (Restorations and repairs, fillings, root canals, oral surgery)	After deductible: Plan pays 80% of reasonable and customary charges
Major Care (Crowns, dentures, inlays, onlays and implants)	After deductible: Plan pays 50% of reasonable and customary charges
Orthodontics	Not covered
Maximum Annual Benefit	\$1,250 per covered person.

Annual Deductible

Under the Non-Network Option, there is no annual deductible for preventive care. For basic and major care, there is a \$75 individual deductible. Once three covered individuals have met their individual deductibles, the family deductible is considered met for the year for all covered family members.

Expenses Covered by the Dental Program

The Plan will pay benefits as shown for the following covered, reasonable and customary dental care expenses.

Preventive and Diagnostic Care

The Plan pays 100% of the covered cost for all preventive and diagnostic care you receive, with no deductible.

- Clinical oral exams, but not more than two per calendar year.
- Emergency palliative treatment of dental pain when no other dental services except X-rays are done (any X-ray taken in connection with palliative treatment is a separate dental service).
- Complete mouth (full mouth), Panoramic or the vertical bitewing survey of X-rays but not more than once every 36 months.
- Individual periapical X-rays.
- Bitewing X-rays, but not more than two series per calendar year.
- Occlusal X-rays.
- Extra-oral X-rays, but not more than two per calendar year.
- Topical application of fluoride, but not more than two per calendar year.
- Dental prophylaxis (with or without oral exams), but not more than two per calendar year.
- Sealants for dependents 14 years of age or younger, one application per tooth every 5 years.

Basic Care

After you meet the deductible, the Plan pays 80% of all reasonable and customary charges.

- Necessary examinations and diagnostic services (including X-ray and laboratory tests) when such services are not covered as preventive and diagnostic care.
- Extractions of unerupted teeth.
- Fillings (amalgams).
- Repair of complete or partial dentures.
- Space maintainers.
- Root canal therapy (endodontic care).
- Treatment of the gums and tissues of the mouth (periodontal treatment).

- The giving of anesthesia in connection with dental care.
- Relining of complete or partial dentures.

Major Care

After you meet the deductible, the Plan pays 50% of all reasonable and customary charges for major care you receive.

- Inlays and onlays, limited to once every five years on the same tooth.
- Initial installation of full or partial dentures.
- Bridgework.
- Crowns or replacement of dentures once every 60 months.
- Implants.

Expenses Not Covered by the Dental Program

The Plan will not pay benefits for the following dental care expenses:

- Dental care or supplies which are not included under the “Covered Dental Program Expenses” section;
- Dental care or supplies furnished by a facility operated for or by the U.S. Government (or its agency) or by a doctor or dentist employed by that place;
- Dental care and supplies for which:
 - No charge is made;
 - You or your dependent would not have to pay if you did not have this coverage;
- Dental care or supplies furnished as a result of taking part in the commission of an assault or felony;
- Dental care or supplies furnished as a result of an illness or injury covered by Workers’ Compensation, occupational disease law or similar laws, or injury if it arises out of or during the course of employment for pay or profit;
- Dental care or supplies payable under another part of the Health Care Program;
- Charges incurred after the covered person is no longer covered for this dental benefit;
- Supplies for dental care other than those used in a doctor’s office, or instructions in dental hygiene;
- Oral care and supplies which are used to change vertical dimension or closure. These include, but are not limited to:
 - Diagnostic procedures;
 - Balance procedures;
 - Restoration;
 - Fixed devices; and/or
 - Movable devices;
- Any service rendered by a close relative or someone having the same legal residence as the patient;
- Extractions for healthy third molars (wisdom teeth);
- Dental treatments started prior to eligibility;

- Temporomandibular Joint (TMJ) Dysfunction charges; and
- Replacement of dentures or appliances due to loss or theft.

Orthodontics

Orthodontia is not covered under the Non-Network option.

Network Option

Depending on where you live, you may be eligible for the network option, which is the Cigna Dental HMO (referred to as DHMO). Cigna DHMO is a group of dentists, orthodontists, and specialists who have agreed to provide dental services to network participants at a discounted rate. You choose a primary dentist who will be responsible for coordinating all of your dental care. Your primary dentist will refer you to specialists, as needed. And, for the most part, there are no deductibles or maximums to be concerned with; you pay a copayment for most services. If you use a Cigna DHMO dentist for services, he or she will also handle the necessary paperwork for you.

You may review the provisions of the Cigna DHMO on EP Energy's intranet. Under Everything HR, select the My Health site, then Cigna Network Dental HMO Summary Plan Description.

If you have questions about the Cigna DHMO or you want to locate providers, call Cigna at 1-800-244-6224. You can also find DHMO providers on their website at www.cigna.com.

Opting Into the Cigna Dental HMO

Employees who do not live in a Cigna Dental HMO network area may be allowed to opt into this network during initial enrollment, annual enrollment upon request or within 60 days of relocating. However, if this network does not appear on the UltiPro website as a dental option in your enrollment, it is because there are not network DHMO providers to support the area. Before deciding to opt into this network, you should visit Cigna's website (www.cigna.com) to find providers and where they are located so that you can determine whether you are willing to travel the distance necessary to use their services. Under the Cigna Dental HMO you choose a primary dentist who will be responsible for coordinating all of your dental care. Your primary dentist will refer you to specialists, as needed. Once you enroll in the network option you cannot change your election until the next annual enrollment period, even if your provider drops out of the network. If, after careful consideration, you decide you want to opt into this network option, you must call the Benefits Center and request this election. You cannot make this election online.

Dental Program Claims Procedures

For information about filing a dental claim under the BCBS non-network option, see "Medical and Dental Program Claims Procedures and Claims" under the Medical Program section in this SPD. For information about dental claims and appeal procedures under the DHMO, please consult the SPD for the Cigna Dental HMO.

Vision Program

Highlights

Regular full-time employees and reduced-schedule employees are eligible for the Vision Program. Part-time employees are not eligible for Vision Program coverage. The Claims Administrator of the Vision Program is Vision Service Plan (VSP). When you need eye care, you can receive services from either a VSP network doctor or a non-VSP provider. If you receive services from a VSP network doctor, you will save money. The Health Care Program has negotiated discounted rates for services with participating network doctors, and there are no claim forms if you use a VSP network doctor.

The Vision Program is designed to help you and your family cover a portion of your vision care expenses, including exams, eyeglasses, and contact lenses. The vision program is a separate option so you have the option of choosing “No Coverage” or you may elect coverage for you and your dependents.

Vision Coverage Chart

Plan Feature	In-Network	Out-of-Network
Annual Exam (once per year)	Plan pays 100% (after \$10 copay)	Plan pays up to \$50 (after \$10 copay)
Eyeglasses (once per year)	<p>After \$35 copay for eyewear (lenses, frames, or both):</p> <p>Frames Plan pays 100% up to \$130 allowance (plus 20% off any out-of-pocket costs)</p> <p>Standard Lenses Plan pays 100% for single vision, lined bifocals, and lined trifocals. <i>Plus</i>, up to 40% off lens extras, such as scratch resistant and anti-reflective coatings and progressives.</p>	<p>After \$35 copay for eyewear (lenses, frames or both):</p> <p>Frames Plan pays up to \$70</p> <p>Standard Lenses:</p> <ul style="list-style-type: none"> • Single vision: Plan pays up to \$50 each • Lined bifocals: Plan pays up to \$75 each • Lined trifocals: Plan pays up to \$100 each
Contact Lenses (once per year in lieu of lenses and frame)	<p>Elective: Plan pays 100% up to \$140 per year.</p> <p>Medically Necessary: Requires prior authorization by VSP Plan pays 100% (after \$35 copay)</p>	<p>Elective: Plan pays 100% up to \$105 per year.</p> <p>Medically Necessary: Plan pays 100% up to \$210 per year</p>

When or before you enroll in the Plan’s vision coverage, you will be informed of the premiums for your coverage. Each year during open enrollment you also will be informed of the premiums for the vision coverage.

If You Use a VSP Network Doctor

The Vision Program offers a network of eye care doctors through VSP. When you use a VSP network doctor, you pay a copay and the Plan pays 100%, up to certain limits. When you call to make an appointment, you will need to identify yourself as a VSP participant. You receive the highest level of benefit coverage if you use a VSP network doctor. To find VSP providers, call VSP at 800-877-7195 or log on to their website at www.vsp.com.

If You Use a Non-VSP Provider

Under the Vision Program, you always have the option of using any licensed optician, optometrist, or ophthalmologist of your choice. However, when you use a doctor that is not in the VSP network, you will receive a lower level of benefit coverage and typically pay more out-of-pocket.

Expenses Covered

Covered expenses include the following:

- Routine eye exams;
- Frames;
- Standard lenses; and
- Contact lenses.

Expenses Not Covered

Vision expenses not covered under the program include the following:

- Orthoptics;
- Two pair of glasses in lieu of bifocals;
- Medical or surgical treatment of the eyes;
- Any eye exam or any corrective eyewear required by an employer as a condition of employment; or
- Corrective vision services, treatments, and eyewear of an experimental nature.

Vision Program Claims Procedures

General Information

Vision benefits under the Plan will be paid only if VSP decides, in its discretion, that you or your covered dependents are entitled to them.

For any claim for benefits, you may be asked to submit additional information so that VSP can determine whether the claim is covered and the amount of the claim.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer or a friend or relative. You may be asked to notify VSP in writing and give VSP the name, address, and telephone number where your personal representative can be reached.

Making a Claim for Vision Benefits

If you visit a VSP network doctor, you do not need to file a claim. If you see a non-VSP provider, you must pay the provider in full at the time of your appointment and file a claim with VSP for partial reimbursement. You may obtain a claim form by calling VSP at 800-877-7195. Send the completed form to:

VSP
Out-of-Network Claims Department
P.O. Box 997105
Sacramento, CA 95899-7105

Your claim must be submitted within 12 months from the date in which you incur the expense that gives rise to the claim. If the Plan is secondary, you must first submit your claim to the primary plan.

VSP will decide the claim within a reasonable time, but not longer than 30 days after VSP received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient

information on which to base a decision, or an extension is required for other reasons beyond VSP's control.

If an extension is required, you will be notified before the end of the original 30-day period of the circumstances necessitating the extension and the date by which a decision is expected. If additional information is required, VSP will specifically describe it in the notice and give you a period of at least 45 days to provide it.

VSP may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

Notice of Denial

If VSP issues an Adverse Benefit Determination, you will be notified of the Adverse Benefit Determination in writing. An "Adverse Benefit Determination includes:

- Coverage denial;
- The Plan's failure to provide or make payment for a benefit including a denial, reduction, termination or failure to provide or make payment based on an eligibility determination;
- Denial because the service is determined to be experimental, investigational, or not medically appropriate;
- Reduction or termination in an ongoing course of treatment (except due to Plan amendment or termination); or
- Cancellation or discontinuance of coverage that has a retroactive effect, regardless of whether there is an adverse effect on any particular benefit at that time.

Written notice of the Adverse Benefit Determination, or denial, will provide:

- The specific reason or reasons for the denial;
- A reference to the Plan provision on which the denial is based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;
- If VSP relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge to you upon request; and
- An explanation of (i) the Vision Program's claim appeal procedures and the time limits applicable to those procedures; (ii) the right to submit written comments, documents, records and other information relating to the claim to have them considered; (iii) the right to have reasonable access to, and copies of (on request at no charge), relevant documents and other information; and (iv) a statement of your right to bring a civil action under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

Appealing a Denied Claim for Vision Benefits

You or your authorized representative may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 180 days of VSP's initial notice of an Adverse Benefit Determination, or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should be sent to:

VSP
Claims Department
P.O. Box 997105
Sacramento, CA 95899-7 105

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You will have the opportunity to submit written comments, documents, records, and other information in support of your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse determination will take into account all comments, documents, records and other information submitted by you relating to the claims, regardless of whether such information was submitted and considered in the initial benefit determination.

Review of Appeal

VSP will review and render a decision on your appeal not later than 60 days after receipt of your written appeal and will notify you of its decision in writing. The individual who reviews and renders a decision on your appeal will not be an individual who participated in or decided your original claim, nor will he/she be a subordinate to the original decision maker. No deference shall be given to the initial decision. VSP may consult with a physician or other licensed health care professional with appropriate training and experience to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in your initial claim and will not be a subordinate of that expert. The identity of a medical expert consulted in connection with your appeal will be provided upon request.

You will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim. The evidence will be provided to you as soon as possible and in advance of the notice of the final determination so that you will have an opportunity to respond prior to that date.

Notice of Appeal Denial

If the decision on appeal affirms the initial denial of your claim, you will be notified of the Adverse Benefit Determination in writing. This notice of denial will provide:

- The specific reason(s) for the denial;
- The Plan provisions on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents and other information;

- If VSP relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational limitation, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to you upon request; and
- A statement of your right to bring suit under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

For information about filing a vision benefit eligibility or enrollment claim, see “Eligibility and Enrollment Claims and Appeals” under the Eligibility and Enrollment section of this SPD.

Coordination of Benefits (COB)

How Coordination of Benefits (COB) Works

If you or your dependents are covered by more than one group medical, dental or vision plan—including Medicare—the benefits you receive from the Plan are subject to Coordination of Benefits (COB) rules.

These rules govern the amount each plan will pay towards any medical, dental or vision claims you file. COB rules prevent a duplication or double payment of the provider's charges for services.

Under EP Energy COB rules, benefits will be coordinated between the two plans to provide coverage up to the amount the Plan would pay if it were your only coverage.

This approach to Coordination of Benefits does not provide for 100% reimbursement of expenses. Instead, it provides for two programs to pay together what the Plan would otherwise pay.

These rules do not apply to any individual insurance you purchased yourself.

Determining Which Plan is Primary

The plan which pays benefits first is considered to be “primary,” while the Plan which pays benefits second is considered “secondary.”

Spouse

If your spouse is covered by this Plan and another group plan for which this Plan will coordinate benefits, the other group plan is primary for your spouse and this Plan is secondary.

Children

If your children are covered by this Plan and another group health plan in which your spouse is enrolled, the “birthday rule” applies. The birthday rule states that the Plan of the parent whose birthday is earlier in the calendar year is primary for the children, regardless of which parent is older.

If you were never married or are separated or divorced with a court decree, the Plan of the parent with custody of and financial responsibility for the child is considered primary, unless the court decree states otherwise.

If you have joint custody, the Plan of the parent with physical custody of the child at the time treatment begins is considered primary.

If you do not have a court decree, the Plan of the parent with custody is considered primary unless that parent has remarried. If so, the Plan of the stepparent is primary. Otherwise, the Plan that has covered the child longer is primary.

Active Employees Over Age 65

When you reach age 65, you're eligible to enroll in Medicare, even if you continue to be an active employee. If you enroll in Medicare while still enrolled in the Plan, your Plan coverage will continue to be primary as long as you are an active employee. Your Medicare coverage will have no effect on your active medical benefits.

Coordination of Benefits with Medicare

If you are enrolled in Medicare, the Plan pays its benefits according to the Medicare Secondary Payor requirements under Federal law. When the Plan is subject to these requirements, the Plan is primary in most instances. Below are some general guidelines to how the Plan's medical program coordinates with Medicare.

Medical Program Primary to Medicare

The Plan's Medical Program is the primary plan for you and your eligible dependents, meaning it pays benefits before Medicare, if you have "current employment status" with EP Energy. Current employment status is defined by Federal law and determined by EP Energy.

Also, if you or any eligible dependent enrolls in Medicare because of end-stage renal disease (ESRD), the Plan's Medical Program is primary, in most circumstances, as explained below.

If you enroll in Medicare due to ESRD, the Plan's Medical Program may be primary during the first 30 months of eligibility for Medicare due to ESRD, unless Medicare is already primary for a covered person at the time he or she becomes eligible for ESRD-based Medicare. If the covered person is entitled to age-based or disability-based Medicare when they become eligible for ESRD, then Medicare remains primary.

Medicare Primary to the Plan's Medical Program

Medicare is the primary plan, meaning it pays benefits before the Plan's Medical Program, if you are:

- Enrolled in Medicare because of total disability and do not have "current employment status" as defined by Federal law and determined by EP Energy; or
- Enrolled in Medicare because of ESRD, but only after the first 30 months of entitlement for Medicare because of ESRD if not otherwise entitled due to age or disability.
- Enrolled in this Plan as a COBRA participant.

Third-Party Liability

If you or your covered dependent has a claim for damages or a right to recover damages from another party or parties for any illness or injury for which benefits are payable under this Plan, the Plan is subrogated to such a claim or right of recovery. The Plan's right of subrogation will be to the extent of any benefits paid or payable under this Plan, and shall include any compromise settlements. The Plan may assert this right independently of you or your covered dependents. Acceptance of benefits is constructive notice of this provision in its entirety.

If you or your covered dependents, or legal representative, estate or heir of you or your covered dependents recovers damages, by settlement, verdict or otherwise, for an illness or injury for which a benefit has been paid under this Plan, you or your covered dependents, or legal representatives, estate or heirs of you or your covered dependents, agrees to promptly reimburse the Plan for benefits paid. The Plan's right to receive reimbursement applies to you or your covered dependent's recovery from any source, including but not limited to any party's liability and medical pay insurance, uninsured and underinsured motorist coverage, no-fault automobile coverage and Workers' Compensation coverage.

The Plan will have a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that you or your covered dependents receive or is entitled to receive from any source, regardless of whether you or your covered dependents receive a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of medical expenses paid under this Plan. The Plan's first priority rights will not be reduced due to you or your covered dependent's own negligence.

