
**Tucson Electric Power
Benefits by Design**

**Plan Document &
Summary Plan Description**

Effective January 1, 2023

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INTRODUCTION

Tucson Electric Power Company (the “Company” or “TEP”) previously established the Tucson Electric Power Benefits by Design Health Plans (the “Plan”). It is part of the Employee Group Insurance Plan, which is a ‘wrap plan.’ The Plan was most recently amended and restated effective January 1, 2020. By this instrument, the Company intends to amend and restate the Plan in its entirety effective January 1, 2023, except as otherwise noted to: (1) clarify the Plan’s eligibility provisions; (2) update and incorporate the Component Program documents by reference; (3) make changes to ensure the Plan complies with applicable law; and (4) make various clarifying changes to the Plan.

The Plan offers various Component Programs to employees including medical, dental, and vision. Some Component Programs are self-funded, while others are fully insured. The Company relies on third party administrators to administer certain self-funded benefits. From time to time third party administrators (for self-funded plans) and insurance companies (for fully insured plans) publish Component Program documents, e.g., benefits booklets, policies, certificates, guides, and other benefits related materials, that explain the Plan’s benefits. For more information, regarding the Component Program documents that have been incorporated into the Plan by reference, see Appendix A.

This document serves as both the written plan document as required by Section 402 of ERISA and the summary plan description as required by Section 102 of ERISA. Although the documents incorporated herein by reference may, from time to time, refer to such benefits as a plan or plans, the Plan is a single plan, and such references shall not create separate plans for such benefits.

SECTION I. COMPONENT PROGRAMS

The Plan includes the Component Programs identified in the charts below. As noted below, an Employee's ability to participate in a Component Program depends on the Employee's Employer, location, and union.

TUCSON ELECTRIC POWER AND FORTISUS INC.					
		Tucson-based		Springerville	
		Unclassified Employees	Classified Employees	Unclassified Employees	Classified Employees
Self-funded Medical Plan	PPOA	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	PPOB	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	HDHP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Self-funded Dental Plan		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
DMO		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Vision Plan		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

UNS ELECTRIC, INC., AND UNS GAS, INC.				
		769 & 387 Employees	Unclassified Employees	Gas 1116
Self-funded Medical Plan	PPOA	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	PPOB	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	HDHP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Self-funded Dental Plan		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
DMO*		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Vision Plan		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

* Not available to UNS Gas Local 1116 Employees.

Classified Employee means a Tucson Electric Power (TEP) Employee represented by the IBEW 1116 Bargaining Agreement. Or, a UNS Electric, Inc. (UEE) Employee or UNS Gas, Inc. (UEG) Employee represented by one of the following bargaining agreements:

- IBEW Local 387 (Santa Cruz UNS Electric and UNS Gas Operations)
- IBEW Local 769 (Mohave County UNS Electric Operations)
- IBEW Local 1116 (Northern Arizona UNS Gas Operations)

Self-funded Medical Plan

The benefits provided under the “Self-funded” Medical Plan options will be funded in part by TEP, FortisUS Inc., UEE, and UEG from their general assets and in part by Participant contributions.

The Plan reimburses only specific medical expenses that result from a non-occupational illness or injury. The Plan does not reimburse medical expenses for any illness or injury arising out of or in the course of employment for which benefits are available under Workers’ Compensation law.

The Self-funded Medical Plan options generally cover hospital, surgical and medical services. But certain services are not covered, and almost all services are more expensive if received from a non-network provider. For more information, please review the medical benefits booklet incorporated by reference in Appendix A and the Schedule of Benefits in Appendix B.

Coverage is conditioned on the Claims Administrator’s determination that the treatment provided meets the specific Plan requirements. The Claims Administrator has the discretionary authority to make such determinations, and to rely on its own materials, expertise and procedures in doing so.

Self-funded Dental Plan

The benefits provided under the “Self-funded” Dental Plan will be funded in part by TEP, FortisUS Inc., UEE and UEG from their general assets and in part by Participant contributions.

For more information, please review the dental benefits booklet incorporated by reference in Appendix A and the Schedule of Benefits in Appendix D.

Coverage is conditioned on the Claims Administrator’s determination that the treatment provided meets the specific Plan requirements. The Claims Administrator has the discretionary authority to make such determinations, and to rely on its own materials, expertise and procedures in doing so.

Dental Maintenance Organization (DMO)

The DMO is fully insured. Insurance premiums for Participants will be funded in part by TEP, FortisUS Inc., UEE and UEG from their general assets and in part by Participants. TEP will determine and periodically communicate to the Employees their share of the premiums, and it may change that determination at any time.

Under the DMO, Participants select a primary care dentist who coordinates dental care. The amount required to be paid for services received from a primary care dentist and services by a referral dentist are specified in a published fee schedule. A DMO generally does not cover services outside the DMO service area or outside of the DMO network. The benefits that are provided by the DMO are described in the DMO documents incorporated by reference in Appendix A.

Coverage is conditioned on the DMO’s determination that the treatment provided meets the specific Plan requirements. The DMO has the discretionary authority to make such determinations, and to rely on its own materials, expertise and procedures in doing so.

Vision Plan

The Vision Plan is fully insured. Insurance premiums for Participants will be funded by Participants. TEP will determine and periodically communicate to the Employees the amount of their premiums, which is subject to change.

The Vision Plan provides coverage through an insurance policy for covered vision care. The benefits that are provided by the Vision Plan are described in the Vision Plan documents incorporated by reference in Appendix A.

Coverage is conditioned on the Insurance Company's determination that the treatment provided meets the specific Plan requirements. The Insurance Company has the discretionary authority to make such determinations, and to rely on its own materials, expertise and procedures in doing so.

SECTION II. OPEN ENROLLMENT

Open Enrollment is held before the beginning of each Plan Year. During the Open Enrollment period, covered Employees will be able to change their benefit decisions based on which benefits and coverages are right for them and their Dependents.

Benefit choices made during the Open Enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in status event during the year (e.g., birth, adoption, death, marriage, divorce, or loss of coverage due to loss of a Spouse's employment). See the Tucson Electric Power Company Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan for more information regarding Special Enrollment and change in status events.

A Participant who fails to make an election during Open Enrollment will automatically retain his or her present medical, dental, and vision coverages. In the event that the Participant's present coverage is no longer available, the Participant will be advised that he/she must make an election or waive coverage by signing a waiver where the Participant attests to having other coverage.

For new hires, failure to make an initial election as a new Participant will result in defaulting to Employee Only PPO B medical coverage with no option to add dental or vision until the next Open Enrollment period, unless there is a Special Enrollment event or a change in status event during the year (e.g., birth, adoption, death, marriage, divorce, or loss of coverage due to loss of a Spouse's employment). See the Tucson Electric Power Company Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan for more information regarding Special Enrollment and change in status events.

Employees will receive detailed information regarding Open Enrollment from their Employer.

SECTION III. MEDICAL, DENTAL, AND VISION ELIGIBILITY, EFFECTIVE DATE, ENROLLMENT AND TERMINATION PROVISIONS

An individual is eligible for the Medical, Dental, and Vision Component Programs under the Plan if he or she satisfies the requirements in the Component Programs Charts in Section II and the eligibility provisions in this Section IV.

A Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific drug, treatment, service, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees - Medical

- (1) All Active Employees of Tucson Electric Power Company or a Participating Affiliate (the Employer).
- (2) Former eligible Employees receiving long-term disability benefits under the Company's Long-Term Disability Plan as described in the section "Termination of Coverage."

Eligible Classes of Employees – Dental and Vision Component Programs

- (1) All Active Employees of Tucson Electric Power Company or a Participating Affiliate (the Employer) who work at least thirty-two (32) hours per week and are on the regular payroll of the Employer for that work.
- (2) Former eligible Employees receiving long-term disability benefits under the Company's Long-Term Disability Plan as described in the section "Termination of Coverage."

Eligibility Requirements for Employee Coverage

An Unclassified Employee and an IBEW Local 387/769 Classified Employee is eligible for Employee coverage from the first day that he or she is in an eligible class of Employees as described above. A 1116 Classified Employee is eligible from the first day of the month following the day that he or she is in an eligible class of Employees as described above.

If covered by a collective bargaining agreement, Employees are eligible only if the agreement provides for participation.

An Employee may be a covered Employee or covered Spouse of an Employee, but not both.

An Employee may only be covered as a Spouse of another Employee in certain circumstances. Specifically, an Employee who is the Spouse of another Employee of the same classification (both Unclassified or both Classified) may be covered as a Spouse, and a Classified Spouse may be covered as the Spouse of an Unclassified Employee, but an Unclassified Employee cannot be covered as a Spouse of a Classified Employee.

Eligible Classes of Dependents

Dependent Definitions: To be an eligible "Dependent," a person must meet the requirements of paragraph 1, 2 or 3 below.

- (1) **Spouse:** The person recognized as the Employee's spouse under the Code and under the laws of the state or country in which the marriage of such parties was performed, and who is a resident of the same country in which the covered Employee resides. An individual who is the divorced former spouse of the Employee is specifically excluded from the definition of Spouse.
- (2) **Dependent Child (Medical):** The child of an Employee by birth, marriage, adoption, or any other children for whom the Employee is the court-ordered Legal Guardian. Coverage for a child

continues until the limiting age of twenty-six (26). However, coverage for a child may continue beyond age twenty-six (26) if the child meets the definition of Totally Disabled and the Employee has applied for continuing disability coverage prior to the loss of eligibility due to limiting age. The child must have been enrolled in the Plan and deemed disabled prior to turning age twenty-six (26).

(3) Dependent Child (Dental and Vision Component Programs Only):

For Unclassified Employees, the child of an Employee by birth, marriage, adoption, or any other children for whom the Employee is the court-ordered Legal Guardian. Coverage for a child continues until the limiting age of twenty-six (26). However, coverage for a child may continue beyond age twenty-six (26) if the child meets the definition of Totally Disabled and the Employee has applied for continuing disability coverage prior to the loss of eligibility due to limiting age.

For Classified Employees, the child of an Employee by birth, marriage, adoption, or any other children for whom the Employee is the court-ordered Legal Guardian. Coverage for a child continues until the limiting age of nineteen (19) unless the child is a full-time student at an accredited school. If the child is a full-time student at an accredited school, the limiting age limit is increased to: (1) age twenty-three (23) for 1116 Classified Employees; or (2) age twenty-six (26) for IBEW Local 387/769 Classified Employees. Additionally, coverage for a child may continue beyond the applicable limiting age if the child meets the definition of Totally Disabled and the Employee has applied for continuing disability coverage prior to the loss of eligibility due to limiting age.

The term "child" shall include:

- (a) A child placed with a covered Employee in anticipation of adoption, and a covered Employee's child who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) as required by the federal Omnibus Budget Reconciliation Act of 1993. The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.
- (b) Any child of a Plan Participant who is an alternate recipient under a QMCSO shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.
- (c) A covered Dependent Child who reaches the limiting age and is Totally Disabled (i.e., generally incapable of self-sustaining employment by reason of mental or physical handicap), primarily dependent upon the Employee for support and maintenance, and unmarried. Such Dependent Child must also qualify as the Employee's tax dependent (i.e., as a qualifying child or as a qualifying relative under Code Section 152).

The Employee must apply for coverage and submit proof of incapacity within thirty (30) days of the date the child would have otherwise lost coverage. The Plan may require, at reasonable intervals, proof of the child's Total Disability and dependency. The Plan reserves the right to have such Dependent examined by a physician of the Plan's choice, at the Plan's expense, to determine the existence of such incapacity.

The Plan Administrator may require documentation proving an individual's Dependent Child status, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

A Dependent may be a child of an Employee or a covered Spouse, but not both. These persons are excluded as Dependents:

- (1) other individuals living in the covered Employee's home, but who are not eligible as defined; or
- (2) any person who is on active duty in any military service of any country; or
- (3) any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts shall be applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage

A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that an individual qualifies or continues to qualify as a Dependent as defined by this Plan.

EFFECTIVE DATE

Effective Date of Employee Coverage for New Unclassified Employees and IBEW Local 387/769 Classified Employees

All new Unclassified Employees and IBEW Local 387/769 Classified Employees will be covered on the date of hire provided that such employees are eligible for coverage and proper enrollment has been completed within the first thirty (30) days of the date of hire and any required contributions have been authorized. If proper enrollment has not been completed within the first thirty (30) days of the date of hire, the employee shall be enrolled in default coverage (explained in more detail below).

Effective Date of Employee Coverage for New 1116 Classified Employees

All new 1116 Classified Employees covered by a collective bargaining agreement will be covered under this Plan on the first day of the month following the date of hire provided that such employees are eligible for coverage and proper enrollment has been completed within the first thirty (30) days of the date of hire. Alternatively, if proper enrollment has not been completed within the first thirty (30) days of the date of hire, then the employee shall be enrolled in default coverage (explained in more detail below).

Active Employee Requirement

Generally, an Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect. If the Employee is not actively at work on the day coverage is scheduled to begin, coverage will start when the Employee is actively at work for at least one day. Absence from work due to a health factor (such as being absent from work due to illness) is treated as being actively at work for this purpose.

Effective Date of Dependent Coverage

Dependent coverage will begin on the same day as the Employee, provided that proper enrollment has been made and any required contributions have been authorized.

ENROLLMENT

Enrollment Requirements

An eligible Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If the Employee does not enroll for coverage within 30 days after the date of hire, then they will be automatically enrolled for default coverage (see below).

Default Coverage

If an eligible New Employee does not make an election within 30 days after the date of hire, then this will result in loss of coverage for Dental and/or Vision Component Programs, and default to Employee-only coverage on the PPO B Medical Plan.

Enrollment Requirements for Newborn Children

An Employee must enroll a newborn child in the Plan by notifying the Plan within 30 days of birth and providing a birth certificate as soon as possible thereafter. Newborn coverage will not be automatic. Failure to enroll the newborn child in the Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, may prevent the newborn child from enrolling in coverage until the next open enrollment period.

TIMELY OR LATE ENROLLMENT

Timely Enrollment

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either under an Initial Enrollment Period or a Special Enrollment Period.

If two Employees are covered under the Plan and the Employee who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

Late Enrollment

An enrollment is "late" if it is not made on a "timely basis" during an Initial Enrollment Period or a Special Enrollment Period. If enrollment is late during an Initial Enrollment Period, the late enrollee will automatically be enrolled in default coverage, specified above. The late enrollee's Dependents may enroll in the plan during the subsequent annual Open Enrollment Period, or during a Special Enrollment Period to the extent applicable. If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a late enrollee.

The time between the date a late enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. If you enroll during an annual Open Enrollment period, coverage begins on January 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his Dependents because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage or if there is a significant change in the plan's benefit or costs. However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

Special Enrollment Rights for State Medicaid or Children's Health Insurance Program (CHIP).

If an Employee has declined enrollment in the Plan for him or herself, or his or her Dependents because of coverage under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request Special Enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. However, a written request for enrollment must be made no later than sixty (60) days after termination of Medicaid or CHIP coverage.

In addition, if an Employee has declined enrollment in the Plan for him or herself, or his or her Dependents, and such Employee or Dependent later becomes eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request Special Enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. However, a written request for enrollment must be made no later than sixty (60) days after the date you are determined to be eligible for assistance.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these provisions, contact Tucson Electric Power Company, P.O. Box 711, Tucson, AZ 85702.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if he or she satisfies each of the following requirements:
 - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
 - (d)** The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (e)** For purposes of these rules, a loss of coverage occurs if:
 - (i)** The Employee or Dependent has a loss of coverage due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g., part-time employees).
 - (ii)** The Employee or Dependent has a loss of coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in

the number of hours of employment or contributions towards the coverage were terminated.

- (iii) The Employee or Dependent has a loss of coverage when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
- (iv) The Employee or Dependent has a loss of coverage when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.
- (v) The Dependent changes coverage elections under his or her employer's health plan that permits mid-year changes and the other plan's coverage period does not correspond to this Plan's Plan Year.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

- (a) The Employee is a Participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption or Legal Guardianship, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the date of the marriage;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption;
- (d) in the case of Legal Guardianship, the date the Employee became the Legal Guardian

High Level Summary of Special Enrollment Circumstances	
If you...	You can...
lose other coverage	enroll in coverage, make a coverage option change
have a Dependent who loses coverage	enroll that Dependent in coverage, make a coverage option change

gain a Dependent by marriage, birth, adoption, or placement for adoption	enroll in coverage for the Employee, Spouse, or Dependent as a result of marriage, birth, adoption, make a coverage option change
lose Medicaid or CHIP coverage	enroll in coverage for the Employee or Dependent who has lost Medicaid or CHIP coverage, make a coverage option change
gain eligibility for state premium assistance subsidy from Medicaid or CHIP	enroll in coverage for the Employee or Dependent who has become eligible for a premium assistance subsidy from Medicaid or CHIP, make a coverage option change

In addition to the Special Enrollment events identified above, Employees and Dependents who experience certain other changes in status events may have the ability to modify their election changes mid-year. See the Tucson Electric Power Company Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan for more information regarding Special Enrollment and change in status events.