The Plan is entitled to reimbursement even if you or your covered dependent is not made whole or fully compensated by the recovery. Any share of attorney fees or costs or Common Fund fees shall not reduce our recovery unless agreed to by the Plan in writing.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of whether the minor's representative has access to or control of any recovery funds.

You or your covered dependent (or parent or legal guardian) will cooperate with the Plan and its agents and help the Plan do what may be reasonably needed to protect the Plan's subrogation rights and obtain the refund. This includes furnishing all relevant information, making assignments in the Plan's favor and signing and delivering any documents needed to protect the Plan's rights. You or your covered dependent shall not take any action that prejudices the Plan's rights.

If you or your covered dependent make a recovery from any source and fail to reimburse the lesser of:

1. the amount recovered (including amounts to be recovered through future installment payments); or
2. the amount of benefits paid related to this illness or injury;

then you or your covered dependent will be personally liable to the Plan for this amount. We may also reduce future benefits up to the amount due to the Plan.

The terms of this subrogation and right of reimbursement provision shall apply regardless of state laws to the contrary.

COBRA

Highlights

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA continuation coverage can become available to you and your family members who would otherwise lose Health Program coverage under the EP Energy Health and Welfare Plan. This section is intended to inform you of your rights and obligations under the COBRA law. For additional information about your rights and obligations under the Health Care Program and under COBRA, you should contact PlanSource, the COBRA Administrator, at 1-888-266-1732.

Benefits You May Continue

The benefits subject to COBRA include medical, dental, vision, employee assistance, mental health and chemical dependency, and prescription drug benefits. For purposes of this COBRA continuation coverage section, these benefits are referred to as the “Health Care Program.”

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan).

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Health Care Program coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Health Care Program is lost because of the qualifying event. Under the Health Care Program, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage (see “Cost of Coverage” further in this section).

Who is Eligible for COBRA?

Employee Continuation Coverage

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Health Care Program because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

Spouse Continuation Coverage

Your spouse will become a qualified beneficiary if he or she loses coverage under the Health Care Program because any of the following qualifying events happen:

- The employee dies;
- The employee’s hours of employment are reduced;
- The employee’s employment ends for any reason other than his or her gross misconduct;
- The employee becomes divorced from his or her spouse.

Dependent Child Continuation Coverage

Your dependent children will become qualified beneficiaries if they lose coverage under the Health Care Program because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced; or
- The child stops being eligible for coverage under the Health Care Program as a "dependent child."

When is COBRA Continuation Coverage Available?

The Health Care Program will offer COBRA continuation coverage to qualified beneficiaries only after PlanSource has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, EP Energy will notify PlanSource within 30 days of the qualifying event.

For What Types of Qualifying Events Must You Give Notice?

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or your dependents must notify the Benefits Center within 60 days of a dependent's loss of coverage, which is the last day of the month in which the qualified change in status occurred. The Benefits Center will in turn notify PlanSource.

Note: Failure to provide notice in accordance with these procedures will result in the loss of continuation coverage rights that would otherwise be available to you under COBRA.

How is COBRA Continuation Coverage Provided?

Once PlanSource receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA continuation coverage even if the employee does not. COBRA continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA continuation coverage on behalf of all of the qualified beneficiaries.

Continued coverage is not automatic. You must enroll by completing an application and returning it to the COBRA administrator within 60 days after the later of:

- the date you cease to be eligible under the group plan; or
- the date the COBRA election notice is provided to you. (This is the date your COBRA election notice is post-marked, if mailed.)

In considering whether to elect COBRA continuation coverage, you should take into account whether you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Health Care Program coverage ends because of a qualifying event listed above. You will also have the same special enrollment right at the end of the COBRA continuation coverage period if you get COBRA continuation coverage for the maximum time available to you. You may also be eligible to buy an individual plan through the Health Insurance Marketplace.

How Long Will COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of Health Care Program coverage. The COBRA continuation coverage periods described below are the maximum coverage periods. COBRA continuation coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled “Termination of COBRA Continuation Coverage.”

COBRA Qualifying Event	How Long Cobra Coverage May Continue	
	You	Dependents
You die	Does not apply	36 months
You and your spouse divorce	Does not apply	36 months
You are no longer eligible due to a reduction in work hours	18 months	18 months
You terminate employment (for reasons other than gross misconduct)	18 months	18 months
Your child is no longer eligible	Does not apply	36 months
You or a dependent become disabled according to Social Security rules	29 months	29 months

18-month and 36-month Periods of COBRA Continuation Coverage

When the qualifying event is the death of the employee, the employee’s divorce, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is end of employment or reduction of hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended: disability or a second qualifying event.

Disability Extension of 18-month Period of COBRA Continuation Coverage

An 11-month extension of coverage may be available if any one of the qualified beneficiaries are determined by the Social Security Administration (“SSA”) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must notify PlanSource and provide a copy of the SSA determination within 60 days after the latest of:

- The date of the SSA disability determination; or
- The date of the covered employee’s termination of employment or reduction of hours.

Notice must also be provided within 18 months after the covered employee’s termination of employment or reduction of hours for entitlement to a disability extension.

Each qualified beneficiary who has elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is later determined by SSA to no longer be disabled, you must notify PlanSource of that fact within 30 days after SSA’s determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect COBRA continuation coverage if a second qualifying event occurs during the first 18 months of COBRA continuation coverage. The maximum amount of COBRA continuation coverage available when a second qualifying event occurs is 36 months from the original date that COBRA coverage began. The second qualifying event is the death of a covered employee, divorce, or a dependent child’s ceasing to be

eligible for coverage as a dependent under the Health Care Program. You must notify PlanSource in writing within 60 days after a secondary qualifying event occurs if you want to extend your COBRA continuation coverage.

In no event will your federal COBRA continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

COBRA and Prior Medicare Entitlement of Employee

When Health Care Program coverage is lost due to termination of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries (other than the employee) who lose Health Care Program coverage as a result of the employee's qualifying event can last up to 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Family and Medical Leave Act

Employees on a Family and Medical Leave Act leave of absence who notify the Company during their leave period that they are not returning to work and are terminating their employment, or fail to return to work following such leave, will be eligible to continue coverage for up to 18 months from the last day of the month in which employment terminated or the last day of the month in which their leave ends and the employee fails to return to work.

New Dependent Children

A child who is born to, adopted or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. PlanSource must be advised within 60 days of the child's birth or placement for adoption.

Cost of Coverage

Your Premium Costs

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent) of the cost to the Health Care Program (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

If you elect continuation coverage, you pay the full cost of coverage each month, plus a 2% administrative fee.

If you qualify for 29 months of COBRA continuation coverage because of disability, you may be required to pay up to 150% of the cost during the last 11 months of coverage.

Premium rates are subject to change each January 1.

First Payment for COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment when you submit your election. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. (This is the date your COBRA election notice is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Health

Care Program. There is no grace period for this first payment. You are responsible for making sure that the amount of your first payment is correct. You will be provided with a payment book detailing the amount and due dates of the initial and subsequent monthly payments. You may also contact PlanSource to confirm the correct amount of your first payment.

Monthly Payments for COBRA Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments for each subsequent month of coverage (known as the coverage period). Under the Health Care Program, each of these periodic payments for COBRA continuation coverage is due on the first day of the month for that month. For example, payment for COBRA continuation for April is due on or before April 1. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Health Care Program will continue for that coverage period without any break. The Health Care Program will not send periodic notices of payments due, but you will be provided with monthly premium coupons.

Grace Periods for Monthly Payments

Although monthly payments are due as explained above, you will be given a grace period of 30 days after the first day of month to make each payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. For example, if you make your April payment (due April 1) by April 30, you will have COBRA continuation coverage for April. However, if you pay a payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Health Care Program will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a payment before the end of the grace period for month, you will lose all rights to any further COBRA continuation coverage under the Health Care Program.

Termination of COBRA Coverage

COBRA continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage;
- the employer ceases to provide any group health plan for its employees; or
- the individual whose SSA disability provided for a disability extension has recovered.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Changes to the Health Care Program and COBRA

If there are changes or modifications to the Health Care Program affecting covered employees, those changes also apply to individuals receiving COBRA continuation coverage, whether in improvements or reductions in benefits.

Other Coverage Options Besides COBRA

In addition to COBRA continuation coverage, you and your family should consider health coverage that may be available to you through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

Questions About COBRA Continuation Coverage

The right to COBRA continuation coverage is protected by law. If the law changes, your rights will change accordingly. If you have any questions about COBRA continuation coverage, please call PlanSource at 1-888-266-1732.

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at <http://www.dol.gov/ebsa>. (Addresses and telephone numbers of regional and district EBSA offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

To protect your family's rights, let PlanSource know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to PlanSource.

Employees on Military Leave

This section sets forth the Plan's provisions concerning continuation of coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Employees going into qualifying military service may elect to continue medical coverage under the Plan as mandated by

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

USERRA under the following circumstances. These rights apply only to an employee and his or her family members covered under the Plan immediately before the employee leaves for military service.

The maximum period of USERRA coverage under such an election shall be the lesser of:

- The 24-month period beginning on the date on which the employee's absence from work begins; or
- The day after the date on which the employee was required to apply for or return to a position of employment and failed to do so.

USERRA coverage during these time periods will cease for the remainder of the coverage period if the employee fails to make the required contributions as discussed below.

USERRA also grants certain rights to the employee and the employee's covered family members upon the Employee's return to employment after military leave. A waiting period will not be imposed in connection with the restatement of coverage upon reemployment.

Employees going on military leave desiring USERRA continuation coverage must elect USERRA continuation coverage. This election must be in writing on a form provided by the Plan and must be completed and returned to the Company within 60 days of the beginning of the leave, except as provided below concerning leaves in which an employee is excused from giving advance notice to the Company. The completed form must be returned to Company's Benefits Department.

If such an election is not received within such time period, the employee will lose any rights the employee and his or her family members have to USERRA continuation coverage. The employee's covered family members do not have the right to USERRA continuation coverage unless the employee elects USERRA continuation coverage for himself or herself.

Payments for USERRA coverage are due on a monthly basis and must be received by the end of the month. For example, coverage for the month of March must be received by the Plan by March 31. The amount of the employee's contribution for the period of USERRA coverage shall be calculated as the total of the usual Company and Employee contributions to the Plan for the Plan Participant, plus a 2% administrative fee, except that if the employee's military service is for fewer than 31 days, the contribution will be only the employee's regular contribution for such coverage. The first payment is due no later than the last day of the month in which the Plan Administrator received the written election to obtain USERRA continuation coverage, and must cover the month or months since the employee's absence from work began through the month in which the election was received by the Plan Administrator. If full payment is not received by the due date, the USERRA continuation coverage will cease retroactively effective as of the last day of the month for which a payment was received on a timely basis.

In most instances, the employee is required by USERRA to give advance notice to the Company of his or her impending military leave. However, in certain situations under USERRA, the employee is excused from giving advance notice to the Company of his or her military service because the giving of advance notice is impossible, unreasonable or precluded by military necessity. In these cases, the employee may elect USERRA continuation coverage by notifying the Plan Administrator of such election in writing within 30 days of the date that giving notice is possible, reasonable or no longer precluded by military necessity. This election must be accompanied by the following: (1) a statement of the reason(s) why the employee was unable to give advance notice; and (2) payment in full for the unpaid contribution amounts due for each month of coverage beginning as of the date the employee was first absent from work due to the USERRA leave up to the contribution amount due for the month of such election. However, if the employee makes such election after the maximum time period for USERRA coverage has elapsed, coverage shall be only for such maximum time period and the payment must be for the entire time period.

If a timely election form is filed in accordance with this paragraph, the employee's coverage will be retroactively reinstated to the date he or she was first absent from work and shall continue for a period of time up to the maximum time period described above.

All notices, election forms, payments and other documents required to be provided must be in writing and sent to the following address:

Benefits Department
EP Energy
P.O. Box 4660
Houston, TX 77210-4660

In many instances, a covered employee eligible for continuation coverage under USERRA will also be eligible for continuation coverage under COBRA. To the extent allowed by law, the continuation periods under COBRA and USERRA will run concurrently (at the same time).

USERRA continuation coverage rights apply only to employees covered under the Plan, who may elect USERRA coverage for themselves and their family members. The following persons do not have USERRA continuation coverage rights:

- The employee's family members if the employee does not elect USERRA continuation coverage for himself or herself.
- The employee's family members who go into military service.

However, family members may have independent rights to elect COBRA continuation coverage and rights under other federal laws. Please see the COBRA Continuation Coverage section below for more information on COBRA continuation coverage.

Dependent Day Care Flexible Spending Account

Dependent Day Care Flexible Spending Account

Highlights

Regular full-time and regular reduced-schedule and part-time employees are eligible for a Dependent Day Care Flexible Spending Account that can help pay for certain expenses not reimbursable by your other benefit plans. This Flexible Spending Account is for dependent day care expenses for certain child and adult dependents.

The Flexible Spending Account is offered under the EP Energy Cafeteria Plan, which is a component plan of the EP Energy Health and Welfare Plan. The Dependent Day Care Flexible Spending Account lets you set aside a portion of your pay through before-tax payroll deductions, which are used to obtain reimbursement for eligible dependent day care expenses.

The Flexible Spending Accounts Claims Administrator is PayFlex. They can be reached at 800-284-4885 or through their website at www.HealthHub.com.

Since there is a tax advantage to participating in a Flexible Spending Account, the Internal Revenue Service (IRS) has strict rules and requirements for using the account, which are described in this section.

Please note that EP Energy also sponsors a Commuter benefit through PayFlex that helps you save money on certain work-related transportation and parking expenses, but this is not a benefit offered under the EP Energy Cafeteria Plan or the EP Energy Health and Welfare Plan. In addition, the Commuter benefit is not subject to ERISA, and you have no rights under ERISA regarding the Commuter benefit. To learn more about the Commuter benefit, please contact PayFlex at 1-800-284-4885.

How to Enroll and When Coverage Begins

New Hires

If you are a new employee, you can begin making before-tax contributions as soon as administratively possible after joining EP Energy, as long as you enroll within 31 days of your hire date. You will need to log on to the UltiPro website at <https://epenergy.ultipro.com> and indicate the annual amount you want to contribute to your account on a before-tax basis. If your enrollment is completed within your 31-day enrollment period, your Flexible Spending Account will become effective on your date of hire. Your contributions will be deducted from your paycheck semi-monthly over the course of the calendar year. Your decision to enroll will stay in effect through the end of the Plan Year (the calendar year) unless you have a qualified change in status, discussed below.

Annual Enrollment

After your initial enrollment, you will need to make a decision each year during annual enrollment about whether you want to participate for the following Plan Year. If you enroll during the annual enrollment period, your Flexible Spending Account coverage will be effective from the following January 1, the beginning of the Plan Year, until December 31, the last day of the Plan Year, as long as you remain eligible.

If you do not enroll by the annual enrollment period deadline, you will not be allowed to enroll in the Dependent Day Care Flexible Spending Account unless you experience a qualified change in status, discussed below.

How the Dependent Day Care Flexible Spending Account Works

The Dependent Day Care Flexible Spending Account allows you to set aside money on a before-tax basis to be used for reimbursement of eligible dependent day care expenses incurred while you (and your spouse) work. Based on your expected eligible dependent day care expenses, you decide how much you want to contribute to a Flexible Spending Account, up to the applicable contribution limits.

Your contributions will be taken on a before-tax basis from your paychecks throughout the year. These paychecks are reduced by the amount of your before-tax contribution. Since contributions are made before taxes are withheld, you generally do not pay Social Security (FICA) tax, federal income tax and, in most cases, state and local income taxes on the money you put into a Flexible Spending Account.

When you have an eligible expense, you submit a claim for reimbursement from your account. If you elect to have your reimbursements directly deposited into your bank account, you will need to complete an Electronic Funds Transfer (EFT) form and attach a voided blank check to the EFT form. After the EFT form is received at PayFlex, your direct deposit will begin as soon as administratively possible.

There are some general rules that apply to the Dependent Day Care Flexible Spending Account:

- **If you have money left in your Flexible Spending Account at the end of the Plan Year, and you do not have claims for expenses incurred during the Plan Year or did not submit your claims on time, you must forfeit the balance as per IRS rules and regulations.** You cannot apply the balance to the next Plan Year or receive a refund of unused amounts. This is known as the “use it or lose it” rule.
- You must use the money contributed to a Flexible Spending Account in the same Plan Year in which you incur the expense. **Claims must be submitted by March 31 of the year following the Plan Year.**
- Contributions to a Dependent Day Care Flexible Spending Account cannot be used to pay health care expenses.

To receive reimbursement, you must incur the dependent day care expenses during the period in which you are enrolled. You should take the following steps in order to make the Dependent Day Care Flexible Spending Account work for you:

Step 1: During your initial enrollment and during annual enrollments, you decide how much to contribute to your account for the year. Your contribution should be based on a careful estimate of your anticipated dependent day care expenses for the coming year. Please remember that you might not be required to pay for day care during your vacation periods.

Due to the tax advantages, the Dependent Day Care Flexible Spending Account is strictly regulated by the IRS. According to the IRS, you cannot receive any money remaining in your account after all your eligible expenses for a given Plan Year have been reimbursed. In other words, if you don't use it, you lose it. Most people find, however, that they can take full advantage of the Dependent Day Care Flexible Spending Account by carefully budgeting for upcoming expenses.

Step 2: According to IRS regulations, approved dependent day care claims will be reimbursed only if the dates of services indicated on the claim form have already occurred. When you have eligible dependent day care expenses you can file a claim. Next, you will receive a tax-free reimbursement of your claim up to the amount you have available in your account at the time you file it.

Important Note: You have until March 31 of the following calendar year to file all claims incurred through December 31 of the prior calendar year.

Tax Considerations

Keep in mind the following tax considerations when deciding whether or not to participate in the Dependent Day Care Flexible Spending Account:

- You may not claim a tax deduction or tax credit for the same expenses that have been reimbursed through a Flexible Spending Account.

- Tax credits and tax deductions reduce income tax at the time you file your tax return. A Flexible Spending Account reduces income tax withholding throughout the year.
- When you make voluntary contributions to a Flexible Spending Account, you are essentially reducing your salary. As a result, you may pay less money in Social Security (FICA) taxes, and the Social Security benefit you ultimately receive may be reduced.
- Many eligible dependent day care expenses can be applied towards a federal income tax deduction. However, if you use the Flexible Spending Account, you lower the amount of expenses you can apply to the federal tax credit, dollar for dollar. You may want to consult with a tax advisor on which opportunity provides you with the most tax savings.
- Even though you generally do not have to pay income taxes on the money you contribute to the Flexible Spending Account, you will be taxed on any reimbursements that exceed IRS limits. This could happen if, for example, your spouse's income is unexpectedly reduced and you receive reimbursement that exceeds his or her annual earnings. If this happens, you have to report the excess as taxable income when filing your federal income tax return.
- Due to the tax advantages of the Flexible Spending Account, the IRS places strict limits on the benefits that certain highly compensated employees may receive, compared to those received by non-highly compensated employees. Tax laws require EP Energy to review such contributions to ensure the accounts do not favor highly compensated employees. If eligible highly compensated employees receive a disproportionate Flexible Spending Account benefit, it may be necessary for such employees to stop contributions during the Plan Year. Some or all benefits provided to these employees may become taxable. You will be notified if this affects you.

In some cases, you may save more by taking the federal dependent care tax credit rather than using the Dependent Day Care Flexible Spending Account. Which method is best for you—a Flexible Spending Account, tax credits, or tax deductions? It all depends on your personal tax situation. You may want to talk to a tax advisor before you make your contribution decisions.

Your Contributions

You may contribute a minimum of \$600 up to a maximum of \$5,000 per year to a Dependent Day Care Flexible Spending Account. The maximum you can contribute depends on your family situation:

- If you and your spouse are employed full-time and file a joint tax return, you can contribute up to \$5,000 each Plan Year (calendar year). However, if your spouse also participates in a Dependent Day Care Flexible Spending Account sponsored by EP Energy or any other employer, this \$5,000 limit applies to your combined contributions.
- If you are married and file separate tax returns, you may contribute up to \$2,500 each Plan Year.
- Contributions cannot be greater than your earned income for the Plan Year or your spouse's earned income for the Plan Year, whichever is less.
- If your spouse is unemployed, the IRS usually does not allow you to receive nontaxable reimbursement for dependent day care expenses. There are two exceptions; these are if your spouse is:
 - A full-time student; or
 - Incapable of self-care.

In either case, the IRS will assume that your spouse has income – \$250 per month if you have one dependent (\$3,000 per year) or \$500 per month if you have two or more dependents (\$5,000 per year). The maximum amount you may be reimbursed is based on your spouse's *assumed* income. If he or she

works part-time, the maximum amount you may be reimbursed is your spouse's assumed income or actual earned income, whichever is *greater*.

You make contributions to your account through convenient before-tax payroll deductions. When you make the election, you are authorizing before-tax payroll deductions for the year. This reduces your taxable income, which means you pay less in taxes. Your contributions are deducted from your paycheck in equal amounts throughout the year, before federal income and Social Security taxes are calculated. In most cases, you will also avoid state and local taxes on your contributions.

You do not have immediate access to your full contribution amount on the date you begin participation. Per IRS regulations, approved dependent day care claims will be reimbursed if the dates of service indicated on the claim form have already occurred and up to the amount contributed to your account when the claims are received. Any claims over that amount will automatically be processed when additional contributions are credited to your account.

Mid-Year Changes to Your Dependent Day Care Flexible Spending Account

Besides annual enrollment, you may change your Flexible Spending Account election only following a qualifying change in status event. If you have a qualifying change in status and change your election by contacting the Benefits Center within 60 days of the change in status event, you may make the following changes to your Flexible Spending Account during the Plan Year (remember, your requested change must be on account of and consistent with your change in status):

- **Marriage.** You can commence coverage or increase your contribution if the marriage increases your dependent day care expenses. You can cease coverage or decrease your contribution if your family elects your spouse's dependent care spending account or if your marriage results in decreased dependent care expenses.
- **Divorce, Legal Separation, Annulment.** You can commence coverage or increase your contribution if your divorce, legal separation (under court order), or annulment causes loss of dependent care spending account coverage under your spouse's plan or causes your dependent day care expenses to increase. You can cease coverage or decrease your contribution if your divorce, legal separation, or annulment causes your dependent day care expenses to decrease.
- **Spouse's Death.** You can commence coverage or increase your contribution if your spouse's death causes loss of dependent day care spending account coverage under your spouse's plan or causes your dependent day care expenses to increase. You can cease coverage or decrease your contribution if your spouse's death causes your dependent day care expenses to decrease.
- **Number of Eligible Dependents Changes.** You can commence coverage or increase your contribution if you have greater dependent day care expenses due to the change in the number of your eligible dependents, or you can cease coverage or decrease your contribution if you have reduced dependent day care expenses due to the change in the number of your eligible dependents.
- **Commencement of an Unpaid Leave of Absence.** You may cease coverage or decrease your contribution if commencement of an unpaid leave causes loss of Flexible Spending Account coverage or if your unpaid leave of absence causes your dependent day care expenses to decrease.
- **Change in Worksite.** You can commence coverage or increase your contribution if you have greater dependent day care expenses due to your change in worksite, or you can cease coverage or decrease your contribution if you have reduced dependent day care expenses due to your change in worksite.
- **Commencement of Employment by Spouse.** You can commence coverage or increase your contribution if your spouse's commencement of employment causes your dependent day care

expenses to increase. You can cease coverage or decrease your election if your family becomes covered under your spouse's dependent day care flexible spending account.

- **Termination of Spouse's Employment.** You can commence coverage or increase your contribution if your spouse's termination of employment adversely affects eligibility for coverage under your spouse's dependent day care flexible spending account. You can cease coverage or decrease your contribution if your spouse's termination of employment causes your dependent day care expenses to decrease.
- **Dependent Ceases to Satisfy Eligibility Requirements.** You can cease coverage or decrease your contribution if one of your dependents ceases to be an eligible dependent under the Flexible Spending Account.
- **A Change in Cost or Coverage.** A change in cost includes a significant cost increase or decrease in the cost of qualifying dependent day care services only if the cost change is imposed by a dependent day care provider who is not your relative. If an increase in cost is imposed, you can increase your contribution. A change in coverage includes a prospective change due to a change in your dependent day care provider. You may increase or decrease your contribution based on whether the new dependent day care provider charges more or less for dependent day care. You may also decrease your contribution if your child's day care is provided by a relative, such as the child's grandparent, who does not charge for this care.

Any changes you make following one of the above events must be on account of and correspond to the reason for the change. This means, for example, that if you add an eligible child to your family, you may begin participation in or increase the amount you contribute to the Flexible Spending Account mid-Plan Year.

If you have a qualified change in status, you must request the change by contacting the Benefits Center within 60 days of the event. You may be asked to provide documentation supporting your request for the change, such as a marriage certificate. Coverage changes due to a qualified event become effective as of the date of the qualifying event.

Eligible Dependents

Expenses reimbursed through the Dependent Day Care Flexible Spending Account must be for "eligible dependents." "Eligible dependents" for this purpose include the following:

- Any dependent child under the age of 13 who is your qualifying child under the Internal Revenue Code (in general, the person must (1) have the same principal place of residence as you do for more than half the taxable year (2) be your child or stepchild (by blood or adoption) and (3) not provide more than half of his or her own support for the taxable year. In case of divorce, only the custodial parent may receive reimbursement from a dependent day care spending account);
- Your spouse, if he or she is mentally or physically incapable of self-care and shares the same principal place of residence as you do for more than half of the taxable year; or
- Any other dependent who is mentally or physically incapable of self-care and who has the same principal place of residence as you do for more than half of the taxable year, and is your tax dependent under the Internal Revenue Code.

Eligible Expenses

Based on IRS guidelines, the following list includes examples of eligible dependent day care expenses you can claim under the Dependent Day Care Flexible Spending Account:

- Preschool and nursery school;

- Payments made for child care or adult day care at a center that meets state and local regulations;
- Wages and taxes paid to a baby-sitter or other care provider such as a nurse who comes to your home to provide care;
- Payments made to a relative who cares for eligible dependents, so long as that relative is not your spouse, your child's parent (who is not your spouse), a dependent for whom you can claim a tax deduction or your dependent child under age 19;
- Payments made to an individual who provides at-home day care; and
- Payments made for before- or after-school programs (not on school premises), summer day camp (in some circumstances), or school vacation programs.

<p>Note: You may be required to provide the name, address, and Social Security number (or other identification number) of your day care provider on your federal income tax return.</p>
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When Participation Ends

Your participation in the Dependent Day Care Flexible Spending Account ends on the earliest of the following:

- If you choose not to participate during annual enrollment, participation will end on December 31 of the current year of participation;
- The last day of the pay period in which you terminate employment or lose eligibility to participate;
- The last day of the month in which the Plan or applicable component plans terminate;
- The day upon which you have a qualifying change in status and cease your contributions as a result of the change in status; or
- The last day of the month in which you do not make your required contributions or go on an unpaid leave of absence (unless the leave is a leave under the Family and Medical Leave Act (FMLA)), and cease making contributions, or go on disability.

What Cannot Be Reimbursed

IRS regulations do not permit reimbursement of expenses that have been paid from other sources, such as another employer's plan, and do not include expenses for the following:

- Food and clothing, unless food and clothing are provided by the day care provider as part of its services;
- Payments made for education in kindergarten or higher;
- Transportation between the dependent's home and the day care center, unless the transportation is furnished by the day care provider to or from a place where care is provided, such as to a day camp or to an after-school program not on school premises;
- Entertainment;
- Baby-sitting during non-working hours; and
- Overnight camps.

You do not qualify for nontaxable reimbursement from the Dependent Day Care Flexible Spending Account if your spouse is unemployed, except as described in "Eligible Dependents" above.

If you are uncertain about whether or not an expense is eligible for reimbursement, call PayFlex at 1-800-284-4885. For more information about eligible Dependent Day Care Flexible Spending Account expenses, refer to the tax instructions for filing Form 1040 and IRS Publication 503, *Child and Dependent Day Care Expenses*. These publications are available from the public library, your local IRS office or www.irs.gov.

Filing a Claim for Reimbursement

To file a claim for reimbursement, follow these steps:

- When you have an eligible expense, pay for the expense as you would normally.
- Before submitting a claim, make sure you have the receipts for the dependent day care services. Your receipts must include the following information:
 - Date the care was provided;
 - Provider’s name and address; and
 - Provider’s taxpayer ID number or Social Security number. (The IRS does not require you to provide taxpayer ID numbers if care is provided by a church, religious organization, or other non-profit organization).
- **Important Note: Cancelled checks and other non-itemized receipts will not be accepted.** Once you have the supporting documents you need, complete a claim form. You can download claim forms from the PayFlex website at www.HealthHub.com. You will need to complete the claim form in full and attach your receipts.
- Mail or fax the claim form, along with required receipts, according to the instructions on the claim form.

Once you have submitted your claim form, you should receive your reimbursement check in the mail as soon as administratively possible. You may also elect to have your reimbursements electronically deposited into your bank account. All claims are processed daily.

Forfeitures

As required by IRS rules, any unused balances in your Dependent Day Care Flexible Spending Account will be forfeited at the end of the Plan Year. For example, if you allocated \$4,000 to your Flexible Spending Account and submitted expenses of only \$3,500, you would forfeit the remaining \$500. You have until March 31 of the following year to submit expenses for the current year.

It is important to carefully plan how much you want to contribute to your account. If you use realistic, even conservative, assumptions, you can make the most of your tax savings and narrow your risk of forfeiture.

Forfeitures are used to offset future plan administration fees or as otherwise allowed by law.

Flexible Spending Account Claims Procedures

Benefits under the Flexible Spending Account will be paid only if PayFlex (the Plan’s Claims Administrator) decides that you are entitled to them.

For any claim for benefits, you may be asked to submit additional information so that PayFlex can determine whether the claim is covered and the amount of the claim.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer, friend or relative. You may be asked to notify PayFlex in writing and give PayFlex the name, address and telephone number where your authorized representative can be reached.

Making a Flexible Spending Account Claim

If you have a Flexible Spending Account claim for dependent day care, you must file a claim form with PayFlex. You can download claim forms from the PayFlex website at www.HealthHub.com or you may call PayFlex at 1-800-284-4885 to request claim forms if you do not have Internet access. Claim forms should be faxed or mailed to the address on the claim form.

The deadline to file a claim is March 31 of the year following the year in which the eligible expense is incurred.

Claim Denial

If you file a written claim for Dependent Day Care Flexible Spending Account (“Flexible Spending Account”) benefits, and PayFlex denies your claim, you will be notified of the claim denial in writing.

The notice of denial will normally be sent within a reasonable time after PayFlex receives your claim or request. If you haven’t received any response within 180 days, your claim will be considered denied and you can proceed with an appeal as described below.

Appealing Denied Claims

If your claim or request for the Dependent Day Care Flexible Spending Account is denied, you may file a written appeal within 180 days after the claim payment date or the date of the notice of denial of benefits. State why you believe the claim was improperly paid or denied and submit any data or documents to support the appeal.

Mail your request to:

PayFlex Systems USA, Inc.
Flex Dept.
P.O. Box 3039
Omaha, NE 68103-3039

PayFlex will review your claim and render a written decision on your appeal within a reasonable time after PayFlex received your claim or request.

For information about filing a Flexible Spending Account benefit eligibility or enrollment claim, see “Eligibility and Enrollment Claims and Appeals” under the Eligibility and Enrollment section of this SPD.

Life Insurance

Highlights

Regular full time and reduced-schedule employees are eligible for basic life, supplemental life and spouse and child life insurance. Part-time employees are not eligible for basic or supplemental life insurance.

Life insurance benefits are available to you, your spouse, and your eligible children.

Employee life insurance offers financial protection to your beneficiary(ies) should you die. You are automatically covered by Basic Life Insurance equal to two times your annual base salary, up to a maximum benefit of \$1 million, at no cost to you.

For new hires, if you want to elect employee Supplemental Life Insurance you must do so within 31 days of your hire date or you must wait until the next annual enrollment period; Evidence of Insurability may be required (see below).

Spouse and Child Life Insurance provide a benefit to you, should your spouse or your children die. You must be enrolled in Supplemental Life Insurance to purchase Spouse or Child Life Insurance. Part-time employees are not eligible to enroll for Spouse or Child Life Insurance.

The Insurer of the Life Insurance benefits is Voya Financial, Inc. (“Voya”).

When Coverage Begins

EP Energy provides you with Basic Life Insurance equal to two times your annual base salary, up to a maximum benefit of \$1 million, at no cost to you, beginning on your first day of work. If you enroll for Supplemental, Spouse or Child Life Insurance within 31 days of your hire date, coverage will be retroactive to your first day at work, unless Evidence of Insurability (EOI) is required. You must be enrolled in Supplemental Life Insurance to purchase Spouse or Child Life Insurance.

If you make any changes during the annual enrollment period, your new coverage takes effect on January 1 of the following calendar year, assuming no EOI is required.

Evidence of Insurability (EOI)

Proof of good health, also called Evidence of Insurability (EOI), is required for some types of coverage. Evidence of Insurability (EOI) is an application process in which you provide information on the condition of your health or your dependent’s health in order to be approved for coverage.

You will be notified when you enroll if EOI is required for Supplemental, Spouse or Child life insurance. You will have 60 days from your coverage effective date to return the form to Voya, otherwise your coverage will be the maximum allowed without EOI.

Once EOI has been approved, your primary coverage and cost will increase as of the date the EOI is approved.

Once completed, you must mail the EOI form to Voya at the address on the form. Until the EOI is approved by Voya, the life insurer, your coverage will be the maximum allowed without EOI.

Paying for Life Insurance Coverage

EP Energy automatically provides you with Basic Life Insurance equal to two times your annual base salary, up to a maximum of \$1 million, at no cost to you. If you want to purchase Employee Supplemental Life Insurance, you pay the full cost with before-tax dollars.

The cost for supplemental life insurance coverage is based on your age and pay, and is shown on the UltiPro website during enrollment.

If you elect Spouse or Child Life Insurance, you pay the full cost of this coverage with after-tax dollars. Benefit credits cannot be applied to this cost. If you elect Child Life insurance, all your eligible children are covered and you pay one premium, regardless of the number of eligible children covered.

Definition of Pay

For purposes of determining life insurance benefits, pay means your annual base pay rounded up to the next \$1,000—for example, if your annual base salary is \$53,268 your life insurance benefit would be \$54,000. For administration purposes, your pay is frozen at a set date each year prior to annual enrollment. Pay changes will not affect the cost of coverage, but will be reflected in any benefits paid.