TERMINATION OF COVERAGE

When Employee Coverage Terminates

Employee coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (3) The last day of the month in which the covered Employee ceases to be in one of the Eligible Classes. This includes termination of Active Employment of the covered Employee.
- (4) If an Employee intentionally commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either retroactively void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

Continuation During Periods of Employer-Certified Disability or Leave of Absence

A person may remain eligible for a limited time if Active, full-time work ceases due to disability or leave of absence. This continuance will end as follows:

For long-term disability leave:

If an eligible Employee becomes disabled and receives long-term disability benefits under the Company's Long-Term Disability Plan, coverage may continue as follows:

For TEP and FortisUS Inc. Employees, coverage can continue from termination of employment until the earlier of death, loss of disability benefits, or the first day of the month during which the Employee attains age sixty-five (65), provided the Employee continues to make required contributions to the Plan.

For UEE and UEG Employees, coverage can continue from the date of termination of employment for up to twenty-nine (29) months, or until the earlier of death, loss of disability benefits, or the first day of the month during which the Employee attains age sixty-five (65) provided the Employee makes required contributions to the Plan.

New Dependent Children who are acquired by the eligible Employee will be eligible for coverage if enrolled within thirty (30) days of being acquired. A new Spouse acquired by the eligible Employee will be eligible for coverage if enrolled within thirty (30) days of being acquired.

For short-term disability leave:

With the exception of the IBEW Local 387 Classified Employees, coverage will continue for up to one-hundred and eighty (180) days and the Employer will deduct contributions from the Employee's short-term disability pay/salary continuance pay. In the case of IBEW Local 387 Classified Employees, coverage will continue during a 'continuous leave' and the Employer will deduct contributions from Employee's short-term disability pay/salary continuance pay. For these purposes continuous leave means sixty-five (65) working days/ninety (90) consecutive days.

For leave of absence:

Coverage will continue for up to thirty (30) days, provided that the Employee makes the required contributions. After thirty (30) days, the Employee may continue coverage for the duration of the leave, up to twelve (12) months following the calendar month in which the leave began, provided that the Employee pays the entire cost of coverage.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave Act (FMLA) Leave

Coverage during an FMLA leave of absence will be administered in accordance with the policies established by the Employer and applicable law including the following: (a) during an FMLA leave of absence, coverage under this Plan shall be maintained on the same terms and conditions as the coverage that would have been provided had the Employee not taken the FMLA leave (including any Employee contribution requirement); and (b) if Plan coverage lapses during the FMLA leave, coverage will be reinstated upon the Employee's return to work at the conclusion of the FMLA leave, but only for the person(s) who had coverage under the Plan when the FMLA leave began. It is the intention of the Employer to provide FMLA benefits only to the extent required by applicable law and not to confer greater rights than those required by law on any covered individual.

Rehiring a Terminated Employee

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements.

If your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and you qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date your coverage ended, your coverage will be reinstated.

If your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and you do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date your coverage ended, and you did not perform any hours of service that were credited within the 13-week period, you will be treated as a new hire and will be required to meet all the requirements of a new Employee.

Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact the Tucson Electric Power Employee Welfare Benefits Committee Benefits Services, P.O. Box 711, Tucson, Arizona 85702.

Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1)** The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a)** The twenty-four (24) month period beginning on the date on which the person's absence begins; or
 - (b)** The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2)** A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3)** An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If coverage ends during the leave of absence because the Employee does not elect to utilize USERRA or an available conversion plan prior to the expiration of USERRA and the Employee is reemployed by the Employer, coverage for Employee and Dependents generally may be reinstated if (a) the Employer was provided advance written or verbal notice of military service leave, and (b) the duration of all military leaves while employed with the Employer does not exceed five (5) years.

If coverage under this Plan terminated as a result of eligibility for military medical and dental coverage and the order to active duty is canceled before active-duty service commences, these reinstatement rights will continue to apply.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under COBRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates

A Dependent's coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled "Continuation Coverage Rights under COBRA"):

- (1)** The date the Plan or Dependent coverage under the Plan is terminated. The date the Employee's coverage under the Plan terminates for any reason including death.
- (2)** The date a covered Spouse ceases to be a Dependent as defined by the Plan.
- (3)** The date a Dependent Child reaches the limiting age under the Plan.

- (4) In the case of a Dependent Child for whom coverage is being continued due to full-time student status at an accredited school, coverage terminates on the earliest of the following dates:
- (a) the last day of the month in which graduation takes place;
 - (b) the last day of the month the Dependent Child voluntarily stops attending school full-time; or
 - (c) August 31st if the Dependent Child completes a full spring semester as a full-time student, regardless of student status for the fall semester, unless the date of graduation or the limiting age birthday is prior to September 1st.

Coverage does not stop solely due to school vacations.

- (5) In the case of a child for whom coverage is being continued due to Total Disability, the earliest to occur of:
- (a) Cessation of such disability; or
 - (b) Failure to furnish any required proof of the uninterrupted continuance of such disability or to submit to any required examination.
- (6) The date a Dependent Child ceases to be a Dependent as defined by the Plan for any other reason not listed above.
- (7) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (8) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either retroactively void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

Continuation of Dependent Coverage following Death of Employee

The coverage of a Dependent of a deceased Employee may continue to midnight on the last day of the month, three (3) calendar months subsequent to the death of the Employee. This extension of coverage shall run concurrent with any continuation coverage available under COBRA and shall not operate to extend any continuation coverage.

SECTION IV. ENERGY FOR LIFE WELLNESS PROGRAM

The Energy for Life Wellness Program is designed to encourage awareness and engagement in healthy activities. Employees enrolled in a Medical Plan Component Program can complete the required steps at any time during the year to begin earning the 12-month incentive.

Complete these steps:

1. Visit your physician for an annual physical exam and set wellness goals.
2. Discuss a plan of action and set your wellness goals with your doctor. They may be based on the national standards, or they may be designed specifically for you by your physician.
3. Have your physician's office complete the Physical Exam Verification Form.
4. Send your completed Physical Exam Verification Form (including a legible copy of your lab results) to the Wellness Council of Arizona.

Once you submit the Physical Exam Verification Form to the Wellness Council of Arizona and it is processed, you will receive a wellness incentive based on the Medical Plan you are enrolled in:

- PPOA and PPOB participants will receive a \$500 premium discount for the 12-month period.
 - Discounts are calculated and issued per pay period at $\$500 / 26 \text{ pay periods} = \19.23 per paycheck.
- HDHP plan participants will receive a \$200 premium discount for the 12-month period.
 - Discounts are calculated and issued per pay period at $\$200 / 26 \text{ pay periods} = \7.69 per paycheck.

Consistent with IRS cafeteria plan rules and the Tucson Electric Power Company Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan, the Cafeteria Plan shall automatically adjust your premiums when you qualify or cease to qualify for the wellness incentive. You will not be able to revoke or change your coverage under the Cafeteria Plan based on such automatic and insignificant cost changes.

SECTION V. CAREHERE CLINIC

CareHere is an on-site clinic operated and staffed by an independent health care provider. All Participants in the Plan are eligible to receive limited care and limited prescriptions from a physician or nurse practitioner without a copayment.

The CareHere Clinic is located at 3950 E. Irvington Road, Tucson, AZ 85714. The CareHere Clinic may further expand to other location(s) in Arizona.

Participants enrolled in the Plan, excluding Participants enrolled in the HDHP, may obtain care through the CareHere Clinic. A Participant may no longer obtain care through the CareHere Clinic when he or she ceases to be enrolled in the Plan – for example when a Participant’s coverage under the Plan is terminated. Eligibility will be verified each time an individual accesses care through the CareHere Clinic.

Note: The CareHere Clinic is provided on a self-funded basis by the Company. While the Company intends to make the CareHere Clinic available indefinitely, this Component Program of the Plan, like all other Component Programs of the Plan, is subject to the Company’s right to amend, terminate or modify it, in whole or in part, at any time in the Company’s sole discretion.

The CareHere Clinic program is completely voluntary.

Note: All medical and support staff at the CareHere Clinic are employed by the independent medical group, separate clinic vendor or other health care provider that has contracted to furnish care or other related services at the CareHere Clinic. Neither the Company nor the Plan employs any medical or pharmacy personnel or their respective support staff. Moreover, nether is responsible for the licensing or certification of any such health care provider personnel. If you have a complaint about the care you received from any provider at the CareHere Clinic, please contact the 24-hour customer service line at 877-423-1330.

CareHere Clinic Services	
CareHere Clinic Office Visits	100% no Deductible
Diagnostic Lab work performed at the CareHere Clinic	100% after Deductible
CareHere Clinic Pharmacy Option	
Limited Prescriptions are available at the CareHere Clinic. The following copay applies to any prescriptions received at the CareHere Clinic:	
Generic Medications	\$0

SECTION VI. DOCTOR ON DEMAND

Doctor on Demand is a telehealth provider available to all employees and family members throughout Arizona. Services may also be available when traveling in most of the United States. Doctor on Demand provides access to US-licensed physicians, psychologists and psychiatrists through on-demand video visits when you need care.

Doctor on Demand provides services for medical issues such as:

Allergies	Skin Infections	Bronchitis and Pneumonia
Cough, Colds, Congestion	Conjunctivitis	Migraine / Headache
Sinus Infections	Back Pain	Urinary Tract Infections
Influenza	Vomiting and Diarrhea	

This service can also be used for behavioral health issues like depression, anxiety, work-related stress, relationship issues, smoking cessation, ADHD, mood changes, trauma, eating disorders and medication management.

There are many conditions that Doctor on Demand can treat effectively through a video visit. But for more serious or life-threatening conditions a visit to a doctor or hospital is important and necessary.

Contact Doctor on Demand at: <http://www.doctorondemand.com/benefits/unsenergy> or call 800-997-6196.

Doctor on Demand Services	Diagnostic Consultation Fee	Psychologists Fee	Psychiatrists Fee
Classified TEP & UEG 1116 Plans			
Member Cost - PPO A	\$20	\$20	\$20
Member Cost - PPO B	\$20	\$20	\$20
Member Cost - HDHP	20% after Deductible	20% after Deductible	20% after Deductible
Unclassified and Classified 769 & 387 Plans			
Member Cost - PPO A	\$20	\$20	\$20
Member Cost - PPO B	\$20	\$20	\$20
Member Cost - HDHP	20% after Deductible	20% after Deductible	20% after Deductible

SECTION VII. DEFINED TERMS

The following terms have special meanings and when used in the Plan will be capitalized. Please refer to the Component Program documents in Appendix A for additional defined terms.

Active Employee means the employee is on the active payroll of the Employer and has not experienced a voluntary or involuntary termination of employment with the Employer, including discharge for any reason, resignation, layoff, death, retirement, or long-term disability.

BCBSAZ means Blue Cross Blue Shield of Arizona.

Cafeteria Plan means the Tucson Electric Power Company Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan.

Calendar Year means January 1 through December 31.

CareHere and CareHere Clinic has the meaning set forth in Section VI. Carehere Clinic.

Claims Administrator means the entity that administers claims for benefits under the Plan. The Plan has various Claims Administrators identified in Section XVIII. General Plan Information.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Administrator means the entity that administers COBRA for the Plan and is identified in Section XII. Continuation Coverage Rights Under COBRA.

Committee means the Tucson Electric Power Company Employee Welfare Benefits Committee. The Committee is the Plan Administrator.

Company means Tucson Electric Power Company.

Component Program means the various health benefits offered under the Plan (e.g., medical, dental, and vision benefits), as identified in Appendix A.

Dependent means a Spouse or Child as set forth in Section IV. Eligibility.

Dependent Child has the meaning set forth in Section IV. Eligibility.

Employee means an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Certain individuals such as leased employees, temporary or per diem employees, nonresident aliens, independent contractors, and individuals working for a staffing agency are not considered Employees. Any individual who is not classified by the Employer as a common-law employee is not an Employee, even if the individual is reclassified as a common-law employee due to action by a court or administrative agency.

Employer means the Company (Tucson Electric Power Company) and Participating Affiliates. Participating Affiliates shall be deemed to have delegated to the Company all authority to amend or terminate the Plan.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Incurred - shall mean that a covered expense is incurred on the date the service is rendered or the supply is obtained and is received by the Participant. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Initial Enrollment and Initial Enrollment Period means the period when an individual first becomes eligible for coverage under the Plan and may enroll in coverage.

Insurance Company means the insurance company that insures one or more of the Plan's Component Programs as applicable.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medical Plan means the Plan's medical Component Program.

Open Enrollment and Open Enrollment Period means the period once a year when an eligible individual may elect to commence or change coverage under the Plan or to cease such coverage as described in Section IV. Eligibility.

Participant or Plan Participant means any Employee or Dependent who is covered under this Plan.

Participating Affiliate means any corporation, limited liability company, or other business entity that has adopted the Plan and is under common control with TEP (as determined under Code Section 414(b) or (c)); a member of an affiliated service group with TEP (as determined under Code Section 414(m)); an entity required to be aggregated with TEP pursuant to Code Section 414(o); or any other entity that TEP permits participation in the Plan. Participating Affiliates that have adopted the Plan are listed in Section XVIII. General Plan Information. Any new related entities, not identified in Section XVIII. General Plan Information, may adopt the Plan and become an Employer by signing a participation agreement that is approved by TEP. By adopting the Plan, a Participating Affiliate is also agreeing to participate in the Cafeteria Plan. TEP may revise Section XVIII. General Plan Information from time to time to reflect additional Participating Affiliates that adopt the Plan without the necessity of adopting a formal Plan amendment.

Plan means the Tucson Electric Power Benefits by Design Health Plans as described in this document.

Plan Administrator means the Committee.

Plan Sponsor means Tucson Electric Power Company.

Plan Year means the 12-month period beginning on January 1 each year and ending on the following December 31.

Special Enrollment and Special Enrollment Period means the period(s) when an eligible individual may elect to commence or change coverage under the Plan due to certain life events as described in Section IV. Eligibility.

Spouse has the meaning set forth in Section IV. Eligibility.

TEP means Tucson Electric Power Company.

Totally Disabled means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Transferred Employee means an Employee who is transferred to FortisUS Inc. and immediately prior to his or her transfer to FortisUS Inc. was employed by Tucson Electric Power Company.

UES means UniSource Energy Services, Inc., which wholly owns UNS Electric, Inc. and UNS Gas, Inc.

SECTION VIII. CLAIM PROVISIONS

Claims for benefits that are insured or administered by a third party administrator shall be filed in accordance with the specific procedures contained in the applicable Component Program documents. Such procedures will be followed unless absent or inconsistent with the requirements of ERISA, in which case the ERISA group health plan procedures specified below will be followed.

Benefits under this Plan shall be paid only if the Claims Administrator decides in its discretion that a Participant is entitled to them.

WHEN CLAIMS SHOULD BE FILED

The deadline for filing claims with the Claims Administrator depends on the type of claim (discussed below). Generally, a claim should be filed within 90 days of the date charges for the services were Incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim within the 90-day period; and
- (b) the claim is submitted within one year from the date Incurred. This one-year period will not apply when the claimant is not legally capable of submitting the claim.

Claimants may wish to submit urgent care claims and certain ongoing course of treatment claims earlier if the claimant is seeking an expedited review. Pre-service claims subject to pre-certification should be filed before receipt of the services.

Benefits are based on the Plan's provisions at the time the charges were Incurred.

CLAIMS PROCEDURE

The following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by an authorized representative of a claimant, which complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. Generally, a period of time begins at the time the claim is filed, regardless of whether all the information necessary to make a benefit determination accompanies the filing. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of claims, and each one has a specific timetable for approval, payment, request for further information, or denial of the claim. If you have any questions regarding this procedure, please contact the Claims Administrator.

The definitions and applicable timetables for the various types of claims follow.