Imputed Income

Under IRS rules, the value of all employer-paid group term life insurance (Basic, Supplemental and Spouse) over \$50,000 is taxable income to you.

Life Insurance Limits

Basic and Supplemental Life

Your maximum life insurance coverage is \$1 million for Basic and \$500,000 for Supplemental Life Insurance. The maximum combined amount for life insurance coverage is \$1,500,000.

Spouse Life

Maximum Spouse Life Insurance coverage is \$150,000.

Child Life

Maximum Child Life Insurance coverage is \$10,000 for each child. Only an unmarried dependent child is eligible for coverage. Coverage ends on the day the unmarried dependent child attains the age of 25.

Changing Your Coverage

Once you enroll, you may change your benefit choices during the year only if you have a qualifying change in status. Change in status includes, but is not limited to:

- Gain or loss of coverage (for employee or other eligible family members);
- Birth or adoption of a child;
- Death of your spouse or child;
- Marriage or divorce;
- Change in dependent eligibility;
- Obtaining legal guardianship of a child; or
- Change in employment status.

You have 60 days from the date of the qualifying event to notify the Benefits Center of the event and request a change in benefits. Otherwise, you must wait until the next annual enrollment period or until you have another qualified change in status. However, your benefit change must be because of, and consistent with, your qualified change in status.

Naming and Changing Your Beneficiary(ies)

You are required to name a beneficiary(ies) for your basic and supplemental life insurance coverage as part of the enrollment process. You may name more than one beneficiary, but you will have to indicate how benefits should be divided among them. Otherwise, the benefit will be divided equally among the beneficiaries. You (the employee) are automatically the beneficiary for Spouse and Child Life Insurance

coverage. You may also name a secondary beneficiary to receive your benefit in the event your primary beneficiary dies before you.

You may name and change your beneficiary(ies) at any time through the Benefits Center by logging on to UltiPro at <https://epenergy.ultipro.com>. Because family situations change, you should review your beneficiary designations from time to time.

If There is Not a Beneficiary(ies)

If your beneficiary dies or if for some other reason there is not a beneficiary, Voya will pay benefits to one or more of the following based on the laws in your state:

- The full benefit to your surviving spouse;
- Divided equally among your surviving children;
- Divided equally between your surviving mother or father; or
- Executors or administrators of your estate as established by a court order.

Your beneficiary(ies) must be living on the 10th day following your death to receive a benefit.

Coverage and Pricing Reduction

Coverage and pricing for Employee Basic and Supplemental Life and Spouse Life Insurance will reduce when participants respectively reach age 65 and 70, based on the following chart:

Benefit Age	Reduction	Coverage
65-69	35%	65%
70 and Over	50%	50%

You may be able to convert your loss of life insurance when your coverage is reduced. You should contact the Benefits Center for more information and to request the proper conversion form(s).

You are not eligible to convert or port Supplemental Life or Spouse Life Insurance once you turn age 70.

Accelerated Death Benefit

If you are diagnosed by your attending physician as having a terminal condition with a life expectancy of less than 12 months, you may file a claim for up to 50% of your Basic Life and Supplemental Life Insurance coverage up to a combined maximum of \$50,000.

Employee Basic Life Insurance

Overview

- You are eligible for Basic Life Insurance if you are a regular full-time or regular reduced-schedule active employee of a participating employer.
- EP Energy automatically provides you with Basic Life Insurance equal to two times your annual base salary, up to a maximum of \$1 million, rounded up to the next \$1,000, at no cost to you.
- No enrollment is necessary.
- No Evidence of Insurability (EOI) is required for Basic Life Insurance.
- The Basic Life Insurance plan pays a benefit to your named beneficiary(ies) in the event of your death while you are working at EP Energy.

Employee Supplemental Life Insurance

Overview

- You are eligible to enroll for Supplemental Life Insurance if you are a regular full-time or regular reduced-schedule active employee of a participating employer.
- You may purchase Employee Supplemental Life Insurance of one to five times your annual base pay (maximum of \$500,000). You pay the cost of this coverage with before-tax dollars.
- Supplemental Life insurance coverage begins on the date you begin work at EP Energy if you enroll within 31 days of your hire date and assuming EOI is not required.
- The Supplemental Life Insurance plan pays a benefit to your named beneficiary(ies) in the event of your death while you are working at EP Energy.

Supplemental Life Insurance Enrollment

For new hires, if you wish to purchase Supplemental Life Insurance coverage, you must initially enroll in this coverage within 31 days of your hire date. During your initial enrollment period (hire event), you may elect coverage at 2 times pay without providing Evidence of Insurability (EOI), or up to 5 times pay with EOI. Review the “Evidence of Insurability” section above.

If you do not enroll for employee supplemental life insurance coverage within 31 days of your hire date, you will receive only the Company-provided Basic Life Insurance. You will have an opportunity to enroll for supplemental life insurance coverage during annual enrollment or within 60 days of a qualified change in status but you will have to provide EOI.

Coverage Options

You may purchase Employee Supplemental Life Insurance with before-tax payroll deductions at an age-related premium. Supplemental Life Insurance coverage uses annual base pay, multiplied by option elected, then rounded up to the next \$1,000. The following options are available for Supplemental Life Insurance:

- No Coverage
- 1 x Annual Base Pay
- 2 x Annual Base Pay
- 3 x Annual Base Pay
- 4 x Annual Base Pay
- 5 x Annual Base Pay

Evidence of Insurability (EOI) Requirements

To enroll in Supplemental Life Insurance, EOI may be required. You will be notified if EOI is required when you enroll.

- During your initial enrollment period (hire event), you may elect coverage up to 2 times pay without providing EOI, or up to 5 times pay with EOI.
- If you did not elect Supplemental Life Insurance coverage when you were first eligible (normally your hire date) and you elect it during annual enrollment, EOI will be required.
- During annual enrollment, or mid-year due to a qualifying change in status event, you may increase your current coverage by one level each enrollment without providing EOI. If you increase your coverage by more than one level, you will need to provide EOI.

If EOI is required, you must complete and submit an EOI form (within 90 days), which can be found on the UltiPro website (<https://epenergy.ultipro.com>), following instructions on the form. Once completed, you must mail the EOI form to Voya at the address on the form. Until the EOI is approved by Voya, the life insurer, your coverage will be the maximum allowed without EOI.

Spouse Life Insurance

Overview

- You are eligible to enroll for Spouse Life Insurance if you are a regular full-time or regular reduced-schedule active employee of a participating employer.
- You must be enrolled in the employee Supplemental Life Insurance Plan to elect Spouse Life Insurance.
- You must be married and your spouse must be listed as a dependent.
- You may purchase up to \$150,000 in Spouse Life Insurance. You pay the cost of this coverage with after-tax dollars.
- EOI may be required for Spouse Life Insurance.
- Spouse Life Insurance will pay a benefit to you in the event your spouse should die while you are working at EP Energy. The beneficiary for Spouse Life Insurance is automatically the employee.

Spouse Life Insurance Enrollment

For new hires, if you wish to purchase Spouse Life Insurance coverage, you must initially enroll in this coverage within 31 days of your hire date. During your initial enrollment period (hire event), you may elect up to the \$100,000 coverage level of Spouse Life Insurance without Evidence of Insurability (EOI). You can purchase \$125,000 or \$150,000 in Spouse Life Insurance with EOI. Review “Evidence of Insurability” section below.

If you do not enroll for spouse life insurance coverage within 31 days of your hire date, you will have another opportunity to enroll for Spouse Life insurance coverage during annual enrollment or within 60 days of a qualified change in status but you may have to provide EOI.

Coverage Options

You may purchase Spouse Life Insurance with after-tax payroll deductions. The following options are available for Spouse Life Insurance:

- No Coverage
- \$25,000
- \$50,000
- \$100,000
- \$125,000
- \$150,000

Spouse Life Evidence of Insurability (EOI) Requirements

To enroll in Spouse Life Insurance, EOI may be required. You will be notified if EOI is required when you enroll.

- During your initial enrollment period (hire event), you may elect Spouse Life coverage of up to \$100,000 without providing EOI, or \$125,000 or \$150,000 in Spouse Life coverage with EOI.

- If you did not elect Spouse Life Insurance coverage when you were first eligible (normally, your hire date) and you elect it during annual enrollment, EOI will be required.
- During annual enrollment, or mid-year due to a qualifying change in status event, you may increase your current Spouse Life coverage by one level each enrollment without providing EOI (up to \$100,000). If you increase your coverage by more than one level, you will need to provide EOI. EOI is always required for \$125,000 or \$150,000 in Spouse Life Insurance coverage.

If EOI is required, you must complete and submit an Evidence of Insurability form (within 90 days), which can be found on the UltiPro website (<https://epenergy.ultipro.com>), following instructions on the form. Once completed, you must mail the EOI form to Voya at the address on the form. Until the EOI is approved by Voya, the life insurer, your coverage will be the maximum allowed without EOI.

Spouse Life Insurance reduces when your spouse reaches age 65 and 70.

Child Life Insurance

Overview

- You are eligible to enroll for Child Life Insurance if you are a regular full-time or regular reduced-schedule active employee of a participating employer.
- You must be enrolled in the employee Supplemental Life Insurance Plan to elect Child Life Insurance.
- You must have a child who qualifies as an eligible dependent. Only an unmarried dependent child is eligible for coverage. Coverage ends on the day the unmarried dependent child attains the age of 25.
- If you elect Child Life insurance, all your eligible children are covered and you pay one premium, regardless of the number of eligible children covered.
- You pay for Child Life Insurance coverage with after-tax dollars.
- EOI may be required for Child Life Insurance.
- If both you and your spouse work for EP Energy, your dependents may be covered by only one parent.
- Child Life Insurance will pay a benefit to you in the event your child should die while you are working at EP Energy. The beneficiary for Child Life Insurance is automatically the employee.

Child Life Insurance Enrollment

For new hires, if you wish to purchase Child Life Insurance coverage, you must initially enroll in this coverage within 31 days of your hire date. During your initial enrollment period (hire event), you may elect up to \$10,000 per child coverage level of Child Life Insurance without Evidence of Insurability (EOI).

If you do not enroll for child life insurance coverage within 31 days of your hire date, you will have another opportunity to enroll for Child Life insurance coverage during annual enrollment or within 60 days of a qualified change in status but you may have to provide EOI.

Coverage Options

EP Energy provides Child Life Insurance at the following coverage levels:

- No Coverage
- \$5,000 per child
- \$10,000 per child

If you elect Child Life insurance, all your eligible children are covered and you pay one premium, regardless of the number of eligible children covered. Only unmarried dependent children are eligible to be covered until their 25th birthday.

Child Life Evidence of Insurability (EOI) Requirements

To enroll in Child Life Insurance, EOI may be required. You will be notified if EOI is required when you enroll.

- During your initial enrollment period (hire event), you may elect child life coverage of up to \$10,000 per child without providing EOI.
- If you did not elect Child Life Insurance coverage when you were first eligible (normally your hire date) and you elect it during annual enrollment, EOI will be required.

If EOI is required, you must complete and submit an EOI form (within 90 days), which can be found on the UltiPro website (<https://epenergy.ultipro.com>), following instructions on the form. Once completed, you must mail the EOI form to Voya at the address on the form. Coverage will not become effective until approved by Voya, the life insurer.

Exclusion for Supplemental Life Insurance

The Supplemental Life Insurance benefits are not paid under this Plan if you commit suicide, while sane or insane, within one year of the date your Supplemental Life Insurance starts. However, in this instance the Plan refunds the amount of premiums paid for the Supplemental Life coverage instead of paying the Supplement Life Insurance death benefit.

Filing a Claim

Overview

If you or your beneficiary is filing a claim, contact the Benefits Department at everythinghr@epenergy.com. A letter with a claim form will be sent to you or your beneficiary. Complete and return the form, along with a copy of the death certificate, to Voya. Once the claim has been processed, a checking account will be set up in your or your beneficiary's name for the amount of the benefit as soon as administratively possible.

For more information, see the "Life Insurance Claims Procedures" section.

Attachment of Benefits

To the extent permitted by law, all rights and benefits under this Plan are exempt from execution, attachment, garnishment, or other legal process for you or your beneficiary's debts or liabilities.

When Coverage Ends

Overview

Your Life Insurance and Spouse and Child Life Insurance Coverages end if:

- You stop working for EP Energy. In this case, coverage will end on the last day of the month in which you terminate;
- You no longer meet the eligibility requirements. In this case, coverage will end on the last day of the month in which you became ineligible;
- You choose to stop coverage because of a qualified change in status. In this case, coverage will end consistent with the rules for that qualified change in status event;
- You choose to stop coverage during the annual enrollment period. In this case, coverage will end on the last day of the current calendar year;

- You are required to make contributions directly to EP Energy and you fail to make the required contributions. In this case, coverage will end at the end of the last month for which payment was made;
- The group plan ends;
- Your child is no longer eligible for coverage. Child Life Insurance will end on the last day of the month in which they become ineligible for coverage;
- If you are a spouse of an employee, you divorce, or your employee-spouse dies. If you are a child of an employee, if you parent-employee dies. In these cases, coverage will end on the last day of the month in which the event occurred; or
- You go on disability. In this case, your life insurance and Child Life and Spouse Life coverage will end on the last day of the month in which your employment status changes from active to Long Term Disability.

If you go on disability, see the Long Term Disability section for information about continuing Supplemental Life insurance.

Extension of Benefits

If you die within 31 days after coverage under this Plan ends, the beneficiary will receive the amount of insurance in effect when coverage ended.

Portability of Coverage

Upon termination of employment, or if you otherwise become ineligible to participate in the Life Insurance Plan, and you are younger than age 70, you may continue and port up to \$50,000 of your Supplemental Life Insurance. If you choose to port your supplemental life coverage, you can then port Spouse Life Insurance up to \$50,000 and your Child Life Insurance. The amount of Employee Supplemental Life Insurance and Spouse Life Insurance that exceeds \$50,000 can be converted to an individual whole life insurance policy as described in the “Conversion of Coverage” paragraph below. Your portability rates will remain the same as the group rates available to EP Energy employees. The cost of any ported coverage will be recalculated based on your age and pay at termination.

If you do not exercise the portability option for Employee Supplemental Life Insurance, then your Spouse Life and Child Life Insurance can be converted to an individual whole life policy as described in the paragraph below.

If you or your covered spouse is age 65 or older, your insurance coverage will reduce. Please review the “Coverage and Pricing Reduction” box found elsewhere in this section. Ported life insurance coverage may continue until age 70. At that time, the coverage may be converted to a whole life policy(ies).

To apply for portable coverage, you must request and complete the appropriate form(s) from the Benefits Center. The form(s) must be returned to Voya within 31 days of the date coverage ends. You must pay the first quarterly premium directly to Voya beginning on the first day of the month following the date you elect the portability option. The quarterly premiums include a billing charge.

If you are rehired by EP Energy and become eligible to participate in the Life Insurance Plan, you may elect to do one, but not both, of the following:

- Keep the continued insurance coverage and not apply for Supplemental, Spouse, or Child Life Insurance Coverage under the Plan; or
- Terminate the continued insurance coverage and re-apply for Supplemental, Spouse, or Child Life Insurance Coverage under the Plan.

Conversion of Coverage

Basic Life Insurance and the amount of Employee Supplemental Life and Spouse Life Insurance coverage that exceeds \$50,000 can be converted to an individual whole life insurance policy. Spouse and Child Life can also be converted to an individual whole life policy in the event you die or if you do not exercise the portability option for Employee Supplemental Life Insurance (described above) if you lose coverage. You must request a conversion Form from the Benefits Center. Complete and return the conversion form to Voya within 31 days of the date your coverage ends.

If you are an active employee and you or your spouse reach age 65 (or older) or 70 (or older), your insurance coverage will reduce. Please review the "Coverage and Pricing Reduction" box found elsewhere in this section for the percentage of reduction. You can then convert the loss in coverage to individual whole life policy(ies). Please contact the Benefits Center for the appropriate form(s) that you will need to complete and send back to Voya within 31 days of the date your coverage is reduced.

Life Insurance Claims Procedures

Life insurance benefits under the Plan will be paid only if Voya decides, in its discretion, that you or your covered dependents are entitled to them.

For any claim for benefits, you may be asked to submit additional information so that Voya can determine whether the claim is covered and the amount of the claim.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer, friend or relative. You may be asked to notify Voya in writing and give Voya the name, address, and telephone number where your authorized representative can be reached.

Making a Claim for Life Insurance Benefits

If you have a claim for life insurance benefits, you must file a claim with Voya. You may obtain a claim form by contacting the Benefits Department at everythinghr@epenergy.com. Send the completed form to:

Voya Financial, Inc.
P.O. Box 1548
Minneapolis, MN 55440

Your claim must be submitted within 12 months from the date of loss.

Life Insurance Benefit Denials and Notice of Denial-

If you make a request for life insurance benefits and Voya issues an Adverse Benefit Determination (or claim denial), you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- The specific reason or reasons for the denial;
- A reference to the Plan provision on which the denial is based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and
- An explanation of the Plan's claim review procedures and the time limits applicable to those procedures, and a statement of your right to bring a civil action under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

Voya will give you notice of the decision no later than 90 days after it received the claim. If, because of special circumstances, the review process cannot be completed within 90 days, you will be notified of the delay within the 90-day period, and the special circumstances requiring an extension of time and the date

by which Voya expects to render the decision upon review. In this situation, the Insurer will provide a final written decision within 180 days of the date it received your request for review.

Appealing a Denied Life Insurance Claim

You or your authorized agent may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 60 days of Voya initial notice of an Adverse Benefit Determination (or claim denial), or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should be sent to:

Voya Financial, Inc.
P. O. Box 1548
Minneapolis, MN 55440

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You will have the opportunity to submit written comments, documents, records, and other information in support of your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse determination will take into account all comments, documents, records and other information submitted by you relating to the claims, regardless of whether such information was submitted and considered in the initial benefit determination.

Review of Appeal

Voya will review and render a written decision on your appeal, adverse or not, no later than 60 days after it received the appeal. If, because of special circumstances, the review process cannot be completed within 60 days, you'll be notified of the delay within the 60-day period and the special circumstances requiring an extension of time and the date by which Voya expects to render the decision upon review. Voya will provide a final written response within 120 days of the date it received your request for review.

Notice of Appeal Denial

If the decision on appeal affirms the initial denial of your claim, you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- The specific reason(s) for the denial;
- The Plan provision on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents and other information; and
- A statement of your right to bring suit under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

For information about filing a life insurance benefit eligibility or enrollment claim, see "Eligibility and Enrollment Claims and Appeals" under the Eligibility and Enrollment section of this SPD.

Accidental Death and Dismemberment (AD&D)

Highlights

Regular full-time employees and reduced-schedule employees are eligible for employee, spouse and child accidental death and dismemberment (AD&D) insurance coverage. Part-time employees are not eligible for employee Basic or Supplemental AD&D insurance coverage.

AD&D provides you, or your beneficiary, a benefit should you die or suffer certain losses as the result of an accident. Spouse AD&D and Child AD&D provide you a benefit if your spouse or child should die or suffer certain losses in an accident.

You are automatically covered by Employee Basic AD&D insurance equal to two times your annual base salary, up to a maximum of \$1 million, at no cost to you.

For new hires, if you want to purchase Employee Supplemental AD&D, Spouse AD&D or Child AD&D you must do so within 31 days of your hire date or you must wait until the next annual enrollment period. Part-time employees are not eligible to enroll for Spouse or Child AD&D insurance.

Evidence of Insurability (EOI) is not required for AD&D insurance.

The Insurer of the Accidental Death and Dismemberment (AD&D) benefits is Voya Financial, Inc. (“Voya”).

Eligibility

Employee AD&D

You are eligible to elect Employee AD&D (basic and supplemental) if:

- You are a regular full-time or regular reduced-schedule active employee of a participating employer; and
- You are not receiving Long Term Disability benefits.

Spouse AD&D

You are eligible to elect Spouse AD&D if:

- You are a regular full-time or regular reduced-schedule active employee of a participating employer;
- You are not receiving Long Term Disability benefits;
- You are enrolled in Employee Supplemental AD&D; and
- You are married.

Child AD&D

You are eligible to elect Child AD&D if:

- You are a regular full-time or regular reduced-schedule active employee of a participating employer;
- You are not receiving Long Term Disability benefits;
- You are enrolled in Employee Supplemental AD&D; and
- You have a child who qualifies as an eligible dependent.

Enrolling for Coverage

Initial Enrollment

You are eligible for Employee, Spouse, and Child AD&D coverage beginning on the first day you begin work at EP Energy. Employee Basic AD&D coverage equal to two times your annual base salary, up to

\$1 million, is provided automatically to you at no cost, effective on your date of hire, and no enrollment is necessary. If you wish to purchase Employee Supplemental AD&D, Spouse AD&D or Child AD&D you must enroll in this coverage within 31 days of your hire date. If you enroll at a later date, you can do so online through the UltiPro website at <https://epenergy.ultipro.com> or by calling the Benefits Center at 1-844-232-4262

If You Do Not Enroll

If you do not enroll within 31 days of your hire date, you will receive only the Company-provided Basic Employee AD&D insurance. You will have an opportunity to change your coverage during annual enrollment or following a qualified change in status.

Annual Enrollment

After you enroll, you can make changes to your coverage during annual enrollment each fall or in the event of a qualified change in status.

When Coverage Begins

If you enroll for Employee Supplemental AD&D within 31 days of your hire, coverage will be made retroactive to your first day at work. If you make any changes during the annual enrollment period, your new coverage takes effect on January 1 of the following calendar year. If you have a qualified change in status, you may change your election within 60 days of the event and the change will become effective as of the date of the qualifying event. Any change must be consistent with your qualified change in status.

Paying for Coverage

If you want to purchase Employee Supplemental AD&D, Spouse AD&D, or Child AD&D, you pay the full cost with before-tax dollars. The cost for coverage is based on the amount you select and is shown on the UltiPro website at <https://epenergy.ultipro.com> during initial enrollment and annual enrollment.

Definition of Pay

For purposes of determining AD&D benefits, pay means your annual base pay rounded to the next higher \$1,000. For administration purposes, your pay is frozen at a set date each year prior to annual enrollment. Pay changes will not affect the cost of coverage, but will be reflected in any benefits paid.

AD&D Insurance Limits

Employee AD&D

Maximum Basic AD&D coverage is \$1 million. Maximum Supplemental AD&D coverage is \$500,000.

Spouse AD&D

Maximum Spouse AD&D Insurance coverage is \$150,000.

Child AD&D

Maximum Child AD&D Insurance coverage is \$10,000 for each child. No other limits apply. Only an unmarried dependent child is eligible for coverage. Coverage ends on the day the unmarried dependent child attains the age of 25.

Changing Your Coverage

Once you enroll, you may change your benefit choices during the year only if you have a qualifying change in status. You have 60 days from the date of the event to notify the Benefits Center. Log on to the UltiPro website at <https://epenergy.ultipro.com> or call the Benefits Center at 1-844-232-4262. Otherwise, you must wait until the next annual enrollment period or until you have another qualified change in status. However, your benefit change must be because of, and consistent with, your qualified change in status.

Naming and Changing Beneficiary(ies)

You are required to name a beneficiary(ies) for your basic and supplemental AD&D coverage as part of the enrollment process. You may name more than one beneficiary, but you will have to indicate how benefits should be divided among them. Otherwise, the benefit will be divided equally among the beneficiaries. You may also name a secondary beneficiary to receive your benefit in the event your primary beneficiary dies before you. You are automatically the beneficiary of Spouse AD&D and Child AD&D.

You may name and change your beneficiary(ies) at any time through the Benefits Center by logging on to the UltiPro website at <https://epenergy.ultipro.com>. Because family situations change, you should review your beneficiary designations from time to time.

If There is Not a Beneficiary(ies)

If your beneficiary dies or if for some other reason there is not a beneficiary, Voya will pay benefits to one or more of the following based on the laws in your state:

- The full benefit to your surviving spouse;
- Divided equally among your surviving children;
- Divided equally between your surviving mother or father; or
- Executors or administrators of your estate as established by a court order.

Coverage Reduction

Coverage and pricing for you and your dependents decrease when reaching age 65 and 70 based on the following chart:

Benefit Age	Reduction	Coverage
65-69	35%	65%
70 and Over	50%	50%

You may not convert or port AD&D coverage for you and your eligible dependents.

Employee AD&D

Overview

- Employee AD&D provides a benefit if you die or suffer certain losses as the result of an accident.
- The company provides Basic AD&D coverage equal to two times base pay, up to a maximum of \$1 million, at no cost.
- You pay for Supplemental AD&D coverage with before-tax money.
- You may purchase Supplemental AD&D up to five times your base pay (maximum of \$500,000).
- The Company also provides Spouse AD&D and Child AD&D. If your spouse or child dies or becomes seriously injured in an accident you will have security and financial protection. You must be enrolled in Employee Supplemental AD&D to purchase Spouse or Child AD&D coverage. You pay the full cost of this coverage with before-tax dollars.

Employee Supplemental AD&D Coverage Options

Following are the Employee Supplemental AD&D coverage options:

- No Coverage
- 1 x Annual Base Pay
- 2 x Annual Base Pay
- 3 x Annual Base Pay
- 4 x Annual Base Pay
- 5 x Annual Base Pay

If You Die in an Accident

If you die as a result of an accident, the Plan will pay your beneficiary an amount equal to your coverage amount based on your salary at the time of the accident. This benefit is in addition to any Life Insurance benefit you receive.

Spouse AD&D

Overview

- Spouse AD&D provides you a benefit if your spouse should die or suffer certain losses as the result of an accident.
- You pay for Spouse AD&D coverage for your spouse with before-tax money.
- You must be enrolled in Employee Supplemental AD&D to purchase Spouse AD&D coverage.
- You are automatically the beneficiary of this benefit.

Spouse AD&D Coverage Options

Following are the Spouse AD&D coverage options:

- No Coverage
- \$25,000
- \$50,000
- \$100,000
- \$125,000
- \$150,000

If Your Spouse Dies in an Accident

If your spouse dies as a result of an accident, the Plan will pay you an amount equal to their coverage amount. This benefit is paid in addition to any Spouse Life Insurance benefit you may receive.

Child AD&D

Overview

- Child AD&D provides you a benefit if your child should die or suffer certain losses as the result of an accident.
- Only an unmarried dependent child is eligible for coverage. Coverage ends on the day the unmarried dependent child attains the age of 25.
- You pay for Child AD&D coverage with before-tax money.

- You must be enrolled in Employee Supplemental AD&D to purchase Child AD&D coverage.
- You are automatically the beneficiary of this benefit.

Child AD&D Coverage Options

Following are the Child AD&D coverage options:

- No Coverage
- \$5,000 (per child)
- \$10,000 (per child)

If Your Child Dies in an Accident

If your child dies as a result of an accident, the Plan will pay you an amount equal to their coverage amount. This benefit is in addition to any Child Life Insurance benefit you may receive.

Benefits for Injuries

In addition to death, the Plan covers certain other losses caused by accidental injuries while you or your dependents are covered. The level of benefits payable depends on the severity of the injury. In this case, only AD&D benefits are paid—not your life insurance—except for loss of life.

Following is a schedule showing the percentage of the AD&D coverage payable for losses, which happen within 365 days of the accident:

Loss	Percentage of Coverage Payable
Life	100%
Both hands or feet or sight of both eyes	100%
One hand and one foot	100%
Speech and hearing	100%
Either hand or foot and sight in one eye	100%
Movement of both upper and lower limbs (quadriplegic)	100%
Paralysis of three limbs	75%
Movement of both lower limbs (paraplegic)	50%
Movement of both upper and lower limb of one side of the body (hemiplegic)	50%
Either hand or foot	50%
Sight of one eye	50%
Paralysis of one limb	25%
Speech or hearing	25%
Thumb and index finger of same hand	25%

The full amount of AD&D insurance is payable only once for all losses (including death) resulting from one accident. If 50% of the insurance is paid for a covered loss, only the other 50% is payable for a later loss caused by the same accident. In other words, once 100% of the insurance amount has been paid for losses caused by an accident, no later losses caused by that same accident are covered.

What Is Not Covered

AD&D benefits will not be paid for loss resulting from:

- Suicide, attempted suicide or intentionally self-inflicted injuries, while sane or insane.

- Declared or undeclared war or act of war.
- Accident occurring while you are serving in the military service for any country or government.
- Travel or flight in any aircraft or device which can fly above the earth's surface if:
 - The aircraft is being used for test or experimental purposes;
 - It is for any military authority;
 - It is for travel or is designed for travel, beyond the earth's atmosphere;
 - You are serving as a pilot or crew member of any aircraft;
 - You are a student taking a flying lesson; or
 - You are hang-gliding or parachuting, except where you have to make a parachute jump for self-preservation.
- Commission of a crime by you.
- Sickness, disease, or bodily infirmity. Bacterial infection resulting from an accidental cut or wound or accidental ingestion of a poisonous food substance are not excluded.
- Voluntary self-administration of any drug or chemical substance not prescribed by or taken according to the directions of a licensed physician. Accidental ingestion of a poisonous substance is not excluded.
- Riding or driving in any kind of a race.
- Intoxication or being under the influence of a controlled substance unless prescribed by and taken under the supervision of a doctor.

Additional Coverage

Seat Belt Benefit

In the event a person insured under the Plan is in an accident and dies while driving or riding in an automobile, the Company may pay an additional 10% of their Basic Accidental Death and Dismemberment (up to a maximum of \$25,000) and 10% of their Supplemental Accidental Death and Dismemberment Benefit (up to a maximum of \$25,000) if:

- The automobile has seatbelts;
- A safety belt was in use and properly fastened at the time of the accident;
- The position of the safety belt is certified in the official accident report, or by the investigating officer; and
- The insured person is driving or riding in an automobile driven by a licensed driver who was not intoxicated or under the influence of a controlled substance at the time of the accident, even if no conviction was made.

Coma Benefit

If, due to a covered accident, you are in a coma (unresponsive to any stimuli and speechless for a period of time not less than 30 days, as determined by a doctor), an additional benefit will be paid. The benefit is 2% of the full amount of the AD&D benefit per month for up to 12 months to a maximum of \$24,000. If you are physically and mentally incapable of receiving and cashing coma benefit payments, the payments will be made to a person legally authorized to receive the payments on your behalf.

Common Carrier Benefit

If you suffer a covered loss due to an accident and the loss occurs while traveling as a fare paying passenger in or on or entering into or alighting from a public conveyance and the public conveyance is operated by a licensed common carrier for passenger service, an additional benefit will be paid. The benefit is an additional 50% of the AD&D benefit otherwise payable for this loss up to a maximum of \$50,000.

Transportation Benefit

If you die due to a covered accident that occurs at least 75 miles from your primary residence, there is a benefit in addition to the AD&D benefit. The benefit is an additional 2% of the full amount of the AD&D benefit.

Occupational Assault Benefit

An additional AD&D amount equal to the AD&D amount otherwise payable for this loss, up to a maximum of \$10,000, will be paid if you suffer a covered loss due to an accident and:

- the loss is due to an intentional and unlawful act of physical violence directed at you by another person,
- you are actively at work, performing assigned duties on behalf of EP Energy at the time of the assault, and
- a report of criminal activity has been filed on your behalf with the appropriate law enforcement authority within 48 hours of the assault.

Occupational Assault benefits are paid to you if living, otherwise to your beneficiary.

Exposure and Disappearance Benefit

If you or any other person covered under the AD&D plan disappears as the result of an accident and the body is not found within one year, a death benefit will be paid.

Child Care Benefit

If you are injured in an accident and die within one year of the date of the accident, an additional benefit will be paid if your death is directly related to the injuries sustained in the accident. This benefit will be paid annually (up to four consecutive years) to any dependent child under age 13 who is enrolled or enrolls in a licensed day care facility within 90 days of the date of your death.

The benefit amount will be equal to the lesser of:

- The actual cost charged by a licensed day care center per year;
- 3% of your Supplemental AD&D (does not include Basic coverage) coverage; or
- \$2,000.

Common Disaster Benefit

If the employee chooses Spouse AD&D coverage and, as a result of the same accident or separate accidents that occur within the same 24-hour period, the employee and the employee's spouse both die within one year of the accident, the employee's spouse's benefit will be increased to 100% of the employee's Supplemental AD&D coverage. The combined benefit will not be more than \$1,000,000.

When Coverage Ends

Overview

Your Employee AD&D (basic and supplemental), Spouse AD&D, and Child AD&D Coverage ends if:

- You stop working for EP Energy. In this case, coverage will end on the last day of the month you terminate;
- You no longer meet the eligibility requirements. In this case, coverage will end on the last day of the month in which you became ineligible;
- You choose to stop coverage because of a qualified change in status. In this case, coverage will end consistent with the rules for that qualified change in status event;
- You choose to stop coverage during the annual enrollment period. In this case, coverage will end on the last day of the current calendar year;
- You are required to make contributions and you fail to make the required contributions. In this case, coverage will end at the end of the last month for which payment was made;
- The group plan ends;
- Your child is no longer eligible for coverage. Child AD&D Coverage will end on the last day of the month in which they become ineligible for coverage;
- You divorce or your spouse dies. In this case, coverage will end on the last day of the month in which the event occurred; or
- You go on disability. In this case, coverage will end on the last day of the month in which your status changes from active to LTD.

Extension of Benefits

If you die within 31 days after coverage under this Plan ends, the beneficiary will receive the amount of insurance in effect when coverage ended.

Conversion of Coverage

AD&D coverage cannot be converted to an individual policy.

AD&D Insurance Benefit Claims Procedures

General Information

AD&D benefits will be paid only if Voya decides that you are entitled to them.

For any claim for benefits, you may be asked to submit additional information so that Voya can determine whether the claim is covered and the amount of the claim.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer, friend or relative. You may be asked to notify Voya in writing and give Voya in writing the name, address and telephone number where your authorized representative can be reached.

You or your beneficiary must contact the Benefits Department at everythinghr@epenergy.com to begin the claim process. The participant or beneficiary will receive a claim form to complete. Send the completed form to:

Voya Financial, Inc.
P.O. Box 1548
Minneapolis, MN 55440

The following items need to be included with the claim form (if applicable):

- A certified copy of the death certificate (one with a raised seal);
- Police accident report (if completed);

- Autopsy report (if completed);
- Medical examiner's report (if completed);
- Verification of premium payments;
- Emergency room records;
- Ambulance report; and
- Dependent verification, if a dependent.

Your claims must be submitted within 12 months from the date in which you incur the expense that gives rise to the claim.