Urgent Care Claim – Definition and Timetable

A claim involving urgent care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

A physician with knowledge of the claimant's medical condition may determine if a claim is one involving urgent care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a claim involving urgent care, the following timetable applies:

Initial benefit determination:	The claimant will be notified within 72 hours.
If the claimant fails to follow the Plan's procedure for filing a claim:	The claimant will be notified of the failure, orally or in writing, and the proper procedures within 24 hours.
If the claim is insufficient:	<p>1. The claimant will be notified of the specific insufficient information within 24 hours.</p> <p>2. The claimant must respond, orally or in writing, within 48 hours of receiving notice of the insufficient claim.</p> <p>3. Notification of the benefit determination will be provided within 48 hours of the earlier of: (i) the Plan's receipt of the claimant's response; or (ii) the end of the period afforded to the claimant to respond.</p>
Appeal of an adverse benefit determination:	<p>1. The claimant may file a written appeal within 180 days of receipt of an adverse benefit determination.</p> <p>Expedited Appeals</p> <p>The claimant may also file an oral or written request for an expedited appeal. For expedited appeals, all necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.</p> <p>2. Notification of the benefit determination will be provided within 72 hours of receipt of the appeal.</p>

Ongoing Courses of Treatment – Definition and Timetable

Ongoing courses of treatment are pre-approved services to be provided over a period of time or for a specified number of treatments. Ongoing courses of treatment claims relate to either: (1) a reduction or termination of the pre-approved period of time or number of treatments; or (2) requests to extend the pre-approved period of time or number of treatments.

In the case of a claim involving an ongoing course of treatment, the following timetable applies:

If the pre-approved period of time or number of treatments is reduced or terminated:	The claimant will be notified at a time sufficiently in advance to allow the claimant to appeal and obtain a review of such adverse benefit determination before the benefit is reduced or terminated.
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<p>If the claimant is requesting an extension of an ongoing course of treatment beyond the pre-approved period of time or number of treatments and the claim involves urgent care:</p>	<p>The claimant will be notified within 24 hours if the claim is made at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments.</p> <p>If the claim is not made at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments, the normal urgent care timetable will apply.</p>
<p>If the claimant is requesting an extension of an ongoing course of treatment beyond the pre-approved period of time or number of treatments and the claim <u>does not</u> involve urgent care:</p>	<p>The claimant will be notified according to the normal pre-service or post-service timetables, as applicable to the claim.</p>
<p>Adverse benefit determination appeals related to reduction or termination of the pre-approved period of time or number of treatments:</p>	<ol style="list-style-type: none"> 1. The claimant may file a written appeal within 30 days of receipt of an adverse benefit determination. 2. Notification of an adverse benefit determination will be provided before the reduction or termination of the benefit.
<p>Adverse benefit determination appeals related to requests to extend the pre-approved period of time or number of treatments:</p>	<ol style="list-style-type: none"> 1. The claimant may file a written appeal within 180 days of receipt of an adverse benefit determination. 2. Notification of benefit determination will be provided according to the urgent care, pre-service or post-service claim timetables, as applicable to the claim.

Pre-Service Claim

A pre-service claim means any claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, claims subject to pre-certification.

In the case of a pre-service claim, the following timetable applies:

<p>Initial benefit determination:</p>	<p>The claimant will be notified within 15 days.</p>
<p>If the claimant fails to follow the Plan's procedure for filing a claim:</p>	<p>The claimant will be notified of the failure, orally or in writing, and the proper procedures within 5 days.</p>
<p>If the claim is insufficient:</p>	<ol style="list-style-type: none"> 1. The claimant will be notified of the specific insufficient information within 15 days. 2. The claimant must respond within 45 days of receiving notice of the insufficient claim. 3. Notification of the benefit determination will be provided by the end of the 15-day benefit determination period as tolled from the date on which the insufficient information notice is sent to the claimant until the earlier of: (i) the date on which the

	claimant responds; or (ii) the end of the period afforded to the claimant to respond.
If an extension is necessary due to matters beyond the control of the Plan:	The benefit determination period may be extended up to 15 days. Before the expiration of the initial 15-day period, the claimant will be notified of: (i) the extension; (ii) the circumstances requiring the extension; and (iii) the date by which the benefit determination is expected.
Adverse benefit determination on appeal:	<ol style="list-style-type: none"> 1. The claimant may file a written appeal within 180 days of receipt of an adverse benefit determination. 2. Notification of the benefit determination will be provided within 30 days of receipt of the appeal.

Post-Service Claim

A post-service claim means any claim for a Plan benefit that is not a claim involving urgent care or a pre-service claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a post-service claim, the following timetable applies:

Initial benefit determination:	The claimant will be notified within 30 days.
If the claimant fails to follow the Plan's procedure for filing a claim:	<ol style="list-style-type: none"> 1. The claimant will be notified of the specific insufficient information within 30 days. 2. The claimant must respond within 45 days of receiving notice of the insufficient claim. 3. Notification of the benefit determination will be provided by the end of the 30-day benefit determination period as tolled from the date on which the insufficient information notice is sent to the claimant until the earlier of: (i) the date on which the claimant responds; or (ii) the end of the period afforded to the claimant to respond.
If an extension is necessary due to matters beyond the control of the Plan:	The benefit determination period may be extended up to 15 days. Before the expiration of the initial 30-day period, the claimant will be notified of: (i) the extension; (ii) the circumstances requiring the extension; and (iii) the date by which the benefit determination is expected.
Adverse benefit determination on appeal:	<ol style="list-style-type: none"> 1. The claimant may file a written appeal within 180 days of receipt of an adverse benefit determination. 2. Notification of the benefit determination will be provided within 60 days of receipt of the appeal.

Notice to Claimant of Adverse Benefit Determinations

Except with urgent care claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. Unless otherwise stated below, a notice of adverse benefit determination for both initial benefit determinations and benefit determinations on appeal will state, in a manner calculated to be understood by the claimant:

- Information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount (if applicable);
- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination was based;
- A statement advising the claimant of the right to request diagnosis and treatment codes and their corresponding meanings;
- For initial benefit determinations, a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of any applicable Plan review procedures, external review rights, the time limits applicable to such procedures, and the right to obtain information about claim procedures. This will include a statement of the claimant's right to bring a civil action under Section 502 of ERISA following an adverse benefit determination on review;
- If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request;
- If the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided at no charge upon request;
- For initial benefit determinations, if the decision is based on a Plan standard (such as a medical necessity standard), a description of that standard;
- For initial benefit determinations, in the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;
- Contact information for the DOL's Employee Benefits Security Administration and any applicable state consumer assistance program;
- For benefit determinations on appeal, 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. The term "Relevant" is defined below (see "Appeals"); and
- For benefit determinations on appeal, a statement that there may be other voluntary alternative dispute resolution options, such as mediation, and that the local U.S. Department of Labor Office and State insurance regulatory agency may be used as resources.

Appeals

When a claimant receives an adverse benefit determination, the claimant has a right to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the claim. If

the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant (as defined below) to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

For purposes of this claims procedure, a document, record, or other information shall be considered "Relevant" to a claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination and is not the subordinate of any health care professional who was involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Before issuing a final decision on appeal that is based on a rationale that was not included in the initial determination, the Plan will provide the claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the final internal adverse benefit determination to give the claimant a reasonable opportunity to respond.

Right to Request External Review

A claimant may request external review of an adverse benefit determination by filing a request for external review within 4 months after the date of receipt of a notice of a final adverse benefit determination.

Within 5 business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether the Claim is eligible for external review. Claims eligible for external review are only those that involve (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; (b) consideration of whether a plan or issuer is complying with the surprise billing and cost-sharing protections set forth in ERISA; or (c) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Furthermore, a claim is not eligible for external review if:

- the claimant is (or was) not covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the claimant was not covered under the Plan at the time the health care item or service was provided;

- the adverse benefit determination is based on the fact that the claimant was not eligible for coverage under the Plan (except where the Claim relates to a rescission of coverage);
- the claimant has not exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); or
- the claimant has not provided all the information and forms required to process an external review.

The claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the claimant to provide the additional information needed (the longer of the initial four-month period within which to request an external review or, if later, 48 hours (or such longer period specifically identified in the notice) after the receipt of the notice).

If the claim is eligible for external review, an Independent Review Organization (IRO) will be assigned to conduct the external review.

Expedited external review may be requested when:

- an adverse benefit determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the claimant's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or
- a final internal adverse benefit determination involves (a) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the claimant's life, health, or ability to regain maximum function; or (b) an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for an expedited external review, a determination will be made as to whether the request meets the requirements described above for a standard external review, the claimant will be notified of the determination, and, if the request meets the requirements, an IRO will be assigned as described above for a standard external review.

The Company, or its delegate, will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and any information considered in making the adverse benefit determination. The claimant may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the request for external review.

The IRO will review all of the information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- the claimant's medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the claimant's treating health care provider;
- the terms of the claimant's summary plan description;
- evidence-based practice guidelines;
- any applicable clinical review criteria developed and used by the Plan; and

- the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

The IRO will provide written notice of the final external review decision to the claimant and the Plan within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final external review decision of the IRO (but may initiate judicial review, as described below).

In the case of an expedited external review, the IRO will provide the notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

Right to Sue

A claimant must exhaust the Plan's internal review procedures before bringing suit in federal court. If a claimant does not timely file his or her appeals, the claimant will lose the right to sue under ERISA Section 502(a) regarding an adverse benefit determination. Upon completion of the Plan's internal review procedures, the claimant may request a judicial review of the final decision on the claim. Any action brought by, or on behalf of, a claimant for Plan benefits must be filed not later than 24 months after completion of the Plan's claims process.

Designating an Authorized Representative

An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these claims procedures. No person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives an Appointment of Authorized Representative form signed by the claimant, except that for urgent care claims the Plan shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating physician) as the claimant's authorized representative unless the claimant provides specific written direction otherwise.

Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise. Where appropriate, references in these claims procedures to claimant include the claimant's authorized representative.

An assignment for purposes of payment (e.g., to a health care professional) does not constitute appointment of an authorized representative under these claims procedures.

Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Participant or Dependent on whose behalf such payment was made.

A Participant, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Participant or other entity does not comply with the provisions of this Section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Participant, provider or other person or entity to enforce the provisions of this Section, then that Participant, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- In error;
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- With respect to an ineligible person;

- In anticipation of obtaining a recovery if a Participant fails to comply with Section XI “Third Party Recovery Provision - Subrogation and Reimbursement Provisions”; or
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Participant or by any of his covered Dependents if such payment is made with respect to the Participant or any person covered or asserting coverage as a Dependent of the Participant.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider’s misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Participant for any outstanding amount(s).

SECTION IX. COORDINATION OF BENEFITS – MEDICAL, PRESCRIPTION, AND DENTAL

Coordination of benefits sets out rules for the order of payment of covered charges when two or more Plans, including Medicare, are paying. When a Participant is covered by this Plan and another plan, or the Participant's Dependent is covered by this Plan and by another plan, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there is no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges.

Benefit Plan

This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1)** Group or group-type plans, including franchise or blanket benefit plans.
- (2)** Group practice and other group prepayment plans.
- (3)** Federal government plans or programs. This includes Medicare.
- (4)** Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (5)** No fault auto insurance, by whatever name it is called, when not prohibited by law.

Allowable / Eligible Expenses

For a charge to be allowable it must be the negotiated rate agreed upon between the Plan and the provider, or the usual and customary and reasonable charge of non-network provider and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other network only plans: this Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Participant does not use an HMO or network provider, this Plan will pay or provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the HMO plan.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage. The Plan's benefits will be excess to, whenever possible:

- (a)** any primary payer besides the Plan;
- (b)** any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (c)** any policy of insurance from any insurance company or guarantor of a third party;
- (d)** worker's compensation or other liability insurance company or
- (e)** any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Automobile Limitations

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit Plan Payment Order

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

- (1)** Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2)** Plans with a coordination provision will pay their benefits up to the allowable charge:
 - (a)** The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b)** The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c)** The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d)** When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
 - (i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e)** When a child's parents are divorced or legally separated, these rules will apply:
 - (i)** This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii)** This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii)** This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
 - (iv)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

- (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- (4) If a Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims Determination Period

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Participant will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

In accordance with the 'Recovery of Payments' provision in Section IX, whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such allowable expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the 'Recovery of Payments' provision in Section IX for more details.

Exception to Medicaid

In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Participant under the Plan.

SECTION X. THIRD PARTY RECOVERY PROVISION; RIGHT OF SUBROGATION AND REFUND

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this Section as "Plan Beneficiary") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Plan Beneficiary, his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or vent, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

As a condition to participating in and receiving benefits under the Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:

- (a)** the responsible party, its insurer, or any other source on behalf of that party;
- (b)** any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (c)** any policy of insurance from any insurance company or guarantor of a third party;
- (d)** worker's compensation or other liability insurance company; or,
- (e)** any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Beneficiary is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Beneficiary.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits shall be excess to:

- (a) the responsible party, its insurer, or any other source on behalf of that party;
- (b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (c) any policy of insurance from any insurance company or guarantor of a third party;
- (d) worker's compensation or other liability insurance company or
- (e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Beneficiary, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Beneficiary, such that the death of the Plan Beneficiary, or filing of bankruptcy by the Plan Beneficiary, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death Claims

In the event that the Plan Beneficiary dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is the Plan Beneficiary's obligation:

- (a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- (b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- (c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- (d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- (e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- (f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

Offset

Failure by the Plan Beneficiary and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under the Plan may be withheld until the Plan Beneficiary satisfies his or her obligation.

Minor Status

In the event the Plan Beneficiary is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator, or its delegate, retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights.

Severability

In the event that any language in this Section is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Section and Plan. The language shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal language had never been inserted in the Plan.

SECTION XI. CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is the Tucson Electric Power Company Employee Welfare Benefits Committee. The Plan Administrator delegates COBRA administration to its COBRA Administrator, WEX/Discovery Benefits. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator or its designee to Participants and Dependents who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries"). The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the loss of coverage, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a loss of coverage (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1)** Any individual who, on the day before loss of coverage, is covered under a Plan by virtue of being on that day either a covered Employee, the covered Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2)** Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a QMCSO. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the loss of coverage) in the absence of COBRA continuation coverage. The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
<ul style="list-style-type: none"> Your employment ends for any reason other than Your gross misconduct 	up to 18 months
<ul style="list-style-type: none"> Your hours of employment are reduced 	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "Under what circumstances can the maximum coverage period be extended?" for more information.)

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a loss of coverage occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

The Spouse of an Employee will become a Qualified Beneficiary if he or she loses coverage under the Plan because one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
<ul style="list-style-type: none"> The Employee dies 	up to 36 months
<ul style="list-style-type: none"> The Employee's hours of employment are reduced 	up to 18 months
<ul style="list-style-type: none"> The Employee's employment ends for any reason other than his or her gross misconduct 	up to 18 months
<ul style="list-style-type: none"> The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both) 	up to 36 months
<ul style="list-style-type: none"> The Employee and Spouse become divorced or legally separated 	up to 36 months

The Dependent Children of an Employee will become Qualified Beneficiaries if they lose coverage under the Plan because one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
<ul style="list-style-type: none"> The parent-Employee dies 	up to 36 months
<ul style="list-style-type: none"> The parent-Employee's employment ends for any reason other than his or her gross misconduct 	up to 18 months
<ul style="list-style-type: none"> The parent-Employee's hours of employment are 	up to 18 months
<ul style="list-style-type: none"> The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both) 	up to 36 months
<ul style="list-style-type: none"> The parents become divorced or legally separated 	up to 36 months
<ul style="list-style-type: none"> The child loses eligibility for coverage under the Plan as a Dependent 	up to 36 months

Note: A Spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

If the Qualifying Event causes the covered Employee, the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the loss of coverage, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

What factors should be considered when determining to elect COBRA continuation coverage? You may have other options available to You when You lose group health coverage. There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage. Some of these options may cost less than COBRA continuation 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 have special enrollment rights under federal law (HIPAA) 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 Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the COBRA Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the COBRA Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the COBRA Administrator) will notify the COBRA Administrator of the loss of coverage within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the Employee,
- (3) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (4) enrollment of the Employee in any part of Medicare.

IMPORTANT

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you or someone on your behalf must notify the

COBRA Administrator or its designee in writing within 60 days after the loss of coverage occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator or its designee during the 60-day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any COBRA notice that you provide must be *in writing*. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

WEX/Discovery Benefits
PO Box 2079
Omaha, NE 68103
Phone: (866) 451-3399
cobraadmin@discoverybenefits.com

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the name of the Plan(s) under which you lost or are losing coverage,
- the name and address of the Employee covered under the plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Once the COBRA Administrator or its designee receives *timely notice* that a Qualifying Event resulting in loss of coverage 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. Covered Employees may elect COBRA continuation coverage for their Spouses, and covered Employees and Spouses may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If you or your Spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the loss of coverage and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) 29 months after the date of the loss of coverage or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Qualified Beneficiary must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the loss of coverage if there is not a disability extension and 29 months after the loss of coverage if there is a disability extension.
 - (a) In the case of a covered Employee's enrollment in the Medicare program before experiencing a loss of coverage that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee

ends on the later of: 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

- (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (2) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (3) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the loss of coverage.

Under what circumstances can the maximum coverage period be expanded? While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA administrator as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA administrator. This additional coverage may be available to the Spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted children) are not eligible to

continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

COBRA COVERAGE UNDER THE HEALTH FSA COMPONENT

COBRA Coverage Is Offered Only in Limited Circumstances. COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A Qualified Beneficiary has an underspent account if the annual limit elected by the covered Employee, reduced by the

reimbursable claims submitted up to the time of the Qualifying Event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

Health FSA COBRA Coverage Lasts Only Until the End of the Plan Year. COBRA coverage will consist of the Health FSA coverage in force at the time of the Qualifying Event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the Qualifying Event). The use-or-lose rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year.

All Qualified Beneficiaries Are Covered Together Under the Health FSA Unless Otherwise Elected. Unless otherwise elected, all Qualified Beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each Qualified Beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the Company for more information.

No Health FSA Open Enrollment. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator and/or the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and HIPAA, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at (866) 444-3272.

KEEP YOUR COBRA ADMINISTRATOR AND PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SECTION XII. PLAN ADMINISTRATION

Plan Administrator

The Plan shall be administered by the Tucson Electric Power Company Employee Welfare Benefits Committee (the "Committee" or "Plan Administrator") in accordance with the Plan's terms and ERISA. For the Plan's insured Component Programs, the Committee and the Insurance Company share responsibility for administering the Plan.

The Committee may delegate to any person or entity such powers, duties and responsibilities as it deems appropriate. The Committee delegates claims administration of the Plan's the self-funded Component Programs to the applicable third party administrator identified in Section XVIII. The Committee delegates claims administration of the Plan's insured Component Programs to the applicable Insurance Company identified in Section XVIII.

Discretionary Authority

The Committee, or its delegate, and the Insurance Company (as applicable), shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan. All decisions of the Committee, or its delegate, and the Insurance Company in regard to the Plan are final and binding on all parties, except as otherwise provided by law. The Committee, or its delegate, and the Insurance Company shall administer the Plan in a uniform and nondiscriminatory manner in accordance with all applicable laws.

Legal Process

Service of legal process may be made upon the Committee.

Appointment of the Committee

The President of the Company shall appoint the members of the Committee. If a member of the Committee resigns, dies, or is otherwise removed from the Committee, the President shall appoint a new member as soon as reasonably possible.

Duties and Powers of the Committee as Plan Administrator

The Plan Administrator shall have such duties and powers as are necessary for the proper administration of the Plan, including, but not limited to, the following:

1. To establish policies, interpretations, practices, and procedures for administering the Plan.
2. To interpret the Plan, including the right to:
 - a. make determinations regarding eligibility for benefits;
 - b. decide disputes which may arise relative to a Participant's rights;
 - c. decide questions of Plan interpretation and those of facts relating to the Plan;
 - d. remedy possible ambiguities, inconsistencies or omissions; and
 - e. decide claims and appeals.
3. To obtain from the Company, Participants, and others, such information as shall be necessary for the proper administration of the Plan;
4. To retain such persons or organizations as it deems necessary or desirable to assist in the administration of the Plan;

5. To engage the Insurance Companies, actuaries and other providers to provide services in connection to the Plan;
6. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate;
7. To appoint and authorize a Claims Administrator to process and pay claims;
8. To design, obtain and provide necessary forms for enrollment in and filing claims under the Plan and as otherwise required for the proper administration of the Plan;
9. To prescribe procedures for filing a claim for benefits and to review claim denials;
10. To review certain decisions made by the Claims Administrator with respect to the appeals of denied claims under the Plan;
11. To keep and maintain the Plan documents and all other records pertaining to the Plan;
12. To perform all necessary reporting as required by ERISA, including an annual report which shall review, analyze, and summarize the operation of the Plan; and
13. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.

Organization and Operation of the Committee

The Committee shall act by a majority of its members at the time in office, and such action may be taken by a vote at a meeting or in writing without a meeting.

The Committee may authorize any one or more of its members to execute any document or documents on behalf of the Committee.

The Committee may adopt bylaws and regulations as it deems desirable for the conduct of its affairs, and may retain such accountants, actuaries, legal counsel, consultants, specialists and other persons as it deems necessary or desirable in connection with the administration of the Plan. The Committee, any member of the Committee, and any person designated by the Committee to exercise a Committee power shall be entitled to rely conclusively upon and shall be fully protected in any action taken in good faith, in relying upon any opinion or reports which shall be furnished by any such accountant, actuary, legal counsel, consultant or other specialist.

Records and Reports

The Committee shall keep a record of all its proceedings and actions. The Committee shall also keep all such books, accounts, records and other data as may be necessary for the proper administration of the Plan.

Inability to Locate Payee

If the Committee is unable to make a benefit payment under this Plan within six months after such payment is due to a Participant because it cannot locate such Participant, or in the case of a valid assignment of payment by the Participant, such individual or other entity to which the Participant has validly assigned such payment, the Committee shall direct that such amount shall be forfeited and shall be used to offset (and to such extent, reduce) subsequent contributions by the Company to the Plan and the assets of the Plan shall be relieved of the liability of such payment. If after such forfeiture, the Participant or, in the case of a valid assignment of the payment by the Participant, the individual or other entity to which the Participant has validly assigned payment, later claims such payment, such payment shall be made.

Uncashed Checks

If the Plan makes a benefit payment by check, and the check is not cashed before it expires (i.e., is void or no longer valid), such amount shall be forfeited and shall be used to offset (and to such extent, reduce) subsequent contributions by the Company to the Plan and the assets of the Plan shall be relieved of the liability of such payment. If after such forfeiture, but within one (1) year of the date the check was issued, the Participant or other payee later claims such payment, such payment shall be made.

Plan Administrator Compensation

The Plan Administrator serves without compensation. However, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. in accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

SECTION XIII. HIPAA PRIVACY AND SECURITY AMENDMENT

Introduction

TEP sponsors the Plan. To the extent required by HIPAA, the Plan is considered a “hybrid entity” as such term is defined in 45 CFR § 164.103. As such, only the self-funded health plan Component Programs of the Plan are considered health plans subject to HIPAA’s privacy rules. All references to the “Plan” in this “HIPAA Privacy and Security Amendment” Section shall refer only to the self-funded health plan Component Programs of the Plan.

Certain designated members of TEP’s workforce have access to the individually identifiable health information of Participants for administration functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI.

HIPAA and its implementing regulations restrict the Plan Sponsor’s ability to use and disclose PHI and Electronic PHI. The following HIPAA definitions of PHI and Electronic PHI apply to this Amendment:

Protected Health Information (PHI). PHI means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased. PHI does not include health information about an employee that is held in the Plan Sponsor’s employment records in its role as an employer.

Electronic Protected Health Information (Electronic PHI). Electronic PHI means PHI that is transmitted by or maintained in electronic media.

The Plan Sponsor shall have access to PHI and Electronic PHI from the Plan only as permitted under this Amendment or as otherwise required or permitted by HIPAA.

To the extent permitted by HIPAA, the Plan, the self-funded health plan Component Programs of the Tucson Electric Power Company Retiree Welfare Plan, and the Tucson Electric Power Medical Flexible Spending Account are part of one “organized health care arrangement” as such term is defined in 45 CFR §160.103. Such programs may share PHI with each other for any health care operations activities of the organized health care arrangement.

Provision of PHI to Plan Sponsor

(1) Enrollment/Disenrollment Information

Enrollment and disenrollment information created by the Plan Sponsor is not considered PHI and is not subject to paragraphs 3 and 4 of this Amendment because, when the Plan Sponsor performs enrollment functions, it does so on behalf of participants and beneficiaries rather than on behalf of the Plan. In addition, in accordance with 45 CFR §164.504(f)(1)(iii), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from health insurance or an HMO offered by the Plan, and paragraphs 3 and 4 of this Amendment do not apply to such disclosures.

(2) Permitted Uses and Disclosure of Summary Health Information

The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of: (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan. In accordance with 45 CFR §164.504(f)(1)(ii), paragraphs 3 and 4 of this Amendment do not apply to these disclosures of Summary Health Information. However, neither the Plan (nor any health insurance issuer or HMO with respect to the Plan) is permitted to disclose genetic information (as defined in 45 CFR §160.103) to the Plan Sponsor for underwriting purposes (as defined in 45 CFR §164.502(a)(5)(i)).

“Summary Health Information” means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(3) Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph 4 of this Amendment, the Plan may disclose PHI and Electronic PHI to the Plan Sponsor, provided that the Plan Sponsor is permitted to use or disclose PHI and Electronic PHI only for Plan administration purposes.

“Plan administration purposes” means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, monitoring, and Plan management (including financial and administrative oversight and HIPAA compliance). Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor (for example, long-term disability or life insurance) or any employment-related actions or decisions.

Notwithstanding any provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

(4) Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than PHI disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) disclosed to it by the Plan, the Plan Sponsor shall:

- not use or further disclose the PHI other than as permitted or required by the Plan (including this Amendment) or as required by law;
- ensure that any agent to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;
- make available all PHI necessary for the Plan to comply with an individual's right to access PHI in accordance with 45 CFR §164.524, including the right to access electronic copies of PHI, if applicable;
- make available PHI required for the Plan to comply with an individual's right to amend PHI, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;
- make available PHI required for the Plan to comply with an individual's right to request an accounting of disclosures in accordance with 45 CFR §164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- ensure that the adequate separation between Plan and Plan Sponsor (i.e., the firewall) described in paragraph 5 of this Amendment is established.

Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than Electronic PHI disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508) on behalf of the Plan, it will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that the adequate separation between the Plan and Plan Sponsor (i.e., the firewall) described in paragraph 5 of this Amendment is supported by reasonable and appropriate security measures;
- ensure that any agent to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and
- report to the Plan any security incident of which it becomes aware.

(5) Adequate Separation Between Plan and Plan Sponsor

The following workforce members may be given access to PHI:

- Human Resources;
- Legal/Corporate Compliance;
- Internal Audit;
- IT Compliance – IT Security/IS Systems Groups;
- Physical Security;
- IT Operations & Security (IT Security, IT Asset Management, IT Client Support, NATs, Systems, iOps, iApps, SGS IT);
- IT Business Applications – Support HR applications & Electronic Medical Records (PrognosisCIS);
- Employee Welfare Benefits Committee;
- Occupational Health Nurse; and
- Certain Contracted Supplemental Workers.

No other persons shall have access to PHI. These specified employees (or classes of employees) shall have access to and use of PHI only to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that a specified employee does not comply with the provisions of this Amendment, the employee shall be subject to disciplinary action by the Plan Sponsor for noncompliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

The Plan Sponsor shall ensure that the provisions of this Amendment are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

(6) Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in paragraph 4 of this Amendment.

SECTION XIV. FUNDING THE PLAN AND PAYMENT OF BENEFITS

Cost of the Plan

The Employer shares the cost of coverage under this Plan with the Participants. A Participant shall be required to contribute to the cost of coverage under the Plan for himself or herself and his or her eligible Dependents, if applicable, in accordance with rules established by the Plan Administrator.

The amount of the Participant contribution for different levels of coverage shall be determined from time to time by the Plan Administrator, in its sole discretion, and communicated to Participants. The Plan Administrator reserves the right to change the level of contributions.

Self-Funded Benefits

The benefits provided under the PPO Plan, HDHP Plan, and Self-funded Dental Plan are self-funded by the Employer. The Employer collects the premiums and pays your health care claims from its general assets. Benefits are paid directly from the Plan through the Claims Administrator.

Insured Benefits

The benefits provided under the DMO and Vision Plan are fully insured. The Employer collects the premiums and pays its portion of the premium from its general assets.

SECTION XV. MISCELLANEOUS PROVISIONS FUNDING THE PLAN AND PAYMENT OF BENEFITS

Plan is not an Employment Contract

This Plan document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan document shall not be deemed to constitute a contract for employment or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Plan document shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any employees.

Eligibility Determined by the Employer

The Employer designates which individuals are eligible to participate in the Plan. If an individual whom the Employer determined was not eligible to participate in this Plan, or another plan sponsored by the Employer, is later characterized as a common law employee, or former common law employee, of the Employer by a governmental agency or court, but not by the Employer, such individual shall be treated as an employee or former employee who has not been designated for participation in this Plan.

Eligibility and Enrollment Requirements

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing of claims or lack of coverage.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Right to Amend or Terminate the Plan

The Company, as Plan Sponsor, reserves the right to amend or terminate the Plan and any Component Programs under the Plan at any time and for any reason. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates. For this purpose, amending the Plan includes making changes to a Component Program. Terminating a Component Program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is considered to be an amendment to the Plan.

If the Plan is amended or terminated, the rights of Participants are limited to covered expenses Incurred before the amendment or termination. Notwithstanding the foregoing, any modification, alteration or amendment of the Plan may be retroactive to the effective date if necessary or appropriate for the Plan to qualify and continue to qualify under the Internal Revenue Code or to preserve the financial integrity of the Plan.

Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Applicable Law

The Plan is subject to ERISA. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Tax Consequences

Neither the Plan Sponsor nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant in connection with the Plan will be excludable from the Participant's gross income for income tax purposes, or that any other income tax treatment will apply or be available to any Participant. It shall be the obligation of each Participant to determine whether any payment in connection with the Plan is subject to income tax, and to notify the Plan Administrator if the Participant has reason to believe that any such payment may be subject to such tax.

Oral Interpretations

No oral interpretations can change this Plan.

Rebates and Other Payments

Tucson Electric Power Company, BCBSAZ, and ESI may receive rebates, refunds, discounts, or similar payments. Tucson Electric Power Company, BCBSAZ, and ESI do not pass these amounts on to you, nor are they applied to your annual deductible or taken into account in determining your coinsurance.

SECTION XVI. ERISA INFORMATION

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), 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 Health Plan Coverage

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 Plan 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 Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 Participants and beneficiaries. No one, including your Employer, your union (if any), 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 which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, 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. The court will decide who would 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.

SECTION XVII. GENERAL PLAN INFORMATION

The Plan is composed of various Component Programs that are self-funded or fully insured. The self-funded benefit programs are administered by a third party Claims Administrator. They are funded in part by the Company from its general assets and in part by Employee contributions. The fully insured benefit programs are administered by the Insurance Company. Insurance premiums are paid in part by the Company from its general assets and in part by Employee contributions.

Name of Plan:	Tucson Electric Power Company Benefits by Design Health Plans, which is a component of the Employee Group Insurance Plan
Plan Sponsor:	Tucson Electric Power Company Benefit Services P.O. Box 711 Tucson, Arizona 85702
Plan Administrator (Named Fiduciary):	Tucson Electric Power Company Employee Welfare Benefits Committee P.O. Box 711 Tucson, Arizona 85702
Plan Sponsor ID No. (EIN):	86-0062700
Source of Funding:	Self-funded (Medical, Dental) Insured (DMO, Vision)
Plan Year:	January 1 through December 31
Plan Number:	501
Plan Type:	Medical (Prescription Drug, CareHere Medical Clinic) Dental Vision
Third Party/Claims Administrator for Medical:	Blue Cross Blue Shield of Arizona P.O. Box 13466 Phoenix, AZ 85002-3466 (855) 818-0239
Third Party/Claims Administrator for Prescription Drugs:	Express Scripts Inc. P.O. Box 66587 St. Louis, MO 63166-6587 Attn: Admin Appeals Department (800) 946-3979
Third Party/Claims Administrator for Dental:	Delta Dental of Arizona P.O. Box 43000 Phoenix, Arizona 85080-3000 (602) 938-3131 (800) 352-6132
DMO Insurance Carrier/Claims Administrator:	Employer's Dental Service (EDS) 4720 N. Oracle Road Suite 100 Tucson, Arizona 85705 (520) 407-2568
Vision Insurance Carrier/Claims Administrator:	Vision Service Plan Insurance Company (VSP) 2111 E. Highland Ave. Suite B-160 Phoenix, Arizona 85016 (602) 956-1820
Adopting Employer:	Tucson Electric Power Company
Participating Affiliate(s):	UNS Electric, Inc., UNS Gas, Inc., FortisUS Inc. (solely with respect to "Transferred Employees")
Agent for Service of Process:	Tucson Electric Power Company Attn: Legal Department P.O. Box 711 Tucson, Arizona 85702 The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

SECTION XVIII. ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Tucson Electric Power Company (the “Company” or the “Plan Sponsor”) as of January 1, 2023, hereby amends and restates the Tucson Electric Power Company Benefits by Design Health Plans (the “Plan”), which was originally adopted by the Company, effective July 1, 1996.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the “Effective Date”).