AD&D Insurance Benefit Denials and Notice of Denial

If you make a request for AD&D insurance benefits and Voya issues an Adverse Benefit Determination (as defined above), you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- The specific reason or reasons for the denial;
- A reference to the specific Plan provision on which the denial is based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and
- An explanation of the Plan's claim review procedures and the time limits applicable to those procedures, and a statement of your right to bring a civil action under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

Voya will give you notice of the decision no later than 90 days after it received the claim. If, because of special circumstances the review process cannot be completed within 90 days, you will be notified of the delay within the 90-day period, and the special circumstances requiring an extension of time and the date by which Voya expects to render the decision upon review. In this situation, Voya will provide a final written decision within 180 days of the date it received your request for review.

Appealing a Denied AD&D Insurance Claim

You or your authorized representative may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 60 days of Voya initial notice of an Adverse Benefit Determination (or claim denial), or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should be sent to:

Voya Financial, Inc.
P.O. Box 1548.
Minneapolis, MN 55440

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You will have the opportunity to submit written comments, documents, records, and other information in support of your appeal. You will be provided, upon request and free of charge, reasonable access to, and

copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse determination will take into account all comments, documents, records and other information submitted by you relating to the claims, regardless of whether such information was submitted and considered in the initial benefit determination.

Review of Appeal

Voya will review and render a written decision on your appeal, adverse or not, no later than 60 days after it received the appeal. If, because of special circumstances, the review process cannot be completed within 60 days, you'll be notified of the delay within the 60-day period and the special circumstances requiring an extension of time and the date by which Voya expects to render the decision upon review. Voya will provide a final written response within 120 days of the date it received your request for review.

Notice of Appeal Denial

If the decision on appeal affirms the initial denial of your claim, you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- The specific reason(s) for the denial;
- The Plan provision on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents and other information; and
- A statement of your right to bring suit under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

For information about filing an accidental death and dismemberment insurance benefit eligibility or enrollment claim, see "Eligibility and Enrollment Claims and Appeals" under the Eligibility and Enrollment section of this SPD.

Short Term Disability Program

Highlights

The Short Term Disability (STD) Program provides protection in the event you are unable to work due to a serious injury or sickness. You must be absent from work for a minimum of 7 consecutive calendar days, unless your disability is due to occupational injury or sickness. Lincoln Life Assurance Company of Boston, also known as Lincoln Financial Group, (“Lincoln”) is the Claims Administrator and is responsible for claim determination and processing. Benefits for this program are self-funded, which means that they are paid from the general assets of EP Energy.

Eligibility

You are eligible to participate in the STD Program if you are a regular full-time or regular reduced-schedule active employee of a participating employer. Part-time employees are not eligible for the STD program.

You are not eligible for STD if you are a(n):

- Member of a collective bargaining unit;
- Leased employee;
- Non-resident alien; or
- Employee working in a foreign country and are not paid from the U.S. payroll.

Maximum Period of Short Term Disability Benefits

The maximum period of STD benefits—whether for non-occupational injury or sickness or occupational injury or sickness—is 26 weeks (182 days).

Short Term Disability and FMLA Leave

If you are eligible for FMLA leave, the use of STD will be considered as part of your FMLA leave entitlement. Refer to the Family and Medical Leave Act policy for FMLA eligibility requirements.

Short Term Disability Payments

Elimination Period and Pay

You must be off work for at least 7 consecutive calendar days (the elimination period) before you are eligible for STD benefits, unless your disability is due to occupational injury or sickness. If you are approved for STD, STD payments will be made retroactive to the first day of your disability. STD benefits will be paid by the Company through regular payroll on a semi-monthly basis. There is no elimination period if your disability is due to occupational injury or sickness.

STD, other than for time off due to an occupational injury or sickness, will be paid at 100% of your base semi-monthly salary for the first 13 weeks of disability and 60% for the next 13 weeks of disability; for up to 26 weeks of disability.

STD due to an occupational injury or sickness

STD due to an occupational injury or sickness will be paid at 90% of your base semi-monthly salary for up to 26 weeks of disability. There is no elimination period if your disability is due to occupational injury or sickness. Workers Compensation benefits (if applicable) will be paid through a third party. Any Workers’ Compensation benefit payable to you will be deducted (offset) from your STD pay.

Repayment to the Company for Overpayments

The Company reserves the right to deduct from your pay any overpayments you may receive in connection with your request for STD benefits (i.e., overpayments received after your claim is denied, as a result of administrative delay or error, Workers' Compensation overpayments, etc.). By submitting your request for STD benefits you expressly authorize the Company to take such actions to the extent applicable. Because exception hours (i.e. short term disability, occupational injury, overtime, etc.) are paid based on a pay period lag, an overpayment may occur and you may owe the Company money even after you return to work.

The Disability Coordinator (713-997-2103) will coordinate disability benefits received from all sources.

Prorated Benefit

If you are not disabled for a full semi-monthly pay period, your disability payment will be prorated. The proration calculation will be your hourly rate times hours of disability times the applicable 100%, 90% or 60% rate.

Payment of Benefits

All benefits shall be payable to the participant except that any benefits unpaid at the participant's death shall be payable to his/her beneficiary. Whenever a covered participant is under a legal disability or incapacitated in any way so as to be unable to manage his/her affairs, the Company may direct payments to such person or to his/her guardian or legal representative to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage for such person's benefit. Any payment made in good faith pursuant to this provision shall fully discharge the Company and the plan of any liability to the extent of such payment.

Applying for STD Disability Benefits

If you are disabled due to a non-occupational injury or sickness, you must call Lincoln at 800-713-7384 (or visit their website at www.mylincolnportal.com, use company code EPENERGY) and apply for STD benefits as soon as you know your absence from work will be at least 7 consecutive calendar days, but no later than 30 days from the first day of your disability. Lincoln will determine if you qualify for STD benefits.

While on STD for any reason (non-occupational or occupational), you are required to communicate on a weekly basis directly with your immediate supervisor regarding the status of your leave, unless directed otherwise.

Recording Short Term Disability (Timekeeping)

If approved for STD, the Disability Coordinator (713-997-2103) may coordinate with your supervisor or department's timekeeping coordinator to ensure your time off due to your personal disabling injury or sickness is recorded correctly. It is your responsibility, along with your department's timekeeping coordinator, to ensure your time is reported accurately. Time must be entered and approved by your supervisor each payday on EP Energy's time reporting system.

Important Note: Because exception hours (i.e. STD, occupational injury, overtime, etc.) are reported at the end of a pay period and paid the following pay period, you may notice the impact of STD pay upon your return to work. Pay adjustments may be necessary even after your return to work.

Non-occupational

If you are losing time from work due to a personal non-occupational injury or sickness (as per your doctor's certification) you should code your time appropriately as STD 100% (Short Term Disability paid at 100% of base pay) or STD 60% (Short Term Disability paid at 60% of base pay).

Occupational

If you are losing time from work due to an occupational injury or sickness (as per your doctor's certification), you should code that time appropriately as Occupational Injury 90%. Occupational Injury hours are paid at 90% of your base pay.

Holidays

Holidays while on disability status should be coded as Short Term Disability (STD 100% or STD 60%) or Occupational Injury 90%, as applicable.

Occupational Injury or Sickness Notification

If your absence from work is due to an occupational injury or sickness you should notify your supervisor or responsible Company personnel as soon as possible. Claim determination and management of your occupational disability claim will be handled by the applicable Workers' Compensation carrier. Disability certification from a qualified physician will be required while you are out due to an occupational injury. Lincoln may also become involved with managing your disability claim.

You are required to communicate on a weekly basis directly with your immediate supervisor regarding the status of your leave, unless directed otherwise.

Definition of Disability

Disability means you, as a result of injury or sickness, are unable to perform one or more of the material and substantial duties of your own job, as determined by Lincoln in its sole discretion, and you require the regular attendance of a physician for such injury or sickness. For purposes of determining disability, an injury must occur and disability must begin while you are covered under the program.

Successive Period of Disability

A successive period of disability means a disability which is related or due to the same cause(s) as a prior disability for which a semi-monthly benefit was payable. A successive period of disability will be treated as part of the prior disability if, after receiving disability benefits under this program, you return to your own job on an active employment basis for less than four continuous weeks and perform all the material and substantial duties of your own job.

To qualify for the successive period of disability benefit, you must experience more than a 20% loss of basic semi-monthly earnings.

If you return to your own job on an active employment basis for four continuous calendar weeks or more, the successive period of disability will be treated as a new period of disability. You must complete another elimination period.

Definition of a Physician

Physician means a person who:

- Is licensed to practice medicine and is practicing within the terms of his/her license; or
- Is a licensed practitioner of the healing arts in a category specifically favored under the health coverage laws of the state where the treatment is received and is practicing within the terms of his/her license.

Physician does not mean you or your spouse or domestic partner or any family member.

Proof of Disability

In order to receive STD benefits, you must, at your own expense, provide Lincoln proof of continued disability, regular attendance of a physician and appropriate available treatment. The proof must be given upon Lincoln's request and within the time frame specified by Lincoln. Lincoln has the right to

determine if your proof of disability is satisfactory. Although Lincoln does not direct treatment or care, Lincoln does have the right to request that you participate in an independent medical examination if warranted.

Partial Disability

To be eligible for partial disability benefits, you must be employed in your own job or another job and must be earning between 20% and 80% of your basic semi-monthly earnings. If eligible for partial disability benefits, you will be paid at either 100%, 90% or 60%, whichever rate is applicable, less any earnings you received during the period of partial disability and any Workers' Compensation you may have received.

How a Short Term Disability Absence Affects Your Benefit Coverage

Health Care Program Coverage

Your current Health Care Program coverage will continue as long as you are receiving STD benefits and make the required contributions. If you die while you are receiving STD benefits, your covered eligible dependents (as of your date of death) will have three months of free active medical, dental and vision coverage (coverage in effect on the date of your death). After the 3-month period they will be eligible to enroll in COBRA coverage.

Flexible Spending Account

Your Flexible Spending Account elections will continue as long as you are receiving STD benefits. However, you may elect to discontinue your Dependent Day Care Flexible Spending Account while you are on STD. You must re-enroll in the Dependent Day Care Flexible Spending Account by calling the Benefits Center upon your return to work.

Life Insurance While on Short Term Disability

Your Basic and Supplemental Life Insurance coverage will be calculated by using your monthly base salary and elections in effect on the first day of your disability. Your Supplemental Life Insurance coverage cannot be increased until you have returned to work for at least 4 continuous weeks of active full-time employment.

Vacation and Sick Leave

You are not allowed to use vacation or sick days while on STD.

Accidental Death & Dismemberment Insurance (AD&D)

AD&D insurance coverage continues while you are on STD.

401(k) Retirement Plan

You may continue to contribute to the 401(k) Retirement Plan as long as you remain on the EP Energy payroll.

When Short Term Disability Benefits End

STD benefits will end on the earliest of the following:

1. the date you fail to provide proof of continued disability or partial disability and regular attendance of a physician;
2. the date you fail to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
3. the date you refuse to be examined or evaluated at reasonable intervals;
4. the date you refuse to receive appropriate available treatment;

5. the date you refuse a job with the Company where workplace modifications or accommodations were made to allow you to perform the material and substantial duties of your job;
6. the date you are able to work in your own job on a part-time basis, but choose not to;
7. the date your current partial disability earnings exceed 80% of your basic semi-monthly earnings;
8. the date you are no longer disabled according to this Program;
9. the date this Program terminates or is amended in a manner that causes you to no longer be eligible for the disability benefit, but without prejudice to any claim originating prior to the time of termination or amendment;
10. the date you are no longer in an eligible class;
11. the date your employment terminates;
12. the date you engage in illegal conduct (as determined by Lincoln in its sole discretion) that injures the Company;
13. the end of the maximum benefit period; or
14. the date you die.

Short Term Disability Exclusions

STD benefits will not be paid for any disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries, while sane or insane;
3. active participation in a riot;
4. the committing of or attempting to commit a felony or misdemeanor;
5. cosmetic surgery unless such surgery is in connection with an injury or sickness; or
6. a gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change.

No benefit will be payable during any period of incarceration.

Short Term Disability (STD) Claims Procedures

Benefits under the Program will be paid only if Lincoln Life Assurance Company of Boston (the Claims Administrator) approves the claim. Lincoln Life Assurance Company of Boston must receive proof that you are disabled due to injury or sickness and are under the regular attendance of a physician.

For any claim for benefits, you may be asked to submit additional information so that Lincoln Life Assurance Company of Boston can determine whether the claim is covered and the amount of the claim.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer or a friend or relative. You may be asked to notify Lincoln Life Assurance Company of Boston in writing and give Lincoln Life Assurance Company of Boston the name, address, and telephone number where your personal representative can be reached.

Making a Claim for STD Benefits

If you have a claim for STD benefits, you must file a claim with Lincoln Life Assurance Company of Boston.

STD Benefit Denials and Notice of Denial

If you make a request for STD benefits and Lincoln Life Assurance Company of Boston issues an Adverse Benefit Determination (or claim denial), you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- The specific reason or reasons for the denial;
- A reference to the Program provision on which the denial is based;
- A description of any additional material or information that is necessary to complete your claim and an explanation of why such material or information is necessary\
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views presented by you to the Plan of health care professionals who treated you and vocational professionals who evaluated you;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - your disability determination, if any, made by the Social Security Administration that you presented to the Plan;
- If Lincoln Life Assurance Company of Boston relied on an internal rule, guideline, protocol, standards or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, or other similar criterion or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined in accordance with applicable Department of Labor Regulations;
- If the Adverse Benefit Determination is based on a lack of medical necessity or the experimental nature of the treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of this Plan to your medical circumstances or a statement that such explanation shall be provided free of charge upon request; and
- An explanation of the Program's claim review procedures and the time limits applicable to those procedures, and a statement of your right to bring a civil action under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

Lincoln Life Assurance Company of Boston will give you notice of the decision no later than 45 days after the claim is received by Lincoln Life Assurance Company of Boston, unless special circumstances require an extension of time for processing. The 45-day period may be extended by as many as two additional 30-day periods if necessary due to matters beyond control of the Program. If there is one extension, you will be notified of the extension within the initial forty-five (45) day period, the reason for the extension and the date by which a determination is expected. The first extension shall not exceed seventy-five (75) days after Lincoln Life Assurance Company of Boston receives the claim. If a second thirty (30) day extension is necessary, you will be notified of the extension within the first thirty (30) day extension period, the reason for the extension and the date by which a determination is expected. The second extension shall not exceed 105 days after Lincoln Life Assurance Company of Boston receives the claim. The extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve

the issues. You shall have at least forty-five (45) days to provide any additional information requested by Lincoln Life Assurance Company of Boston. The deadline for the claim determination shall be extended by the time taken by you to provide any such additional information.

Appealing a Denied Short Term Disability Claim

You or your authorized representative may appeal an Adverse Benefit Determination (including a rescission of coverage). Your appeal must be made in writing within 180 days of Lincoln Life Assurance Company of Boston's initial notice of an Adverse Benefit Determination, or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal right, which is generally a prerequisite to bringing suit. Your written appeal should be sent to:

Lincoln Life Assurance Company of Boston
Attn: Group Benefits Disability Claims
P.O. Box 7210
London, KY 40742-7209

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You will have the opportunity to submit written comments, documents, records, and other information in support of your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse determination will take into account all comments, documents, records and other information submitted by you relating to the claims, regardless of whether such information was submitted and considered in the initial benefit determination.

Review of Appeal

Lincoln Life Assurance Company of Boston will review and render a decision on your appeal within the time frames outlined below and will notify you of its decision in writing. The individual who reviews and renders a decision on your appeal will not be an individual who participated in or decided your original claim, nor will he/she be a subordinate to the original decision maker. No deference shall be given to the initial decision. Lincoln Life Assurance Company of Boston may consult with a physician or other licensed health care professional with appropriate training and experience to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in your initial claim and will not be a subordinate of that expert. The identity of a medical expert consulted in connection with your appeal will be provided upon request. You will be notified of the decision on appeal, adverse or not, no later than 45 days after Lincoln Life Assurance Company of Boston received the appeal. If, because of special circumstances, the review process cannot be completed within 45 days, you'll be notified of the delay within the 45-day period of the special circumstances requiring an extension of time and the date by which Lincoln Life Assurance Company of Boston expects to render the decision upon review. In this instance, Lincoln Life Assurance Company of Boston will provide a final written response within 90 days of the date the Program received your request for review.

You will be provided with any new or additional evidence considered, relied upon, or generated by the Lincoln Life Assurance Company (or at its direction) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the decision is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before Lincoln Life Assurance Company can issue its decision on appeal of an Adverse Benefit Determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the decision is required to be provided to give you a reasonable opportunity to respond prior to that date.

Notice of Appeal Denial

If the decision on appeal affirms the initial denial of your claim, you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- The specific reason(s) for the denial;
- The Program provision on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents, records and other information;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views presented by you to the Plan of health care professionals treating you and the vocational professionals who evaluated you;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
 - your disability determination, if any, made by the Social Security Administration that you presented to the Plan a disability determination;
 - if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- A statement of your right to bring suit under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

For information about filing a short term disability benefit eligibility or enrollment claim, see “Eligibility and Enrollment Claims and Appeals” under the Eligibility and Enrollment section of this SPD.

Long Term Disability (LTD) Insurance

Highlights

Only full-time regular and reduced-schedule employees are eligible for Long Term Disability (LTD) insurance coverage. Part-time employees are not eligible for LTD insurance coverage. LTD coverage is fully insured by Lincoln Life Assurance Company of Boston (also known as Lincoln Financial Group). You may review Lincoln Life Assurance Company of Boston's certificate of insurance coverage on EP Energy's intranet. Under Everything HR, select my Health site, then the Lincoln Life Assurance Company of Boston certificate of insurance coverage.