Adoption of the Plan Document

This Plan Document represents both the Plan document and the summary plan description, which is required by ERISA. This Plan document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Tucson Electric Power Company

By:



Name: Todd Hixon

Title: SVP and Chief Legal Officer

Date: March 12, 2023

APPENDIX A

COMPONENT PROGRAM DOCUMENTS

The Company provides benefits under this Plan through various insurance contracts or policies as set forth below:

Self-Funded Benefits Books

1. Blue Cross Blue Shield of Arizona PPO and HDHP Active Benefit Plan Book (Effective January 1, 2022)
2. Delta Dental of Arizona Administrative Services Only Group Dental Benefits Booklet (Revised 0621)
3. Delta Dental of Arizona, Inc. Summary of Benefits – UNE, UNG, & TEP Unclassified (Effective January 1, 2021)
4. Delta Dental of Arizona, Inc. Summary of Benefits – TEP Classified (Effective January 1, 2021)
5. Express Scripts booklets, summaries, and formulary documents

Insurance Contracts and Policies

1. Employers Dental Services (EDS) Dental Enrollment and Coverage Guide
2. Vision Service Plan Insurance Company (VSP) Policy (Effective January 1, 2021)

Benefits provided under this Plan are defined in these Component Documents. The foregoing documents are incorporated by reference into this Plan document as if fully set forth herein. This Appendix A may be amended at any time at the sole discretion of the Company or a designated committee without need for formal amendment of this Plan document.

APPENDIX B

MEDICAL PLAN INFORMATION

Your employer sponsors a self-funded Employee Health Care Plan (“the Plan”) to provide its employees with health care coverage. The Plan is established by your employer and is maintained pursuant to a written document called a Plan Document.

Your employer has contracted with Blue Cross Blue Shield of Arizona (“BCBSAZ”) to provide certain administrative claims processing and utilization management services for this PPO benefit plan. Benefits under the Plan are paid from the general assets of the Plan Sponsor*.

BCBSAZ, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BCBSAZ is an independent contractor and shall not for any purpose be deemed an agent of your employer or the employer’s Plan Administrator*, nor shall BCBSAZ and your employer be deemed partners, joint venturers or governed by any legal relationship other than that of independent contractor. In this book, BCBSAZ refers to the administrative services agreement with your employer as a group master contract.

This PPO benefit plan gives you access to a network of providers that have agreed to negotiated discounts with BCBSAZ or a local Blue Cross and/or Blue Shield plan if covered services are rendered outside of Arizona.

Please note: Not all services are covered. As this is a self-funded employer health care plan, benefits provided in this PPO plan may not include all benefits required for those health care plans, which are not self-funded. Read this benefit book carefully to understand the benefits and limitations of the PPO benefit plan.

*Plan Sponsor and Plan Administrator are terms defined under the Employee Retirement Income Security Act (ERISA). These parties are often your employer, but may be another entity, e.g., a trust or association sponsoring your Plan. Your Plan Document or Summary Plan Description names these parties for you.

SCHEDULES OF BENEFITS FOR: CLASSIFIED TEP AND CLASSIFIED UEG 1116 EMPLOYEES

PPO A: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Deductible (per Calendar Year)		
Per Plan Participant	\$250	\$500
Per Family Unit	\$500	\$1,000
The Family Deductible can be met one of two ways: (1) If several family members have satisfied a portion of their individual Deductible and the aggregate amount satisfies the family Deductible then all family members are treated as meeting the Deductible requirement for the Calendar Year. (2) If two (2) members of the family have met their individual Deductible, then all family members are treated as meeting the Deductible requirement for the year.		
Network expenses for Covered Charges will apply to the non-Network Deductible and non-Network expenses for Covered Charges will apply to the Network Deductible.		
Out of Pocket Maximum (per Calendar Year, including Deductible)		
Per Plan Participant	\$1,250	\$3,500

PPO A: Classified TEP & UEG 1116 Employees			Network Providers	Non-Network Providers
Per Family Unit	\$3,000	\$7,000		
The Plan will pay the designated percentage of Covered Charges until the Out of Pocket Maximum is reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.				
Network expenses for Covered Charges will apply to the non-Network Out of Pocket and non-Network expenses for Covered Charges will apply to the Network Out of Pocket.				
The following charges do not apply toward the Out of Pocket Maximum and are never paid at 100%. <ul style="list-style-type: none"> • Cost containment penalties • Any amount in excess of the Usual and Customary and Reasonable Charge • Prescription Drug costs (see below) 				
Out of Pocket Maximum Including Medical and Prescription Copayments (per Calendar Year)				
Per Plan Participant	\$9,100	N/A		
Per Family Unit	\$18,200	N/A		
Medical and Prescription Copayments will apply to this Out of Pocket Maximum amount. Once this Out of Pocket Maximum is reached, the Copayment requirements of the Plan cease to apply.				
Covered Charges				
Hospital Services				
Intensive Care Unit	90% after Deductible	70% after Deductible		
Room and Board	90% after Deductible	70% after Deductible		
Outpatient Surgery	90% after Deductible	70% after Deductible		
(Facility)	90% after Deductible	70% after Deductible		
Emergency Room – Emergent Care				
- Facility	\$100 Copayment	\$100 Copayment		
- Physician	100% Deductible waived	100% Deductible waived		
Emergency Room – Non-Emergent Care				
- Facility	\$100 Copayment	70% after Deductible		
- Physician	100% Deductible waived	70% after Deductible		
The Emergency Room Copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.				
Urgent Care	\$35 Copayment	70% after Deductible		
Physician Services				
Inpatient Visits	90% after Deductible	70% after Deductible		
Office Visits	\$20 Copayment	70% after Deductible		
- Primary Care Physician	\$30 Copayment	70% after Deductible		
- Specialist Physician	Copay waived for primary care services	N/A		
- Health on Broadway providers				

Inpatient/Outpatient Surgery (Physician)	90% after Deductible	70% after Deductible
Dental Services requiring Medical Treatment (Physician)	90% after Deductible	70% after Deductible
PPO A: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
Other Covered Services		
Acupuncture Acupuncture services are only covered if provided by a licensed chiropractor (12 visits Calendar Year maximum)	\$30 Copayment	70% after Deductible
Allergy Serum and Injections	90% Deductible waived	70% after Deductible
Allergy Testing (In Physician's Office) - Primary Care Physician - Specialist Physician	\$20 Copayment \$30 Copayment	70% after Deductible 70% after Deductible
Ambulance Service	90% after Deductible	
Body Scans	90% after Deductible	70% after Deductible
CT, MRI, PET Scans	90% after Deductible	70% after Deductible
Diabetic Equipment & Supplies	90% after Deductible	70% after Deductible
Diabetic Self-Management Training (6 visits Lifetime maximum)	90% after Deductible	70% after Deductible
Durable Medical Equipment	90% after Deductible	70% after Deductible
Eye Exam - Primary Care Physician - Specialist Physician Eyewear (as part of required treatment of diseases of the eye such as glaucoma or cataracts, covered once every 24	\$20 Copayment \$30 Copayment 90% after Deductible	70% after Deductible 70% after Deductible 70% after Deductible
Home Health Care (60 days Calendar Year maximum)	90% after Deductible	70% after Deductible
Hospice Care (12 months inpatient & outpatient Lifetime maximum)	90% after Deductible	70% after Deductible
Infertility - Diagnostic (Includes: care, supplies and services for the diagnosis of infertility.) - Treatment	90% after Deductible Not Covered	70% after Deductible Not Covered
IV/Chemo/Radiation Therapy	90% after Deductible	70% after Deductible

Lab and Radiology In Physician's Office - Primary Care Physician	\$20 Copayment	70% after Deductible
- Specialist	\$30 Copayment	70% after Deductible
Physician In	\$20 Copayment	70% after Deductible
Freestanding Facility In	90% after Deductible \$20 Copayment	70% after Deductible 70% after Deductible
Maternity / Pregnancy	90% after Deductible	70% after Deductible
ACA Required Preventive Maternity Services	100% Deductible waived	70% after Deductible

PPO A: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
Mental Health / Substance Abuse - Office Visit	\$20 Copayment	70% after Deductible
Morbid Obesity Treatment	90% after Deductible	Not Covered
Newborn Inpatient Care (healthy newborn) (In-patient Nursery & Physician Charges)	90% Deductible waived	70% after Deductible
Occupational Therapy	90% after Deductible	70% after Deductible
Organ & Tissue Transplants - Facility Charges* - Transplant Surgeon charges*	90% after Deductible 90% after Deductible	Not Covered 70% after Deductible
<p>*In order to receive transplant benefits under the Plan you must utilize a Network or approved facility.</p> <ul style="list-style-type: none"> If a Non-Network facility is utilized, no benefits are payable under the Plan. <p>If you use a Network facility but select a Non-Network Transplant Surgeon expenses will be paid at the Non-Network level.</p>		
Orthotic Appliances	90% after Deductible	70% after Deductible
Pregnancy Termination - Abortion (Elective)	90% after Deductible	70% after Deductible
Physical Therapy	90% after Deductible	70% after Deductible
Prosthetic Devices	90% after Deductible	70% after Deductible
Respiratory Therapy	90% after Deductible	70% after Deductible
Skilled Nursing Facility (60 days Calendar Year maximum)	90% after Deductible	70% after Deductible
Speech Therapy	\$30 Copayment	70% after Deductible
Spinal Manipulation / Chiropractic (12 visits Calendar Year maximum)	\$15 Copayment	80% after Deductible
Sterilization (male only)	90% after Deductible	70% after Deductible
All Other Covered Services	90% after Deductible	70% after Deductible

Preventive Care

“Preventive Services” are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

This plan will at all times comply with the Patient Protection and Affordable Care Act (PPACA) regulations regarding certain preventive care services to be provided without cost sharing.

Routine Preventive Care	100% Deductible waived	70% after Deductible
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**Prescription Drug Benefit: PPO A
Classified TEP & UEG 1116 Employees**

Network Provider: Express Scripts

	Retail	Mail-Order	90 Day Retail Option	Specialty Pharmacy*
	30 Day Supply	90 Day Supply	90 Day Supply	30 Day Supply
Generic Medications	\$10 Copayment per Prescription	\$20 Copayment per Prescription	\$30 Copayment per Prescription	\$10 Copayment per Prescription
Formulary Brand Name Medications	\$20 Copayment per Prescription	\$40 Copayment per Prescription	\$60 Copayment per Prescription	\$20 Copayment per Prescription
Non-Formulary Brand Name Medications	\$30 Copayment per Prescription	\$60 Copayment per Prescription	\$90 Copayment per Prescription	\$30 Copayment per Prescription
Affordable Care Act (ACA) Medications (see below)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	N/A

The following are included as Affordable Care Act (ACA) Medications:

- **Aspirin** for men age 45-79 and women age 55-79
- **Oral Fluoride** for children 6 months - 5 years
- **Folic Acid** for women age 11 - 60
- **Iron** for children 6-12 months
- **Contraception** for women
- **Preventive Immunizations**

Limits apply – please contact Express Scripts for a complete list of covered medications, restrictions, and procedures.

Phone: (844) 581-4864

Website: www.express-scripts.com

***Specialty Pharmacy:** Only certain drugs are available. Contact Accredo for a list of drugs or help with any Specialty Prescription: www.accredo.com / (800) 803-2523

NOTE: Retail medications can be supplied in a 60 or 90-day quantity and will require a Copayment per each month supply that is dispensed. Contact Express Scripts for specific information. Prior authorization may also be required.

Prescription Copayments apply to the Out of Pocket Maximum for Medical and Prescription Copayments

High Dollar Limits: Any prescription that exceeds \$2999.99 (retail or mail order) or \$374.99 (compounds) will require pre-authorization (PA) by Express Scripts.

Non-participating pharmacy: Plan Participant must supply proof no Participating Pharmacy was available, pay full retail price and submit proof of purchase to ESI for reimbursement. Reimbursement is calculated based on the billed charges less any applicable Copay.

PPO B: Classified TEP & UEG 1116 Employees		
	Network Providers	Non-Network Providers
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total, which may be split between Network and Non-Network providers.		
Deductible (per Calendar Year)		
Per Plan Participant	\$800	\$1,600
Per Family Unit	\$1,600	\$3,200
The Family Deductible can be met one of two ways: (1) If several family members have satisfied a portion of their individual Deductible and the aggregate amount satisfies the family Deductible then all family members are treated as meeting the Deductible requirement for the Calendar Year. (2) If two (2) members of the family have met their individual Deductible, then all family members are treated as meeting the Deductible requirement for the year.		
Network expenses for Covered Charges will apply to the non-Network Deductible and non-Network expenses for Covered Charges will apply to the Network Deductible.		
Out of Pocket Maximum (per Calendar Year, including Deductible)		
Per Plan Participant	\$3,300	\$6,600
Per Family Unit	\$6,600	\$13,200
The Plan will pay the designated percentage of Covered Charges until the Out of Pocket Maximum is reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
Network expenses for covered charges will apply to the non-Network Out of Pocket and non-Network expenses for covered charges will apply to the Network Out of Pocket.		
The following charges do not apply toward the Out of Pocket Maximum and are never paid at 100%: <ul style="list-style-type: none"> • Cost containment penalties • Any amount in excess of the Usual and Customary and Reasonable Charge • Prescription Drug costs (see below) 		
Out of Pocket Maximum Including Medical and Prescription Copayments (per Calendar Year)		
Per Plan Participant	\$9,100	N/A
Per Family Unit	\$18,200	N/A
Medical and Prescription Copayments only will apply to this Out of Pocket Maximum amount. Once this Out of Pocket Maximum is reached, the Copayment requirements of the Plan cease to apply.		
Covered Charges		
Hospital Services		
Intensive Care Unit	70% after Deductible	50% after Deductible
Room and Board	70% after Deductible	50% after Deductible
Outpatient Surgery (Facility)	70% after Deductible	50% after Deductible
All other Outpatient services	70% after Deductible	50% after Deductible

PPO B: Classified TEP & UEG 1116 Employees		
	Network Providers	Non-Network Providers
Emergency Room – Emergent Care - Facility - Physician	\$150 Copayment 100% Deductible waived	\$150 Copayment 100% Deductible waived
Emergency Room – Non-Emergent Care - Facility - Physician	\$150 Copayment 100% Deductible waived	50% after Deductible 50% after Deductible
The Emergency Room Copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
Urgent Care	\$35 Copayment	50% after Deductible
Physician Services Inpatient Visits	70% after Deductible	50% after Deductible
Office Visits - Primary Care Physician	\$20 Copayment	50% after Deductible
- Specialist Physician	\$50 Copayment	50% after Deductible
- Health on Broadway providers	Copay waived for primary care services	N/A
Inpatient/Outpatient Surgery (Physician)	70% after Deductible	50% after Deductible
Dental Services requiring	70% after Deductible	50% after Deductible
Other Covered Services		
Acupuncture Acupuncture services are only covered if provided by a licensed chiropractor (12 visit Calendar Year maximum)	\$50 Copayment	50% after Deductible
Allergy Serum and Injections	70% Deductible waived	50% after Deductible
Allergy Testing (In Physician's Office) - Primary Care Physician	\$20 Copayment	50% after Deductible
- Specialist Physician	\$50 Copayment	50% after Deductible
Ambulance Service	70% after Deductible	
Body Scans	70% after Deductible	50% after Deductible
CT, PET, MRI Scans	70% after Deductible	50% after Deductible
Diabetic Equipment & Supplies	70% after Deductible	50% after Deductible
Diabetic Self-Management Training (6 visits Lifetime maximum)	70% after Deductible	50% after Deductible
Durable Medical Equipment	70% after Deductible	50% after Deductible

Eye Exam - Primary Care Physician - Specialist Physician Eyewear (as part of required treatment of diseases of the eye such as glaucoma or cataracts, covered once every 24	\$20 Copayment \$50 Copayment 70% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible
PPO B: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
Home Health Care (60 days Calendar Year maximum)	70% after Deductible	50% after Deductible
Hospice Care (12 months inpatient and outpatient Lifetime maximum)	70% after Deductible	50% after Deductible
Infertility - Diagnostic (Includes: care, supplies and services for the diagnosis of infertility.) - Treatment	70% after Deductible Not Covered	50% after Deductible Not Covered
IV/Chemo/Radiation Therapy	70% after Deductible	50% after Deductible
Lab and Radiology In Physician's Office - Primary Care Physician - Specialist Physician In Freestanding Facility	\$20 Copayment \$50 Copayment \$20 Copayment 70% after Deductible \$20 Copayment	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible
Maternity / Pregnancy	70% after Deductible	50% after Deductible
ACA Required Preventive Maternity Services	100% Deductible waived	50% after Deductible
24-28 weeks and for women at high risk. All other laboratory tests will be paid as any other Illness.		
Mental Health / Substance Abuse - Office Visit	\$20 Copayment	50% after Deductible
Morbid Obesity Treatment	70% after Deductible	Not Covered
Newborn Inpatient Care (healthy newborn) (In-patient Nursery & Physician	70% Deductible waived	50% after Deductible
Occupational Therapy	70% after Deductible	50% after Deductible
Organ & Tissue Transplants - Facility Charges* - Transplant Surgeon charges*	70% after Deductible 70% after Deductible	Not Covered 50% after Deductible
*In order to receive transplant benefits under the Plan you must utilize a Network or approved facility. If a Non-Network facility is utilized, no benefits are payable under the Plan. If you use a Network facility but select a Non-Network Transplant Surgeon expenses will be paid at the Non-Network level.		
Orthotic Appliances	70% after Deductible	50% after Deductible

Physical Therapy	70% after Deductible	50% after Deductible		
Pregnancy Termination - Abortion (Elective)	70% after Deductible	50% after Deductible		
Prosthetic Devices	70% after Deductible	50% after Deductible		
Respiratory Therapy	70% after Deductible	50% after Deductible		
Skilled Nursing Facility Acupuncture services are only covered if provided by a licensed chiropractor (60 days Calendar Year maximum)	70% after Deductible	50% after Deductible		
PPO B: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers		
Speech Therapy	\$50 Copayment	50% after Deductible		
Spinal Manipulation / Chiropractic	\$30 Copayment	50% after Deductible		
Sterilization (Male only)	70% after Deductible	50% after Deductible		
All Other Covered Services	70% after Deductible	50% after Deductible		
Preventive Care				
<p>“Preventive Services” are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.</p> <p>This plan will at all times comply with the Patient Protection and Affordable Care Act (PPACA) regulations regarding certain preventive care services to be provided without cost sharing.</p>				
Routine Preventive Care	100% Deductible waived	70% after Deductible		
Prescription Drug Benefit For PPO B CLASSIFIED TEP & UEG 1116 EMPLOYEES				
Network Provider: Express Scripts				
	Retail	Mail-Order	90 Day Retail Option	Specialty Pharmacy*
	30 Day Supply	90 Day Supply	90 Day Supply	30 Day Supply
Generic Medications	\$10 Copayment per Prescription	\$20 Copayment per Prescription	\$30 Copayment per Prescription	\$10 Copayment per Prescription
Formulary Brand Name Medications	\$35 Copayment per Prescription	\$70 Copayment per Prescription	\$105 Copayment per Prescription	\$35 Copayment per Prescription
Non-Formulary Brand Name Medications	\$70 Copayment per Prescription	\$140 Copayment per Prescription	\$210 Copayment per Prescription	\$70 Copayment per Prescription
Affordable Care Act (ACA) Medications (see below)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	N/A

The following are included as Affordable Care Act (ACA) Medications:

- **Aspirin** for men age 45-79 and women age 55-79
- **Oral Fluoride** for children 6 months - 5 years
- **Folic Acid** for women age 11 - 60
- **Iron** for children 6-12 months
- **Contraception** for women
- **Preventive Immunizations**

Limits apply – please contact Express Scripts for a complete list of covered medications, restrictions, and procedures.

Phone: (844) 581-4864

Website: www.express-scripts.com

***Specialty Pharmacy:** Only certain drugs are available. Contact Accredo for a list of drugs or help with any Specialty Prescription: www.Accredo.com / (800) 803-2523

NOTE: Retail medications can be supplied in a 60 or 90-day quantity and will require a Copayment per each month supply that is dispensed. Contact Express Scripts for specific information. Prior authorization may also be required.

PPO B: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
Prescription Copayments apply to the Out of Pocket Maximum for Medical and Prescription Copayments		
High Dollar Limits: Any prescription that exceeds \$2999.99 (retail or mail order) or \$374.99 (compounds) will require pre-authorization (PA) by Express Scripts.		
Non-participating pharmacy: Plan Participant must supply proof no Participating Pharmacy was available, pay full retail price and submit proof of purchase to ESI for reimbursement. Reimbursement is calculated based on the billed charges less any applicable Copay.		

High Deductible Health Plan: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
<p>Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.</p>		
<p>Deductible (per Calendar Year)</p>		
Employee Only Coverage	\$1,750	\$3,500
For Family Coverage including: Employee + Spouse, Employee + Children or Employee + Family	\$3,500	\$7,000
<p>The Family Deductible must be met as a Family Unit, without regard to which family member Incurred the expenses. The entire family Deductible must be met before any money is paid by the Plan for any Covered Charge (except for certain preventive care and preventive medications listed in the Schedule of Benefits). For Single coverage, the individual Deductible must be met before any money is paid by the Plan for any Covered Charge (except for certain preventive care and preventive medications listed in the Schedule of Benefits).</p>		
<p>Network expenses for Covered Charges will apply to the non-Network Deductible and non-Network expenses for Covered Charges will apply to the Network Deductible.</p>		
<p>Out of Pocket Maximum (per Calendar Year, including Deductible)</p>		
For Employee Only Coverage	\$3,500	\$10,500
For each Family Member under Family Coverage	\$7,000	N/A
For the entire Family under Family Coverage including: Employee + Spouse, Employee + Children or Employee + Family	\$7,000	\$21,000
<p>For Employee Only coverage, the individual Out of Pocket must be met before the Plan begins to pay at 100% (except for certain preventive care and preventive medications listed in the Schedule of Benefits). For members covered under any Family Coverage category, each Family Member has a maximum out of pocket including deductible as shown above. Once a Family Member meets the Family Member OOP the plan begins to pay 100% of Network Provider Covered Services (except for certain preventive care and preventive medications listed in the Schedule of Benefits). For the Family as a whole the Family Out of Pocket must be met as a Family Unit. When the entire family Out of Pocket is met, the Plan begins to pay at 100% (except for certain preventive care and preventive medications listed in the Schedule of Benefits).</p>		
<p>Network expenses for Covered Charges will apply to the non-Network Out of Pocket and non-Network expenses for Covered Charges will apply to the Network Out of Pocket.</p>		
<p>The Plan will pay the designated percentage of Covered Charges until the Out of Pocket Maximum is reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.</p>		
<p>The following charges do not apply toward the Out of Pocket Maximum and are never paid at 100%.</p> <ul style="list-style-type: none"> • Cost containment penalties • Any amount in excess of the Usual and Customary and Reasonable Charge 		

Covered Charges		
High Deductible Health Plan: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
Hospital Services Intensive Care Unit	80% after Deductible	50% after Deductible
Room and Board Outpatient	80% after Deductible	50% after Deductible
Surgery (Facility)	80% after Deductible	50% after Deductible
All other Outpatient services	80% after Deductible	50% after Deductible
Emergency Room – Emergent Care - Facility - Physician	80% after Deductible 80% after Deductible	80% after Deductible 80% after Deductible
Emergency Room – Non-Emergent Care - Facility - Physician	80% after Deductible 80% after Deductible	50% after Deductible 50% after Deductible
The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
Urgent Care	80% after Deductible	50% after Deductible
Physician Services		
Inpatient Visits	80% after Deductible	50% after Deductible
Office Visits	80% after Deductible	50% after Deductible
Health on Broadway providers	100% after Deductible for primary care services	N/A
Inpatient/Outpatient Surgery (Physician)		50% after Deductible
Dental Services requiring Medical Treatment (Physician)	80% after Deductible 80% after Deductible	50% after Deductible 50% after Deductible
Other Covered Services		
Acupuncture Acupuncture services are only covered if provided by a licensed chiropractor (12 visit Calendar Year maximum)	80% after Deductible	50% after Deductible
Allergy Serum and Injections	80% after Deductible	50% after Deductible
Allergy Testing In Physician's Office	80% after Deductible	50% after Deductible
Ambulance Service	80% after Deductible	
Body Scans	80% after Deductible	50% after Deductible
CT, PET, MRI Scans	80% after Deductible	50% after Deductible
Diabetic Equipment & Supplies	80% after Deductible	50% after Deductible
Diabetic Self-Management Training	80% after Deductible	50% after Deductible
Durable Medical Equipment	80% after Deductible	50% after Deductible

Eye Exam Eyewear (as part of required treatment of diseases of the eye such as glaucoma or cataracts, covered once every 24 months)	80% after Deductible 80% after Deductible	50% after Deductible 50% after Deductible
High Deductible Health Plan: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
Home Health Care (60 days Calendar Year maximum)	80% after Deductible	50% after Deductible
Hospice Care (12 months inpatient and outpatient Lifetime maximum)	80% after Deductible	50% after Deductible
Infertility - Diagnostic (Includes: care, supplies and services for the diagnosis of infertility.) - Treatment	80% after Deductible Not Covered	50% after Deductible Not Covered
IV/Chemo/Radiation Therapy	80% after Deductible	50% after Deductible
Lab and Radiology In Physician's Office - Primary Care Physician - Specialist Physician In Freestanding Facility In a Hospital - Diagnostic Mammogram	80% after Deductible 80% after Deductible 80% after Deductible 80% after Deductible 80% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible
Maternity / Pregnancy	80% after Deductible	50% after Deductible
ACA Required Preventive Maternity Services	100% Deductible waived	50% after Deductible
Mental Health / Substance Abuse	80% after Deductible	50% after Deductible
Morbid Obesity Treatment	80% after Deductible	Not Covered
Newborn Inpatient Care (healthy newborn) (In-patient Nursery & Physician Charges)	80% after Deductible	50% after Deductible
Occupational Therapy	80% after Deductible	50% after Deductible
Organ & Tissue Transplants - Facility Charges* - Transplant Surgeon charges*	80% after Deductible 80% after Deductible	Not Covered 50% after Deductible
*In order to receive transplant benefits under the Plan you must utilize a Network or approved facility. If a Non-Network facility is utilized, no benefits are payable under the Plan. If you use a Network facility but select a Non-Network Transplant Surgeon expenses will be paid at the Non-Network level for those services provided by Non-network providers.		
Orthotic Appliances	80% after Deductible	50% after Deductible
Physical Therapy	80% after Deductible	50% after Deductible
Pregnancy Termination - Abortion (Elective)	80% after Deductible	50% after Deductible
Prosthetic Devices	80% after Deductible	50% after Deductible

Respiratory Therapy	80% after Deductible	50% after Deductible
Skilled Nursing Facility (60 days Calendar Year maximum)	80% after Deductible	50% after Deductible
Speech Therapy	80% after Deductible	50% after Deductible

High Deductible Health Plan: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
Spinal Manipulation / Chiropractic (12 visit Calendar Year maximum)	80% after Deductible	50% after Deductible
Sterilization (Male only)	80% after Deductible	50% after Deductible
All Other Covered Services	80% after Deductible	50% after Deductible

Preventive Care		
<p>“Preventive Services” are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.</p> <p>This plan will at all times comply with the Patient Protection and Affordable Care Act (PPACA) regulations regarding certain preventive care services to be provided without cost sharing.</p>		
Routine Preventive Care	100% Deductible waived	70% after Deductible

Prescription Drug Benefit: High Deductible Health Plan Classified TEP & UEG 1116 Employees

Network Provider: Express Scripts

	Retail	Mail-Order	90 Day Retail Option	Specialty Pharmacy*
	30 Day Supply	90 Day Supply	90 Day Supply	30 Day Supply
Generic Medications	80% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible
Formulary Brand Name Medications	80% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible
Non-Formulary Brand Name Medications	80% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible
Preventive Care Formulary Medications**	100% Deductible waived	100% Deductible waived	100% Deductible waived	Not Available
Affordable Care Act (ACA) Medications (see below)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	N/A

The following are included as Affordable Care Act (ACA) Medications:

- **Aspirin** for men age 45-79 and women age 55-79
- **Oral Fluoride** for children 6 months - 5 years
- **Folic Acid** for women age 11 - 60
- **Iron** for children 6-12 months
- **Contraception** for women
- **Preventive Immunizations**

Limits apply – please contact Express Scripts for a complete list of covered medications, restrictions, and procedures.

Phone: (844) 581-4864 Website: www.express-scripts.com		
*Specialty Pharmacy: Only certain drugs are available. Contact Accredo for a list of drugs or help with any Specialty Prescription: www.Accredo.com / (800) 803-2523		
NOTE: Retail medications can be supplied in a 60 or 90-day quantity and will require a Copayment per each month supply that is dispensed. Contact Express Scripts for specific information. Prior authorization may also be required.		
Prescription copayments apply to the Medical Deductible and Out of Pocket Maximums.		
High Deductible Health Plan: Classified TEP & UEG 1116 Employees	Network Providers	Non-Network Providers
**See UNS Energy Preventive Drug List for complete list of Preventive Care Medications.		
High Dollar Limits: Any prescription that exceeds \$2999.99 (retail or mail order) or \$374.99 (compounds) will require pre-authorization (PA) by Express Scripts.		
Non-participating pharmacy: Plan Participant must supply proof no Participating Pharmacy was available, pay full retail price and submit proof of purchase to ESI for reimbursement. Reimbursement is calculated based on the billed charges less any applicable Copay.		

SCHEDULES OF BENEFITS FOR: ALL UNCLASSIFIED TEP, FORTISUS INC., AND UEE/UEG EMPLOYEES, CLASSIFIED 769 AND 387 EMPLOYEES

PPO A: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Deductible (per Calendar Year)		
Per Plan Participant	\$400	\$800
Per Family Unit	\$800	\$1,600
The Family Deductible can be met one of two ways: (1) If several family members have satisfied a portion of their individual Deductible and the aggregate amount satisfies the family Deductible then all family members are treated as meeting the Deductible requirement for the Calendar Year. (2) If two (2) members of the family have met their individual Deductible, then all family members are treated as meeting the Deductible requirement for the year.		
Network expenses for Covered Charges will apply to the non-Network Deductible and non-Network expenses for Covered Charges will apply to the Network Deductible.		
Out of Pocket Maximum (per Calendar Year, including Deductible)		
Per Plan Participant	\$1,900	\$3,800
Per Family Unit	\$3,800	\$7,600
The Plan will pay the designated percentage of Covered Charges until the Out of Pocket Maximum is reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
Network expenses for covered charges will apply to the non-Network Out of Pocket and non-Network expenses for covered charges will apply to the Network Out of Pocket.		