LTD insurance coverage is designed to replace part of your base pay should you become disabled because of injury or sickness from your current position, and as a result cannot work for an extended period of time.

EP Energy automatically provides you with LTD insurance coverage equal to 60% of your monthly base pay (not to exceed a maximum monthly benefit of \$25,000) at no cost to you. LTD insurance benefits are based on the base salary in effect as of your date of disability. You do not need to enroll to receive this basic coverage. LTD coverage is effective as of your hire date.

Before you are eligible to receive LTD insurance benefits, you must first be disabled and exhaust the 182-day elimination period. The Short Term Disability program is designed to assist you through the elimination period. You can find more information about the Short Term Disability Program in this SPD.

Note: Active medical coverage ends when an employee is approved for LTD. COBRA continuation coverage will be available, and medical plan options are available through the Health Insurance Marketplace. For more information about COBRA, see the "COBRA" section in this SPD. For more information about the Marketplace, go to healthcare.gov.

Qualifying for Insurance Benefits

You may qualify for LTD insurance benefits if you become disabled from your current position while you are covered under the Plan and you remain disabled during and after the 182-Day Elimination Period (described below). Before LTD insurance benefits can start, Lincoln Life Assurance Company of Boston, the Insurer, must approve your claim for LTD insurance benefits. They must receive proof that you:

- Are disabled due to sickness or injury; and
- Require the regular care of a physician.

You may be asked to submit to a medical examination as proof of your continuing disability. Review the sections below describing the "Definition of Disability" and "Definition of a Physician."

Your disability must occur after your insurance coverage becomes effective and cannot be the result of a Pre-Existing Condition. See "Pre-Existing Condition" below for more information. You must be actively at work to qualify for benefits under this Plan. See "Definition of Active Employment" below.

182-Day Elimination Period

LTD insurance will begin paying insurance benefits if you have been disabled from your current position during and after the 182-day elimination period. The elimination period begins on your first day of absence from work due to a disabling illness or injury. Disability certification from a qualified physician is required. See "Definition of Disability" below.

Benefits paid from vacation, sick leave, or Short Term Disability will not extend the 182-day elimination period.

Pre-Existing Condition

Pre-existing condition means a condition resulting from an injury or sickness for which you are diagnosed or received treatment within three months prior to your effective date.

This Plan will not cover any disability or partial disability which:

- Is caused by or relates to a Pre-Existing Condition; and
- Begins in the first 12 months after your insurance coverage becomes effective, unless you have received no treatment of the condition for six consecutive months after your effective date.

Definition of Active Employment

You will be considered actively employed if you are actually at work on the day immediately preceding:

- A weekend (except where one or both of these days are scheduled days of work);
- Holidays (except when the holiday is a scheduled work day);
- Paid time off (unless due to medical reasons); or
- Any non-scheduled workday.

Definition of a Physician

Physician means a person who:

- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- Is a licensed practitioner of the healing arts in a category specifically favored under the health insurance laws of the State where the policy is delivered and practicing within the terms of his or her license.

Physician does not mean you or your spouse, daughter, son, father, mother, sister, or brother.

Definition of Disability

Disability means that due to injury or sickness:

- You are unable to perform all of the material and substantial duties of your own occupation during the elimination period and the 12 months following the elimination period; and
- After 12 months of receiving LTD insurance benefits, you are unable to perform with reasonable continuity all of the material and substantial duties of your own and any occupation on a full-time basis for which you are, or may be, reasonably qualified to perform based on education, training, or experience.

Continued Proof of a Disability

At any time, Lincoln Life Assurance Company of Boston may require you to provide proof by a physician that you continue to be disabled. See definition of physician above.

Successive Periods of Disability

If a successive disability is related to a previous disability for which LTD insurance benefits were paid under the following circumstances, it will be treated as part of the prior disability and you will not be required to complete an additional elimination period if:

- You returned to your own occupation for less than six continuous months; and
- You were able to perform all the material and substantial duties of your own occupation. LTD insurance benefits will be subject to the terms of this coverage for the prior disability.

If you return to work after a disability for six consecutive months or more, any subsequent disability will be treated as a new disability and you must complete an additional elimination period.

Partial Disability

Partial disability means that, due to injury or sickness, you are:

- Able to perform at least one or more, but not all, of the material and substantial duties of your own or any other occupation on a part-time or full-time basis; or
- Able to perform all of the material and substantial duties of your own or any occupation on a part-time basis.

Work Incentive and Partial Disability Program

The Work Incentive and Partial Disability Program is available to help employees return to work on a limited basis due to partial disability. If you qualify, you may return to work and still receive LTD insurance benefits in addition to your part-time work earnings. While you are working part-time, you may be eligible to receive up to 100% of your pre-disability earnings for the first 12 months, as long as it does not exceed 100% of your earnings before you were disabled. Following 12 months, you may be eligible to receive up to 75% of lost earnings if you are permanently and partially disabled. These benefits create an incentive for you to return and continue to work, even if in a limited capacity. If you would like additional information, contact Lincoln Life Assurance Company of Boston.

Total Disability Income

Long Term Disability (LTD) Insurance Benefits

Your LTD insurance benefits are calculated by multiplying your monthly base pay on the first day of your disability by 60%, less any applicable taxes and deductions (offsets) from certain other sources of income. See the “Definition of LTD Insurance Benefits Pay” below.

Other sources of income that you may be receiving as a result of the same disability for which Lincoln Life Assurance Company of Boston pays an insurance benefit, such as Social Security disability benefits or Workers’ Compensation benefits, will be offset from the insurance benefit that the LTD insurance pays you.

For example, if your LTD insurance benefit was \$1,250 and you are also receiving \$1,012 in Social Security disability benefits each month, LTD insurance takes into account the benefit amount you receive from Social Security and offsets it from your LTD benefit as shown below:

Monthly Income Insurance Coverage	Monthly Amount You Receive From Social Security	What the Plan Pays Each Month
\$1,250	minus \$1,012	Equals \$238 less applicable taxes

The amounts you receive from other income sources will offset the percentage of pay you receive under the LTD insurance. If the total of all other income sources exceeds your LTD insurance benefit, you will receive a minimum monthly benefit of \$100 or 10% of your gross monthly insurance benefit, whichever is greater.

Definition of LTD Insurance Benefits Pay

For purposes of determining the amount of your LTD insurance benefits, pay means your monthly base pay as of your date of disability. Your monthly base pay is multiplied by 60% to arrive at your monthly LTD insurance benefit.

Minimum and Maximum Insurance Benefits

The minimum LTD insurance benefit you will receive is \$100 a month or 10% of your gross monthly benefit, whichever is greater. The maximum LTD insurance benefit you can receive is \$25,000 per month.

Taxation of LTD Insurance Benefits

Generally, LTD insurance benefits you receive through the program are considered taxable income. You are responsible for reporting these insurance benefits on your tax return. For more information about the taxable status of your LTD insurance benefits, contact your tax advisor.

How You Receive Payments

If you are approved, LTD insurance benefits will be paid monthly by Lincoln Life Assurance Company of Boston.

Delay or Loss of Benefits

Assuming you qualify for LTD insurance coverage, the following situations could cause a loss or delay of your LTD insurance benefits:

- Failure to timely apply for LTD insurance benefits; or
- Refusal to provide satisfactory medical evidence of your disability.

Attachment of Insurance Benefits

To the extent permitted by law, all rights and benefits under this Plan are exempt from execution, attachment, garnishment, or other legal process for your debts or liabilities.

Duration of LTD Insurance Benefits

Generally, your LTD insurance benefit is payable to age 65, as long as you remain disabled.

LTD insurance benefits will continue until one of the following occurs:

- You are no longer disabled;
- You reach age 65 (if your disability occurred prior to age 60);
- You die;
- You reach the Maximum Benefit Duration; or
- The date your current earnings exceed 80% of your earnings on the date you become disabled.

If You Are Disabled Between Ages 60 And 69 (Or Later)

If you become disabled between ages 60 and 69 (or later), your LTD insurance benefits are paid according to the following schedule:

Age at Start of Disability Benefits	Maximum Benefit Duration
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Termination of Employment Relationship

In administering the EP Energy Long Term Disability Plan, it is the Company's practice to continue the employment relationship for an LTD participant until the earlier of the commencement of LTD benefits or the receipt of a Social Security Disability Income Award (the initial benefit period). At that time, the Company will evaluate your status based on updated medical information you submit from your health care provider, as well as your return to work plans and the reasonableness of any accommodations you may request in order to return to work. If you are still unable to return to work with or without an accommodation at the end of the initial period, the Company will evaluate any further requests for accommodation at that time. If you are unable to return to work with or without reasonable accommodation, your employment will be terminated.

Survivor Benefits

If you die, your eligible survivor(s) will receive a lump-sum benefit if, when you died:

- You had been on disability for 182 or more consecutive days; and
- You were receiving a monthly LTD insurance benefit.

The lump-sum benefit will be equal to three times the last monthly benefit you received.

Eligible survivor means your:

- Spouse, if living; otherwise
- Your children under age 25.

If there are no eligible survivors, survivor benefits will be made to your estate.

Important Note: Please read the "Health Care Coverage" and "Life Insurance" sections below for more information on how these benefits are affected should you die while you are receiving LTD insurance benefits

How LTD Affects Your Benefit Coverage

Health Care Coverage

Once approved for an LTD insurance benefit, your Medical, EAP, Dental and Vision coverage may continue through COBRA. For more information about COBRA continuation coverage, go to the "COBRA" section of this SPD.

Life Insurance

The Company-paid Basic Life Insurance coverage continues as long as you are eligible to receive LTD insurance benefits. Basic Life is equal to two times your base annual salary (a maximum benefit of \$1 million) as of your date of disability.

If you were under age 60 when your disability began, then you may apply within 12 months from your date of disability for waiver of premium with the insurance carrier, Voya, to continue any Supplemental Life Insurance you had in effect as of your date of disability. Subject to approval by the life insurance carrier, supplemental life premiums may be waived while you are receiving benefits. Pending approval for waiver of premium, you will only have Basic Life Insurance coverage. An application for waiver of premium should be provided for your completion (if applicable). You may be able to convert your Supplemental Life Insurance coverage to an individual policy if the waiver of premium is denied. Please contact the Benefits Department at everythinghr@epenergy.com within 31 days of your denial for more information and forms. Voya stops waiving premiums on the earliest of the following dates:

- The date you are no longer disabled;
- The date you do not give Voya proof of total disability when asked; or
- The date you attain age 70.

Accidental Death & Dismemberment (AD&D) Coverage

AD&D coverage ceases when LTD insurance benefits begin.

Vacation, Sick Leave and Short Term Disability

Vacation and sick leave days are forfeited and Short Term Disability coverage is no longer applicable once your LTD insurance benefits begin.

Employees returning from LTD must be actively at work for three months before vacation or sick leave days are reallocated regardless of the calendar year.

401(k) Retirement Plan

Once you are approved for LTD benefits and no longer being paid through the EP Energy payroll, you will not be able to contribute to your 401(k) Retirement Plan. If you have an outstanding loan, you can continue to make payments through a preauthorized check agreement, or stop making payments, which will result in loan default. Defaulted loans are reported as a taxable distribution to you. You are also eligible to take a distribution from this Plan upon your termination from employment. Please refer to the 401(k) Retirement Plan SPD for more information or contact Empower Retirement at 1-888-846-4015.

Applying for Long Term Disability (LTD) Benefits

Lincoln Life Assurance Company of Boston (also known as Lincoln Financial Group) is the insurer for Long Term Disability insurance coverage (LTD). To apply for benefits, Lincoln Life Assurance Company of Boston will need you and/or your doctor to provide certain information so they are able to make a determination as to whether or not you qualify for LTD insurance benefits. Lincoln Life Assurance Company of Boston will send you the forms or applications to complete.

Please contact Lincoln Life Assurance Company of Boston at 800-838-5290 if you have not received any information from them at least two months before your elimination period is over (your 18th week of disability).

If your request is approved, Lincoln Life Assurance Company of Boston will provide a date that your LTD insurance benefits will commence. If insurance benefits are denied, you can appeal the decision, and that process will also be described to you by Lincoln Life Assurance Company of Boston.

An LTD information packet and a waiver of premium application for Supplemental Life Insurance, if applicable, should be sent to you before the end of your elimination period.

When LTD Insurance Benefits Are Not Payable

Although the Plan pays benefits for most disabilities, benefits will not be paid for disabilities resulting from:

- War, declared or undeclared, or any act of war;
- Intentionally self-inflicted injuries, while sane or insane;
- Active participation in a riot;
- Committing of or attempting to commit felony or misdemeanor;
- Cosmetic surgery unless such surgery is in connection with an injury or sickness while you are covered under the Plan;
- Gender change, including but not limited to any operation, drug therapy or any other procedure related to gender change; or
- During any period of incarceration.

When LTD Insurance Coverage Ends

LTD insurance coverage ends if you stop working for any reason other than disability or you are no longer eligible.

Your disability insurance coverage will end when any of the following conditions occur:

- You terminate employment.
- You no longer meet LTD eligibility requirements.
- The Plan ends.
- The last day for which any required employee contribution is made.

LTD Claims Procedures

Insurance benefits under the Plan will be paid only if Lincoln Life Assurance Company of Boston (the Insurer) approves the claim. Lincoln Life Assurance Company of Boston must receive proof that you are disabled due to injury or sickness and are under the regular attendance of a physician.

For any claim for insurance benefits, you may be asked to submit additional information so that Lincoln Life Assurance Company of Boston can determine whether the claim is covered and the amount of the claim.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer or a friend or relative. You may be asked to notify Lincoln Life Assurance Company of Boston in writing and give Lincoln Life Assurance Company of Boston the name, address, and telephone number where your personal representative can be reached.

Making a Claim for LTD Insurance Benefits

If you have a claim for long term disability insurance benefits, you must file a claim with Lincoln Life Assurance Company of Boston

LTD Insurance Benefit Denials and Notice of Denial

If you make a request for long term disability insurance benefits and Lincoln Life Assurance Company of Boston issues an Adverse Benefit Determination (or claim denial), you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- The specific reason or reasons for the denial;

- A reference to the Plan provision on which the denial is based;
- A description of any additional material or information that you feel is necessary to complete your claim and an explanation of why such material or information is necessary;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views presented by you to the Plan of health care professionals who treated you and vocational professionals who evaluated you;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - your disability determination, if any, made by the Social Security Administration that you presented to the Plan;
- If Lincoln Life Assurance Company of Boston relied on an internal rule, guideline, protocol, standards or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined in accordance with applicable Department of Labor Regulations;
- If the Adverse Benefit Determination is based on a lack of medical necessity or the experimental nature of the treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of this Plan to your medical circumstances or a statement that such explanation shall be provided free of charge upon request; and
- An explanation of the Plan's claim review procedures and the time limits applicable to those procedures, and a statement of your right to bring a civil action under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

Lincoln Life Assurance Company of Boston will give you notice of the decision no later than 45 days after the claim is received by Lincoln Life Assurance Company of Boston, unless special circumstances require an extension of time for processing. The 45-day period may be extended by as many as two additional 30-day periods if necessary due to matters beyond control of the Plan. If there is one extension, you will be notified of the extension within the initial forty-five (45) day period, the reason for the extension and the date by which a determination is expected. The first extension shall not exceed seventy-five (75) days after Lincoln Life Assurance Company of Boston receives the claim. If a second thirty (30) day extension is necessary, you will be notified of the extension within the first thirty (30) day extension period, the reason for the extension and the date by which a determination is expected. The second extension shall not exceed 105 days after Lincoln Life Assurance Company of Boston receives the claim. The extension notice will explain the standards on which entitlement to an insurance benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve the issues. You shall have at least forty-five (45) days to provide any additional information requested by Lincoln Life Assurance Company of Boston. The deadline for the claim determination shall be extended by the time taken by you to provide any such additional information.

Appealing a Denied Long Term Disability Claim

You or your authorized representative may appeal an Adverse Benefit Determination (including a rescission of coverage). Your appeal must be made in writing within 180 days of Lincoln Life Assurance Company of Boston's initial notice of an Adverse Benefit Determination, or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal right, which is generally a prerequisite to bringing suit. Your written appeal should be sent to:

Lincoln Life Assurance Company of Boston
Attn: Group Benefits Disability Claims
P.O. Box 7210
London, KY 40742-7210

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You will have the opportunity to submit written comments, documents, records, and other information in support of your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse determination will take into account all comments, documents, records and other information submitted by you relating to the claims, regardless of whether such information was submitted and considered in the initial benefit determination.

Review of Appeal

Lincoln Life Assurance Company of Boston will review and render a decision on your appeal within the time frames outlined below and will notify you of its decision in writing. The individual who reviews and renders a decision on your appeal will not be an individual who participated in or decided your original claim, nor will he/she be a subordinate to the original decision maker. No deference shall be given to the initial decision. Lincoln Life Assurance Company of Boston may consult with a physician or other licensed health care professional with appropriate training and experience to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in your initial claim and will not be a subordinate of that expert. The identity of a medical expert consulted in connection with your appeal will be provided upon request.