<p>The following charges do not apply toward the Out of Pocket Maximum and are never paid at 100%.</p> <ul style="list-style-type: none"> • Cost containment penalties • Any amount in excess of the Usual and Customary and Reasonable Charge • Prescription Drug costs (see below) 		
Out of Pocket Maximum Including Medical and Prescription Copayments (per Calendar Year)		
Per Plan Participant	\$9,100	N/A
Per Family Unit	\$18,200	N/A
<p>Medical and Prescription Copayments will apply to this Out of Pocket Maximum amount. Once this Out of Pocket Maximum is reached, the Copayment requirements of the Plan cease to apply.</p>		
Covered Charges		
PPO A: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
Hospital Services		
Intensive Care Unit	85% after Deductible	60% after Deductible
Room and Board	85% after Deductible	60% after Deductible
Outpatient Surgery (Facility)	85% after Deductible	60% after Deductible
All other Outpatient services	85% after Deductible	60% after Deductible
Emergency Room – Emergent Care		
- Facility	\$150 Copayment	\$150 Copayment
- Physician	100% Deductible waived	100% Deductible waived
Emergency Room – Non-Emergent Care		
- Facility	\$150 Copayment	60% after Deductible
- Physician	100% Deductible waived	60% after Deductible
<p>The Emergency Room Copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.</p>		
Urgent Care	\$35 Copayment	60% after Deductible
Physician Services		
Inpatient Visits	85% after Deductible	60% after Deductible
Office Visits		
- Primary Care Physician	\$20 Copayment	60% after Deductible
- Specialist Physician	\$50 Copayment	60% after Deductible
- Health on Broadway providers	Copay waived for primary care services	N/A
Inpatient/Outpatient Surgery (Physician)	85% after Deductible	60% after Deductible
Dental Services requiring Medical Treatment (Physician)	85% after Deductible	60% after Deductible
Other Covered Services		
Acupuncture		
Acupuncture services are only covered if provided by a licensed chiropractor (12 visits Calendar Year maximum)	\$50 Copayment	60% after Deductible
Allergy Serum and Injections	85% Deductible waived	60% after Deductible

Allergy Testing (In Physician's Office) - Primary Care Physician	\$20 Copayment	60% after Deductible
- Specialist Physician	\$50 Copayment	60% after Deductible
Ambulance Service	85% after Deductible	
Body Scans	85% after Deductible	60% after Deductible
CT, MRI, PET Scans	85% after Deductible	60% after Deductible
Diabetic Equipment & Supplies	85% after Deductible	60% after Deductible
Diabetic Self-Management Training (6 visits Lifetime maximum)	85% after Deductible	60% after Deductible
Durable Medical Equipment	85% after Deductible	60% after Deductible

PPO A: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
Eye Exam - Primary Care Physician - Specialist Physician	\$20 Copayment \$50 Copayment	60% after Deductible 60% after Deductible
Eyewear (as part of required treatment of diseases of the eye such as glaucoma or cataracts, covered once every 24 months)	85% after Deductible	60% after Deductible
Home Health Care (60 days Calendar Year maximum)	85% after Deductible	60% after Deductible
Hospice Care (12 months inpatient and outpatient Lifetime maximum)	85% after Deductible	60% after Deductible
Infertility - Diagnostic (Includes: care, supplies and services for the diagnosis of infertility.) - Treatment	85% after Deductible Not Covered	60% after Deductible Not Covered
IV/Chemo/Radiation Therapy	85% after Deductible	60% after Deductible
Lab and Radiology In Physician's Office - Primary Care Physician - Specialist Physician In Freestanding Facility In a Hospital - Diagnostic Mammogram	\$20 Copayment \$50 Copayment \$20 Copayment 85% after Deductible \$20 Copayment	60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible
Maternity / Pregnancy	85% after Deductible	60% after Deductible
ACA Required Preventive Maternity Services	100% Deductible waived	60% after Deductible
Mental Health / Substance Abuse - Office Visit	\$20 Copayment	60% after Deductible
Morbid Obesity Treatment	85% after Deductible	Not Covered

Newborn Inpatient Care (healthy newborn) (In-patient Nursery & Physician Charges)	85% Deductible waived	60% after Deductible
Occupational Therapy	85% after Deductible	60% after Deductible
Organ & Tissue Transplants - Facility Charges* - Transplant Surgeon charges*	85% after Deductible 85% after Deductible	Not Covered 60% after Deductible
*In order to receive transplant benefits under the Plan you must utilize a Network or approved facility. If a Non-Network facility is utilized, no benefits are payable under the Plan. If you use a Network facility but select a Non-Network Transplant Surgeon expenses will be paid at the Non-Network level.		
Orthotic Appliances	85% after Deductible	60% after Deductible
Physical Therapy	85% after Deductible	60% after Deductible
Pregnancy Termination - Abortion (Elective)	85% after Deductible	60% after Deductible
Prosthetic Devices	85% after Deductible	60% after Deductible
Respiratory Therapy	85% after Deductible	60% after Deductible

PPO A: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
Skilled Nursing Facility (60 days Calendar Year maximum)	85% after Deductible	60% after Deductible
Speech Therapy	\$50 Copayment	60% after Deductible
Spinal Manipulation / Chiropractic (12 visits Calendar Year maximum)	\$50 Copayment	60% after Deductible
Sterilization (Male only)	85% after Deductible	60% after Deductible
All Other Covered Services	85% after Deductible	60% after Deductible

Preventive Care				
<p>“Preventive Services” are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.</p> <p>This plan will at all times comply with the Patient Protection and Affordable Care Act (PPACA) regulations regarding certain preventive care services to be provided without cost sharing.</p>				
Routine Preventive Care		100% Deductible waived	70% after Deductible	
Prescription Drug Benefit: PPO A Unclassified TEP/FORTISUS INC./UEE/UEG Employees Classified 769 & 387 Employees				
Network Provider: Express Scripts				
	Retail	Mail-Order	90 Day Retail Option	Specialty Pharmacy*
	30 Day Supply	90 Day Supply	90 Day Supply	30 Day Supply
Generic Medications	\$10 Copayment per Prescription	\$20 Copayment per Prescription	\$30 Copayment per Prescription	\$10 Copayment per Prescription
Formulary Brand Name Medications	20% Copayment; \$30 minimum, \$50 maximum	20% Copayment; \$60 minimum, \$100 maximum	20% Copayment; \$90 minimum, \$150 maximum	20% Copayment; \$30 minimum, \$50 maximum
Non-Formulary Brand Name Medications	30% Copayment; \$60 minimum, \$100 maximum	30% Copayment; \$120 minimum, \$200 maximum	30% Copayment; \$180 minimum, \$300 maximum	30% Copayment; \$60 minimum, \$100 maximum
Affordable Care Act (ACA) Medications (see below)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	N/A
<p>The following are included as Affordable Care Act (ACA) Medications:</p> <ul style="list-style-type: none"> • Aspirin for men age 45-79 and women age 55-79 • Oral Fluoride for children 6 months - 5 years • Folic Acid for women age 11 - 60 • Iron for children 6-12 months • Contraception for women • Preventive Immunizations <p>Limits apply – please contact Express Scripts for a complete list of covered medications, restrictions, and procedures.</p>				
Phone: (844) 581-4864 Website: www.express-scripts.com				
<p>*Specialty Pharmacy: Only certain drugs are available. Contact Accredo for a list of drugs or help with any Specialty Prescription: www.Accredo.com / (800) 803-2523</p>				
<p>NOTE: Retail medications can be supplied in a 60 or 90-day quantity and will require a Copayment per each month supply that is dispensed. Contact Express Scripts for specific information. Prior authorization may also be required.</p>				
Prescription Copayments apply to the Out of Pocket Maximum for Medical and Prescription Copayments				
<p>High Dollar Limits: Any prescription that exceeds \$2999.99 (retail or mail order) or \$374.99 (compounds) will require pre-authorization (PA) by Express Scripts.</p>				
<p>Non-participating pharmacy: Plan Participant must supply proof no Participating Pharmacy was available, pay full retail price and submit proof of purchase to ESI for reimbursement. Reimbursement is calculated based on the billed charges less any applicable Copay.</p>				

PPO B: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
<p>Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.</p>		
Deductible (per Calendar Year)		
Per Plan Participant	\$800	\$1,600
Per Family Unit	\$1,600	\$3,200
<p>The Family Deductible can be met one of two ways:</p> <p>(1) If several family members have satisfied a portion of their individual Deductible and the aggregate amount satisfies the family Deductible then all family members are treated as meeting the Deductible requirement for the Calendar Year.</p> <p>(2) If two (2) members of the family have met their individual Deductible, then all family members are treated as meeting the Deductible requirement for the year.</p>		
<p>Network expenses for Covered Charges will apply to the non-Network Deductible and non-Network expenses for Covered Charges will apply to the Network Deductible.</p>		
Out of Pocket Maximum (per Calendar Year, including Deductible)		
Per Plan Participant	\$3,300	\$6,600
Per Family Unit	\$6,600	\$13,200
<p>The Plan will pay the designated percentage of Covered Charges until the Out of Pocket Maximum is reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.</p>		
<p>Network expenses for covered charges will apply to the non-Network Out of Pocket and non-Network expenses for covered charges will apply to the Network Out of Pocket.</p>		
<p>The following charges do not apply toward the Out of Pocket Maximum and are never paid at 100%:</p> <ul style="list-style-type: none"> • Cost containment penalties • Any amount in excess of the Usual and Customary and Reasonable Charge • Prescription Drug costs (see below) 		
Out of Pocket Maximum Including Medical and Prescription Copayments (per Calendar Year)		
Per Plan Participant	\$9,100	N/A
Per Family Unit	\$18,200	N/A
<p>Medical and Prescription Copayments will apply to this Out of Pocket Maximum amount. Once this Out of Pocket Maximum is reached, the Copayment requirements of the Plan cease to apply.</p>		
Covered Charges		
Hospital Services		
Intensive Care Unit	70% after Deductible	50% after Deductible
Room and Board	70% after Deductible	50% after Deductible
Outpatient Surgery (Facility)	70% after Deductible	50% after Deductible
All other Outpatient services	70% after Deductible	50% after Deductible

PPO B: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
Emergency Room – Emergent Care - Facility - Physician	\$150 Copayment 100% Deductible waived	\$150 Copayment 100% Deductible waived
Emergency Room – Non-Emergent Care - Facility - Physician	\$150 Copayment 100% Deductible waived	50% after Deductible 50% after Deductible
The Emergency Room Copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
Urgent Care	\$35 Copayment	50% after Deductible
Physician Services Inpatient Visits Office Visits - Primary Care Physician - Specialist Physician - Health on Broadway providers Inpatient/Outpatient Surgery (Physician) Dental Services requiring Medical Treatment (Physician)	70% after Deductible \$20 Copayment \$50 Copayment Copay waived for primary care services 70% after Deductible 70% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible N/A 50% after Deductible 50% after Deductible
Other Covered Services		
Acupuncture Acupuncture services are only covered if provided by a licensed chiropractor (12 visit Calendar Year maximum)	\$50 Copayment	50% after Deductible
Allergy Serum and Injections	70% Deductible waived	50% after Deductible
Allergy Testing (In Physician's Office) - Primary Care Physician - Specialist Physician	\$20 Copayment \$50 Copayment	50% after Deductible 50% after Deductible
Ambulance Service	70% after Deductible	
Body Scans	70% after Deductible	50% after Deductible
CT, PET, MRI Scans	70% after Deductible	50% after Deductible
Diabetic Equipment & Supplies	70% after Deductible	50% after Deductible
Diabetic Self-Management Training (6 visits Lifetime maximum)	70% after Deductible	50% after Deductible
Durable Medical Equipment	70% after Deductible	50% after Deductible

PPO B: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
Eye Exam - Primary Care Physician - Specialist Physician Eyewear (as part of required treatment of diseases of the eye such as glaucoma or cataracts, covered once every 24 months)	\$20 Copayment \$50 Copayment 70% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible
Home Health Care (60 days Calendar Year maximum)	70% after Deductible	50% after Deductible
Hospice Care (12 months inpatient and outpatient Lifetime maximum)	70% after Deductible	50% after Deductible
Infertility - Diagnostic (Includes: care, supplies and services for the diagnosis of infertility.) - Treatment	70% after Deductible Not Covered	50% after Deductible Not Covered
IV/Chemo/Radiation Therapy	70% after Deductible	50% after Deductible
Lab and Radiology In Physician's Office - Primary Care Physician - Specialist Physician In Freestanding Facility In a Hospital - Diagnostic Mammogram	\$20 Copayment \$50 Copayment \$20 Copayment 70% after Deductible \$20 Copayment	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible
Maternity / Pregnancy	70% after Deductible	50% after Deductible
ACA Required Preventive Maternity Services	100% Deductible waived	50% after Deductible
Mental Health / Substance Abuse - Office Visit	\$20 Copayment	50% after Deductible
Morbid Obesity Treatment	70% after Deductible	Not Covered
Newborn Inpatient Care (healthy newborn) (In-patient Nursery & Physician Charges)	70% Deductible waived	50% after Deductible
Occupational Therapy	70% after Deductible	50% after Deductible
Organ & Tissue Transplants - Facility Charges* - Transplant Surgeon charges*	70% after Deductible 70% after Deductible	Not Covered 50% after Deductible
<p>*In order to receive transplant benefits under the Plan you must utilize a Network or approved facility.</p> <ul style="list-style-type: none"> If a Non-Network facility is utilized, no benefits are payable under the Plan. <p>If you use a Network facility but select a Non-Network Transplant Surgeon expenses will be paid at the Non-Network level.</p>		

Orthotic Appliances	70% after Deductible	50% after Deductible		
Physical Therapy	70% after Deductible	50% after Deductible		
PPO B: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers		
Pregnancy Termination - Abortion (Elective)	70% after Deductible	50% after Deductible		
Prosthetic Devices	70% after Deductible	50% after Deductible		
Respiratory Therapy	70% after Deductible	50% after Deductible		
Skilled Nursing Facility (60 days Calendar Year maximum)	70% after Deductible	50% after Deductible		
Speech Therapy	\$50 Copayment	50% after Deductible		
Spinal Manipulation / Chiropractic (12 visit Calendar Year maximum)	\$50 Copayment	50% after Deductible		
Sterilization (Male only)	70% after Deductible	50% after Deductible		
All Other Covered Services	70% after Deductible	50% after Deductible		
Preventive Care				
<p>“Preventive Services” are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.</p> <p>This plan will at all times comply with the Patient Protection and Affordable Care Act (PPACA) regulations regarding certain preventive care services to be provided without cost sharing.</p>				
Routine Preventive Care	100% Deductible waived	70% after Deductible		
Prescription Drug Benefit: PPO B Unclassified TEP/FORTISUS INC./UEE/UEG Employees Classified 769 & 387 Employees				
Network Provider: Express Scripts				
	Retail	Mail-Order	90 Day Retail Option	Specialty Pharmacy*
	30 Day Supply	90 Day Supply	90 Day Supply	30 Day Supply
Generic Medications	\$10 Copayment per Prescription	\$20 Copayment per Prescription	\$30 Copayment per Prescription	\$10 Copayment per Prescription
Formulary Brand Name Medications	20% Copayment; \$30 minimum, \$50 maximum	20% Copayment; \$60 minimum, \$100 maximum	20% Copayment; \$90 minimum, \$150 maximum	20% Copayment; \$30 minimum, \$50 maximum
Non-Formulary Brand Name Medications	30% Copayment; \$60 minimum, \$100 maximum	30% Copayment; \$120 minimum, \$200 maximum	30% Copayment; \$180 minimum, \$300 maximum	30% Copayment; \$60 minimum, \$100 maximum
Affordable Care Act (ACA) Medications (see below)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	Covered 100% (Prescription required)	N/A

The following are included as Affordable Care Act (ACA) Medications:

- **Aspirin** for men age 45-79 and women age 55-79
- **Oral Fluoride** for children 6 months - 5 years
- **Folic Acid** for women age 11 - 60
- **Iron** for children 6-12 months
- **Contraception** for women
- **Preventive Immunizations**

Limits apply – please contact Express Scripts for a complete list of covered medications, restrictions, and procedures.

PPO B: Unclassified and Classified 769 & 387 Employees

Network Providers

Non-Network Providers

Phone: (844) 581-4864

Website: www.express-scripts.com

***Specialty Pharmacy:** Only certain drugs are available. Contact Accredo for a list of drugs or help with any Specialty Prescription: www.Accredo.com / (800) 803-2523

NOTE: Retail medications can be supplied in a 60 or 90-day quantity and will require a Copayment per each month supply that is dispensed. Contact Express Scripts for specific information. Prior authorization may also be required.

Prescription Copayments apply to the Out of Pocket Maximum for Medical and Prescription Copayments

High Dollar Limits: Any prescription that exceeds \$2999.99 (retail or mail order) or \$374.99 (compounds) will require pre-authorization (PA) by Express Scripts.

Non-participating pharmacy: Plan Participant must supply proof no Participating Pharmacy was available, pay full retail price and submit proof of purchase to ESI for reimbursement. Reimbursement is calculated based on the billed charges less any applicable Copay.