You will be notified of the decision on appeal, adverse or not, no later than 45 days after Lincoln Life Assurance Company of Boston received the appeal. If, because of special circumstances, the review process cannot be completed within 45 days, you'll be notified of the delay within the 45-day period of the special circumstances requiring an extension of time and the date by which Lincoln Life Assurance Company of Boston expects to render the decision upon review. In this instance, Lincoln Life Assurance Company of Boston will provide a final written response within 90 days of the date the Plan received your request for review.

You will be provided with any new or additional evidence considered, relied upon, or generated by the Lincoln Life Assurance Company (or at its direction) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the decision is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before Lincoln Life Assurance Company can issue its decision on appeal of an Adverse Benefit Determination based on a new or additional rationale, you must be provided, free of charge, with the

rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the decision is required to be provided to give you a reasonable opportunity to respond prior to that date.

Notice of Appeal Denial

If the decision on appeal affirms the initial denial of your claim, you will be notified of the Adverse Benefit Determination in writing. This notice of denial will include:

- The specific reason(s) for the denial;
- The Plan provision on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents, records and other information;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - the views presented by you to the Plan of health care professionals treating you and the vocational professionals who evaluated you;
 - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
 - your disability determination, if any, made by the Social Security Administration that you presented to the Plan a disability determination;
 - if the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
 - A statement of your right to bring suit under ERISA section 502(a) within one year after the date of the final decision on the claim appeal.

For information about filing a long term disability insurance benefit eligibility or enrollment claim, see “Eligibility and Enrollment Claims and Appeals” under the Eligibility and Enrollment section of this SPD.

Certificate of Coverage

EP Energy’s Long Term Disability coverage is insured through the Lincoln Life Assurance Company of Boston. The certificate of coverage may be found on the EP Energy intranet site under Everything HR > My Health.

Sponsor: EP Energy Global LLC

Policy Number: GF3-890-457889-01

Effective Date: May 25, 2012

Please read the certificate carefully. If you have any questions about any terms and provisions, please

contact the Insurance Administrator at your work location or write to Lincoln Financial. Lincoln Financial will help you understand your benefits. Also, if the terms of your certificate of coverage and the policy differ, the policy will govern. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the policy.

Business Travel Accident Insurance

Eligibility

You are eligible to participate in Business Travel Accident Insurance if you are a regular full-time or regular reduced-schedule active employee of a participating employer and are regularly scheduled to work at least 32 hours per week. Part-time employees are not eligible to participate in Business Travel Accident Insurance.

You are eligible for coverage under Business Travel Accident Insurance on the first day you are actively at work or on the first day you move into an eligible status.

You are **not** eligible for Business Travel Accident Insurance if you are a(n):

- Member of a collective bargaining unit;
- Non-resident alien;
- Employee working in a foreign country and are not paid from the U.S. payroll; or
- Employee whose customary employment is less than five months in a calendar year.

Business Travel Accident insurance is provided by The Hartford.

Business Travel Accident Insurance will pay you or your beneficiary five times your annual base salary, up to a maximum benefit of \$500,000, if you are injured or die in an accident while traveling on Company business. This benefit is in addition to any payments from basic or supplemental group life insurance and basic or supplemental accidental death and dismemberment insurance.

This benefit provides extra protection for Accidental Death or Dismemberment while you are traveling on Company business. You are also protected if you travel within the 48-hour period before or after your actual business meeting, as long as you are not using vacation days. For example, if your business concludes on Friday and you stay over until Sunday, you will be covered as long as you are still within the 48-hour time period. You are not covered, however, while traveling to and from your normal work location.

Your full covered amount is equal to five times your annual base salary, up to a maximum benefit of \$500,000. The Company pays for your Business Travel Accident Insurance.

If you are in an accident while traveling on Company business resulting in a loss within a year after the accident, benefits will be paid as follows:

- Loss of life—full covered amount.
- Loss of both hands, feet, or sight of both eyes, or any combination—full covered amount.
- Loss of one hand, foot, or sight of one eye—one-half covered amount.
- Loss of thumb and index finger on the same hand—one-quarter covered amount.

If more than one loss occurs, only one benefit is payable.

Beginning at age 75, your Business Travel Accident Insurance will be reduced as follows:

Age at Date of Loss	Percentage of Actual Covered Amount
75-79	45%
80-84	30%
85 and over	15%

What the Plan Does Not Cover

Business travel accident benefits will not be paid for the following:

- Intentionally self-inflicted injury, suicide or attempted suicide whether sane or insane;
- Losses which occur while serving in the armed forces;
- Losses resulting from declared or undeclared war;
- Losses which occur while engaged in illegal conduct;
- Losses sustained while legally intoxicated from the use of alcohol;
- Losses sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
- Losses which occur while traveling on non-Company business;
- Losses which occur while commuting to and from work;
- Losses resulting from service as a pilot or crew member of any aircraft;
- Losses which occur while traveling in an unlicensed aircraft or helicopter; or
- Losses which occur while traveling in an aircraft owned or leased by the Company or an affiliate, or employee, or a member of an employee's household.

If you must travel in an aircraft or helicopter other than one operated by a regularly scheduled commercial airline, United States Military Air Lift Command or Air Transport Command of Canada, be sure to contact Human Resources first. They can tell you if business travel accident insurance applies.

How Benefits for Business Travel Accident Insurance Will Be Paid

Death benefits from Business Travel Accident Insurance may be made to your beneficiary as either:

- A single lump-sum payment available as soon as administratively possible after your death or after a specified period of time; or
- Monthly, annual, or other periodic installments.

Dismemberment benefits from the Business Travel Accident Plan are paid to you in a single lump-sum.

Administrative Information

The Benefits Committee of the EP Energy Health and Welfare Plan (“Benefits Committee”) has the sole authority to administer the EP Energy Health and Welfare Plan and its component plans, component benefits and benefit programs (“Plan”).

Benefits Committee

Responsibility for the general administration of the Plan and for carrying out the provisions of the Plan has been placed with the Benefits Committee, which is a committee of three or more members, each of whom is an employee of EP Energy and each of whom has been appointed by the Chief Executive Officer of EP Energy. The Plan provides that the Benefits Committee has all powers necessary for the administration of the Plan and is the “Plan Administrator.” The Benefits Committee may designate any person, partnership or corporation to carry out any of its responsibilities under the Plan. The Benefits Committee has delegated day-to-day ministerial administration of the Plan under an administrative services contract.

Plan Expenses

All Plan expenses are paid by the Company.

Claims and Appeals

The Benefits Committee or its delegate has the authority to interpret Plan provisions and render claim decisions based on their interpretation, unless the interpretation relates to an insured benefit offered under the Plan. For insured benefits offered under the Plan, the Benefits Committee has delegated to DHMOs or insurance carriers (“Insurers”) the sole authority to interpret the terms of the insured benefit. (For claims decisions and appeals of insured benefits, please see “Claims and Appeals of Insured Benefits” below.)

Interpretation of all other Plan provisions includes but is not limited to determining factual and legal questions under the Plan, interpreting and administering the terms and conditions of the Plan, deciding all questions concerning the eligibility of any person to participate in the Plan, granting or denying benefits, construing any ambiguous provision of the Plan, correcting any defect, supplying any omission, or reconciling any inconsistency, as the Benefits Committee or its delegate, in its discretion, may determine.

Any person who believes that he or she is entitled to any non-insured benefit or right provided under the Plan has the right to file a written claim with a “Claims Administrator.” A Claims Administrator is any person or entity who is authorized by the Benefits Committee to determine claims for benefits under the Plan, including someone on the Company’s human resources staff authorized to decide claims.

Claims and Appeals Procedure for Non-Insured Benefits

The claims and appeals procedures for the non-insured benefits listed below are included within each section:

- Medical benefits
- Dental benefits (non-DHMO)
- Mental health and chemical dependency benefits
- Prescription drug benefits
- Flexible Spending Accounts
- Short Term Disability benefits

The names and addresses of the Claims Administrators can be found in the General Information section.

Claims and Appeals Procedure for Insured Benefits

For each insured benefit offered under the Plan, the Insurer has the sole authority, discretion and responsibility to interpret the terms of the benefit. Interpretation of the insured benefit includes but is not limited to determining factual and legal questions, interpreting and administering the terms and conditions of the insured benefit and granting or denying the insured benefit, correcting any defect, supplying any omission, or reconciling any inconsistency as the Insurer, in its discretion, may determine.

If you are enrolled in the Dental HMO (DHMO) or have vision, life, accidental death & dismemberment, business travel accident or long term disability insurance coverage, you must follow the claims and appeals procedures outlined in the certificates of insurance coverage that are available from the Insurer. (These claims procedures are also summarized in vision, life, accidental death & dismemberment, business travel accident and long term disability insurance coverage sections of this Summary Plan Description.) Any person who believes he or she is entitled to payment of an insured benefit shall look solely to the applicable insurance policy or contract, and not to the Company for payment of such insured benefits.

The names and addresses of Insurers can be found in the “General Information” section.

Right of Recovery

If you receive a payment under the Plan to which you are not entitled, the Plan shall have the right to recover that payment from you. Alternatively, the Benefits Committee may cause the amount to which you were not entitled to be deducted from future payments under the Plan.

Amendment and Termination of the Plan

EP Energy, the sponsor of the Plan, retains the right to amend, modify, or terminate the Plan, in whole or in part, at any time and for any reason.

Plan Documents Control

This summary is known as a Summary Plan Description (SPD), as explained in “About This Summary Plan Description.” In certain situations, this SPD together with the Plan and/or a Component Plan form the official Plan document. All of the Plan documents are available from the Benefits Center. The statements in the SPD are intended to be read as a whole. You should not rely on statements or explanations taken out of context. Subsequent changes to the Plan, Component Plan(s) and the SPD may be communicated in written materials such as newsletters, postings, and flyers.

In the event of any inconsistency between this SPD or any other communication regarding the Plan and the Plan documents, Section 9.1(b) of the Plan shall control in all cases. The Benefits Committee has the sole and exclusive authority to interpret the Plan documents, except to the extent it has delegated that authority.

Privacy

The Plan is required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing privacy and security rules to maintain the privacy of your “protected health information” and to safeguard your “electronic protected health information.” These privacy and security requirements apply to all group health benefits, referred to as “HIPAA Benefits.” “HIPAA Benefits” include EAP Services, the Medical Program, the DHMO, the Mental Health and Chemical Dependency Program, the Prescription Drug Program, the Dental Program, the Wellness Programs and the Vision Program.

“Protected health information” is information that identifies you and that relates to your physical or mental health. The Plan provided you with a Notice of Privacy Practices (“Notice”) summarizing the Plan’s responsibilities and your rights concerning your protected health information.

Generally, the Plan may disclose your protected health information to the Plan Sponsor to enable the Plan Sponsor to carry out the Plan's administrative functions relating to HIPAA Benefits. Protected health information may not be disclosed to the Plan Sponsor for other employment-related purposes without your prior authorization. Limited exceptions allowing other disclosures are detailed in the Notice.

You have the right to inspect and obtain a copy of your protected health information. You may access your protected health information by submitting a written request. You may also request that your protected health information be amended. In certain circumstances your request for access to or amendment of your records may be denied, as outlined in the Notice.

The Plan is committed to protecting medical information about you. The Plan may disclose protected health information to EP Energy under limited circumstances. The Plan may disclose summary health information to EP Energy for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Plan. The Plan may disclose protected health information to carry out program administration functions that are consistent under applicable law. The Plan may not disclose protected health information to EP Energy for the purpose of employment-related actions or decisions in connection with other benefits or employee benefit plans of EP Energy. A limited number of employees of EP Energy have access to protected health information for the purposes of carrying out plan administration functions in the ordinary course of business.

The Plan has put into place and will follow reasonable and appropriate security measures to ensure that access to and use of electronic protected health information is restricted to its employees or group of employees who are required to access or use such for the proper administration of the Plan or for such other reasons as may be proper under HIPAA. EP Energy will provide an effective mechanism for resolving any issues of non-compliance with such security measures by ensuring that appropriate sanctions are imposed against any employee who violates or fails to follow them. The Plan will require that any of its agents or subcontractors to whom it provides electronic protected health information agree to implement reasonable and appropriate security measures to protect the electronic protected health information. EP Energy will report to the Plan any security incident of which it becomes aware. The terms of this paragraph shall not apply if protected health information is disclosed to the EP Energy pursuant to an Authorization that meets the requirements of the HIPAA Privacy Rules, or if the protected health information is summary health information that EP Energy has requested in order (a) to obtain premium bids from health insurers for providing health insurance coverage the Plan; or (b) to amend or terminate the Plan.

For more information, review the Notice of Privacy Practices you received from the Plan you participate in. Also, the Plan's responsibilities with respect to HIPAA Benefits and your rights are more fully described in federal regulations which can be found at www.hhs.gov/ocr/hipaa. Finally, if you have questions about privacy or wish to object to or complain about any use or disclosure of your protected health information as explained above, the contact information is provided in the Notice. A copy of the Notice may be obtained by writing to the below address and requesting a copy:

Benefits Department
EP Energy
P.O. Box 4660
Houston, TX 77210-4660

General Information

Information about the Plan

Name of Plan:	EP Energy Health and Welfare Plan
Plan Number:	501
Plan Year:	Calendar Year
Sponsor of Plan:	EP Energy Global LLC P.O. Box 4660 Houston, TX 77210-4660
Sponsor's IRS Employer Identification Number:	76-0637534
Plan Administrator:	Benefits Committee of the EP Energy Health and Welfare Plan c/o EP Energy P.O. Box 4660 Houston, TX 77210-4660 (713) 997-7299
Type of Administration:	Benefits Committee

Plan Year

For accounting purposes, the Plan Year is the calendar year.

Service of Process

The agent for service of legal process is:

Chairman of the Benefits Committee of the
EP Energy Health and Welfare Plan
EP Energy
P.O. Box 4660
Houston, TX 77210-4660

Type of Plan

The Plan is a "welfare benefit plan" providing group health benefits, disability insurance benefits, life and AD&D insurance benefits. Insurance contracts are in place with certain insurers and health maintenance organizations. In addition, the insurers, health maintenance organizations, and third-party administrators are responsible for certain aspects of Plan administration (including payment of claims).

Sources of Plan Funding

The Plan is funded by the contributions made by the Plan participants and by participating employers. The amount of the contributions to be made by Plan participants is determined by EP Energy, or the Benefits Committee from time to time upon consideration of all the factors that each may consider relevant. The amount of these contributions may be changed from time to time, and the amount of contributions made by one or more Plan participants need not be identical to the amount of contributions to be made by other participants.

Participating Employers

Listed below are the participating employers as of January 1, 2021. A complete current list of participating employers may be obtained by participants and beneficiaries upon written request to the Plan Administrator.

Name of Employer
EP Energy Global L.L.C.

Names and Addresses of Claims Administrators, Other Service Providers and Insurers

The following entities are responsible for certain aspects of Plan administration, including the determination of covered claims and the payment of covered claims:

Source	Telephone	Address
BlueCross BlueShield of Texas <i>Medical, non-network Dental and Mental Health/Chemical Dependency Claims Administrator</i>	1-800-521-2227	Medical and Mental Health and Chemical Dependency Claims: P.O. Box 660044 Dallas, TX 75266-0044 Dental Claims: P.O. Box 660247 Dallas, TX 75266-0247
Cigna Dental DHMO <i>Network Dental Insurer</i>	1-800-244-6224	P.O. Box 189062 Plantation, FL 33318-9062
PlanSource <i>COBRA Administrator: Service Provider</i>	1-888-266-1732	P.O. Box 3850 Omaha, NE 68103
Express Scripts <i>Prescription drug benefits Claims Administrator</i>	1-877-657-2491	P.O. Box 650322 Dallas, TX 75265-0322
Lincoln Life Assurance Company of Boston Also known as Lincoln Financial Group <i>Short Term Disability Claims Administrator and Long Term Disability Insurer</i>	1-800-713-7384 (report a claim) 1-800-291-0112 (claims mgmt)	P.O. Box 7210 London, KY 40742
Magellan Health Services <i>Employee Assistance Program Claims Administrator</i>	1-800-327-1393	14100 Magellan Plaza, MO-10 Maryland Heights, MO 63043
Bank of New York Mellon (BNY Mellon) <i>Trustee of the Health Savings Accounts BenefitWallet Customer Service Center: Service Provider for HSAs</i>	1-877-472-4200	
PayFlex <i>Dependent Day Care Flexible Spending Account Claims Administrator</i>	1-800-284-4885	P.O. Box 3039 Omaha, NE 68103-3039
Voya Financial <i>Life and AD&D Insurer</i>	1-800-955-7736	P.O. Box 1548 Minneapolis, MN 55440
The Hartford <i>Business Travel Accident Insurer</i>	1-888-563-1124	The Hartford – Group Life and AD&D Claims Unit P.O. Box 14299 Lexington, KY 40512-4299
VSP <i>Vision Plan Insurer</i>	1-800-877-7195	For Non-VSP claims: P.O. Box 997105 Sacramento, CA 95899-7105

Statement of ERISA Rights

As a participant in the EP Energy Health and Welfare Plan (“Plan”), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan’s Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all Plan documents. These may include insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- If you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Plan Administration

As Plan Administrator, the Benefits Committee reserves the absolute authority and discretion to interpret and administer the Plan including all Component Plans and benefit programs, including resolving any discrepancies, supplying any omissions, and correcting any defects. The Benefits Committee also reserves the absolute authority and discretion to make all determinations under the Plan, such as decisions concerning eligibility and benefits, including factual determinations. Subject only to the Plan's claims review procedure, all decisions affecting the Plan that are made by the Benefits Committee will be final and binding.