High Deductible Health Plan: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
<p>Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.</p>		
<p>Deductible (per Calendar Year)</p>		
For Employee Only Coverage	\$1,750	\$3,500
For Family Coverage including: Employee + Spouse, Employee + Children or Employee + Family	\$3,500	\$7,000
<p>The Family Deductible must be met as a Family Unit, without regard to which family member incurred the expenses. The entire family Deductible must be met before any money is paid by the Plan for any Covered Charge (except for certain preventive care and preventive medications listed in the Schedule of Benefits). For Single coverage, the individual Deductible must be met before any money is paid by the Plan for any Covered Charge (except for certain preventive care and preventive medications listed in the Schedule of Benefits).</p>		
<p>Network expenses for Covered Charges will apply to the non-Network Deductible and non-Network expenses for Covered Charges will apply to the Network Deductible.</p>		
<p>Out of Pocket Maximum (per Calendar Year, including Deductible)</p>		
For Employee Only Coverage	\$3,500	\$10,500
For each Family Member under Family Coverage	\$7,000	N/A
For the entire Family under Family Coverage including: Employee + Spouse, Employee + Children or Employee + Family	\$7,000	\$21,000
<p>For Employee Only coverage, the individual Out of Pocket must be met before the Plan begins to pay at 100% (except for certain preventive care and preventive medications listed in the Schedule of Benefits). For members covered under any Family Coverage category, each Family Member has a maximum out of pocket including deductible as shown above. Once a Family Member meets the Family Member OOP the plan begins to pay 100% (except for certain preventive care and preventive medications listed in the Schedule of Benefits). For the Family as a whole the Family Out of Pocket must be met as a Family Unit. When the entire family Out of Pocket is met, the Plan begins to pay at 100% (except for certain preventive care and preventive medications listed in the Schedule of Benefits).</p>		
<p>The Plan will pay the designated percentage of Covered Charges until Out of Pocket Maximum is reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.</p>		
<p>Network expenses for Covered Charges will apply to the non-Network Out of Pocket and non-Network expenses for Covered Charges will apply to the Network Out of Pocket.</p>		
<p>The following charges do not apply toward the Out of Pocket Maximum and are never paid at 100%:</p> <ul style="list-style-type: none"> • Cost containment penalties • Any amount in excess of the Usual and Customary and Reasonable Charge 		

Covered Charges		
Hospital Services		
Intensive Care Unit	80% after Deductible	50% after Deductible
Room and Board	80% after Deductible	50% after Deductible
Outpatient Surgery (Facility)	80% after Deductible	50% after Deductible
All other Outpatient services	80% after Deductible	50% after Deductible
High Deductible Health Plan: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
Emergency Room – Emergent Care - Facility - Physician	80% after Deductible 80% after Deductible	80% after Deductible 80% after Deductible
Emergency Room – Non-Emergent Care - Facility - Physician	80% after Deductible 80% after Deductible	50% after Deductible 50% after Deductible
The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
Urgent Care	80% after Deductible	50% after Deductible
Physician Services		
- Inpatient Visits	80% after Deductible	50% after Deductible
-Office Visits	80% after Deductible	50% after Deductible
-HHealth on Broadway providers	100% after Deductible for primary care services	N/A
Inpatient/Outpatient Surgery (Physician)	80% after Deductible	50% after Deductible
Dental Services requiring Medical Treatment (Physician)	80% after Deductible	50% after Deductible
Other Covered Services		
Acupuncture Acupuncture services are only covered if provided by a licensed chiropractor (12 visit Calendar Year maximum)	80% after Deductible	50% after Deductible
Allergy Serum and Injections	80% after Deductible	50% after Deductible
Allergy Testing In Physician's Office	80% after Deductible	50% after Deductible
Ambulance Service	80% after Deductible	
Body Scans	80% after Deductible	50% after Deductible
CT, PET, MRI Scans	80% after Deductible	50% after Deductible
Diabetic Equipment & Supplies	80% after Deductible	50% after Deductible
Diabetic Self-Management Training	80% after Deductible	50% after Deductible
Durable Medical Equipment	80% after Deductible	50% after Deductible

Eye Exam	80% after Deductible	50% after Deductible
Eyewear (as part of required treatment of diseases of the eye such as glaucoma or cataracts, covered once every 24 months)	80% after Deductible	50% after Deductible
Home Health Care (60 days Calendar Year maximum)	80% after Deductible	50% after Deductible
Hospice Care (12 months inpatient and outpatient Lifetime Maximum)	80% after Deductible	50% after Deductible

High Deductible Health Plan: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
Infertility - Diagnostic (Includes: care, supplies and services for the diagnosis of infertility.) - Treatment	80% after Deductible Not Covered	50% after Deductible Not Covered
IV/Chemo/Radiation Therapy	80% after Deductible	50% after Deductible
Lab and Radiology In Physician's Office - Primary Care Physician - Specialist Physician In Freestanding Facility In a Hospital - Diagnostic Mammogram	80% after Deductible 80% after Deductible 80% after Deductible 80% after Deductible 80% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible
Maternity / Pregnancy	80% after Deductible	50% after Deductible
ACA Required Preventive Maternity Services	100% Deductible waived	50% after Deductible
Mental Health / Substance Abuse	80% after Deductible	50% after Deductible
Morbid Obesity Treatment	80% after Deductible	Not Covered
Newborn Inpatient Care (healthy newborn) (Inpatient Nursery & Physician Charges)	80% after Deductible	50% after Deductible
Occupational Therapy	80% after Deductible	50% after Deductible
Organ & Tissue Transplants - Facility Charges* - Transplant Surgeon charges*	80% after Deductible 80% after Deductible	Not Covered 50% after Deductible
<p>*In order to receive transplant benefits under the Plan you must utilize a Network or approved facility.</p> <ul style="list-style-type: none"> If a Non-Network facility is utilized, no benefits are payable under the Plan. <p>If you use a Network facility but select a Non-Network Transplant Surgeon expenses will be paid at the Non-Network level for those services provided by Non-network providers.</p>		
Orthotic Appliances	80% after Deductible	50% after Deductible
Physical Therapy	80% after Deductible	50% after Deductible
Pregnancy Termination - Abortion (Elective)	80% after Deductible	50% after Deductible
Prosthetic Devices	80% after Deductible	50% after Deductible
Respiratory Therapy	80% after Deductible	50% after Deductible
Skilled Nursing Facility (Based on the facility's semiprivate room rate 60 days Calendar Year maximum)	80% after Deductible	50% after Deductible
Speech Therapy	80% after Deductible	50% after Deductible
Spinal Manipulation / Chiropractic (12 visit Calendar Year maximum)	80% after Deductible	50% after Deductible

Sterilization (Male only)	80% after Deductible	50% after Deductible
All Other Covered Services	80% after Deductible	50% after Deductible

High Deductible Health Plan: Unclassified and Classified 769 & 387 Employees	Network Providers	Non-Network Providers
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Preventive Care

“Preventive Services” are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

This plan will at all times comply with the Patient Protection and Affordable Care Act (PPACA) regulations regarding certain preventive care services to be provided without cost sharing.

Routine Preventive Care	100% Deductible waived	70% after Deductible
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**Prescription Drug Benefit: High Deductible Health Plan
Unclassified TEP/FORTISUS INC./UEE/UEG Employees
Classified 769 & 387 Employees**

**Network Provider:
Express Scripts**

	Retail	Mail-Order	90 Day Retail Option	Specialty Pharmacy*
	30 Day Supply	90 Day Supply	90 Day Supply	30 Day Supply
Generic Medications	80% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible
Formulary Brand Name Medications	80% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible
Non-Formulary Brand Name Medications	80% after Deductible	80% after Deductible	80% after Deductible	80% after Deductible
Preventive Care Medications	80% Deductible waived	80% Deductible waived	80% Deductible waived	Not Available
Affordable Care Act (ACA) Medications (see below)	Covered 100% (prescription required)	Covered 100% (prescription required)	Covered 100% (prescription required)	N/A

The following are included as Affordable Care Act (ACA) Medications:

- **Aspirin** for men age 45-79 and women age 55-79
- **Oral Fluoride** for children 6 months - 5 years
- **Folic Acid** for women age 11 - 60
- **Iron** for children 6-12 months
- **Contraception** for women
- **Preventive Immunizations**

Limits apply – please contact Express Scripts for a complete list of covered medications, restrictions, and procedures.

Phone: (844) 581-4864
Website: www.express-scripts.com

***Specialty Pharmacy:** Only certain drugs are available. Contact Accredo for a list of drugs or help with any Specialty Prescription: www.Accredo.com / (800) 803-2523

NOTE: Retail medications can be supplied in a 60 or 90-day quantity and will require a Copayment per each month supply that is dispensed. Contact Express Scripts for specific information. Prior authorization may also be required.

Prescription copayments apply to the Medical Deductible and Out of Pocket Maximums.

See UNS Energy Preventive Drug List for the complete list of Preventive Care Medications.

High Dollar Limits: Any prescription that exceeds \$2999.99 (retail or mail order) or \$374.99 (compounds) will require pre-authorization (PA) by Express Scripts.

High Deductible Health Plan: Unclassified and Classified 769 & 387 Employees

Network Providers

Non-Network Providers

Non-participating pharmacy: Plan Participant must supply proof no Participating Pharmacy was available, pay full retail price and submit proof of purchase to ESI for reimbursement. Reimbursement is calculated based on the billed charges less any applicable Copay.

APPENDIX C

PRESCRIPTION DRUG BENEFITS

Express Scripts, Inc. (ESI) is the pharmacy benefits manager for the pharmacy drug plan. To reach the **Pharmacy Benefits Manager**, contact the ESI Patient Customer Care Service at:

Phone: (844) 581-4864

Website: www.express-scripts.com

Specialty Pharmacy: Only certain drugs are available. Contact Accredo for a list of drugs or help with any Specialty Prescription:

Phone: (800) 803-2523

Website: www.accredo.com

Retail Pharmacy Benefit

The applicable Copayment will be applied to each covered pharmacy drug charge as detailed in the Summary of Benefits. Any one Prescription is limited to a 90-day supply at a retail pharmacy.

If a drug is purchased from a Non-Network pharmacy or a Network pharmacy when the Plan Participant's ID card is not used, the Employee must submit a Reimbursement form to the pharmacy benefit manager in order to be reimbursed. The amount reimbursed will be the Network rate minus the applicable Copayment.

Mail Order Drug Benefit

For savings and convenience, ESI has partnered with Express Scripts Mail Order Pharmacy. Plan Participants are encouraged to use mail order for maintenance medications (those that are taken for long periods of time, such as drugs prescribed for heart disease, high blood pressure, asthma, birth control, etc.). Significant savings are offered to Plan Participants through the mail order pharmacy. Up to a 90-day supply of medication can be obtained through Mail Order.

The applicable Copayment will be applied to each covered pharmacy drug charge as detailed in the Schedule of Benefits. Any one Prescription is limited to a 90-day supply at the mail order pharmacy, excluding Specialty drugs which may be limited to a 30-day supply. If a drug is purchased from a non-participating pharmacy, there will be no reimbursement from the Plan except as noted in the Schedule of Benefits.

90 Day Retail Drug Benefit – 90-Day supply of certain medications

The 90-Day Retail Drug Benefit Option is available for most maintenance medications (those that are taken for long periods of time for conditions such as high blood pressure, asthma, etc.). This benefit is only available at participating pharmacy locations. For the most up-to-date, complete list of participating pharmacies, please visit www.express-scripts.com or call the Express Scripts member services number listed on your ID card.

Specialty Pharmacy Benefit

Certain oral and injectable drugs covered under the Plan may fall under the category of specialty pharmacy. These drugs should be obtained through Accredo Mail Order Pharmacy and may be subject to prior authorization requirements for coverage. Some drug indications that fall under the specialty products category include, but are not limited to: Cystic Fibrosis, Hepatitis, Multiple Sclerosis, Oncology, Osteoporosis, Psoriasis, Rheumatoid Arthritis, Growth Hormone medications. For a list of specialty drugs and for help in obtaining a specialty Prescription, please contact Accredo: (800) 803-2523. Any one specialty prescription is limited to a 30- day supply for the applicable specialty drug Copayment.

Refills

This benefit applies only when a Plan Participant incurs a covered Prescription drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.
- (3) As specified under the Plan. Contact ESI Customer Care for any possible specific prescription limitations.

COVERED PRESCRIPTION DRUGS

Contact the Pharmacy Benefits Manager for the complete and specific list of covered medications and any restrictions.

- (1) Drugs which are approved by the Food and Drug Administration.
- (2) Drugs which must be dispensed by a Licensed Pharmacist or physician.
- (3) **Anti-Fungals.** Lamisil, Diflucan, and Penlac. Limits apply. (Prior Authorization required)
- (4) **Diabetic Supplies.** Insulin, Insulin syringes / pen needles, pump supplies, diabetic supplies, testing strips and lancets, urine tests.
- (5) **Federal Legend Drugs** (that is, drugs that federal law prohibits dispensing without a prescription).
- (6) **Female contraceptives.** Barrier (sperm-targeted agents, cervical cap, female condom, sponge, diaphragm), hormonal (oral combination agents, oral Progestin only, extended cycle/continuous, transdermal patch, ring, injection), emergency (Levonorgestrel, Progestin blocker), implanted devices (Progestin IUD, copper IUD, Progestin interdermal implant).

Effective January 1, 2023, male condoms.

If an individual's provider recommends a particular service or FDA-approved, cleared, or granted product not included in a category described above, the plan must cover that service or product without cost sharing. Express Scripts has established a standard exceptions process for providers through electronic prior authorization vendors. More information is available here: <https://www.express-scripts.com/corporate/prior-authorization-resources>.

- (7) **Impotency drugs:** Injectable and oral medications. Limits apply.
- (8) **Injectable:** Self-administered injectable medication. These medications are usually covered under the Specialty Pharmacy Program and may require prior authorization.
- (9) **Legend Vitamins.** (i.e. Prenatal, therapeutic (Rocaltrol, Calcitriol, Niacin), Legend Multivitamins, supplemental agents, Hemopoetic agents (Folic Acid, Niferex).
- (10) **Legend Medical Foods.**
- (11) **Legend Fluoride Products.** Dependent Children through age 18.
- (12) **Preventive Medications** under the HDHP Plans as described in a separate list made available annually.
- (13) **Preventive Medications** for all plans as required under the Affordable Care Act (prescription required):
 - Aspirin: Men age 45 – 79; Women age 55 – 79
 - Oral Fluoride: Dependent Children Birth to 5 years
 - Folic Acid: Women age 18-45
 - Iron: Dependent Children age Birth to 12 months
 - Immunizations
- (14) **Respiratory Therapy Supplies.** Aerochamber, Spacers, and Nebulizers only.
- (15) **Smoking Cessation** medications for adults age 18 or older. Limited to a 180-day supply.
- (16) **Topical Agents for Acne,** such as Tretinoins (Atralin, Avita, Retin-A), Differin, Duac, Tazorac. (Prior Authorization is required).

- (17) **Vaccines** dispensed at a Participating Pharmacy including: flu, pneumonia, shingles, travel, rabies, etc. Subject to age limitations in accordance with the Advisory Committee on Immunization Practices and Centers for Disease Control and Prevention. Coverage for vaccines may also be available under the Medical Plan.

PREScription DRUG EXCLUSIONS

Note: All exclusions related to Medical Benefits are shown in the Medical Plan Exclusions. All exclusions related to Dental Benefits are shown in the Dental Plan Exclusions.

For all Prescription Drugs, a charge for the following is not covered:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug. This does not apply to the administration of vaccines covered under this plan at a Participating Pharmacy.
- (2) **Appetite Suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a Prescription or prescription vitamin supplements containing fluoride (except as may be required by the Patient Protection and Affordable Care Act).
- (3) **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Cosmetic.** Charges for oral or topical drugs used for cosmetic purposes, such as but not limited to Renova. Propecia, Botox injections, anabolic steroids, Retin-A or medications for hair growth or removal. In the event these medications are used to treat a covered medical condition prior authorization may be requested. Contact Express Scripts for specific information.
- (5) **Durable Medical Equipment (DME).** Unless otherwise specified. This equipment is covered under the Medical Plan.
- (6) **Diagnostic Testing & Imaging Supplies.** Charges for all dosage forms including injectables used for outpatient testing.
- (7) **Error.** Care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.
- (8) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant.
- (9) **FDA.** Any drug not approved by the Food and Drug Administration.
- (10) **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (11) **Immunization.** Immunization agents or biological sera, serums, toxoids, vaccines, all dosage forms including injectables, except as required by the Patient Protection and Affordable Care Act (PPACA) for non-grandfathered plans. Immunizations may also be covered on the Medical Plan.
- (12) **Infertility or Fertility Agents.** A charge for infertility medication or fertility agents.
- (13) **Injectable supplies.** A charge for hypodermic syringes and/or needles (Excludes all diabetic supplies).
- (14) **Inpatient Medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (15) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (16) **Legend Homeopathic Drugs.**

- (17) **Lifestyle Drugs.** The pharmacy benefit manager may restrict the availability of certain prescription medications typically prescribed in order to enhance an individual's lifestyle, such as Retin-A for Participants above a specified age.
- (18) **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.
- (19) **Medical Marijuana.** Includes all supplies and formulations related to Medical Marijuana.
- (20) **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (21) **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (22) **Not Specified as Covered.** Services, treatments and supplies which are not specified as covered under the Plan.
- (23) **Over the Counter Medications / Non-Legend Medications.** Unless otherwise specified.
- (24) **Plan Design Excludes.** Charges excluded by the Plan design as mentioned in this document.
- (25) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (26) **Services Before or After Coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan or after coverage ceased under the Plan.
- (27) **Subrogation, Reimbursement, and/or Third Party Responsibility.** Care, supplies, treatment, and/or services of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.
- (28) **Supply Limits.** Coverage for drugs for the amount dispensed which exceeds the supply limit.
- (29) **Weight Loss.** A charge for Prescription Drugs such as, but not limited to Phentermine formulations, Meridia and Xenical for weight loss.

DEFINED TERMS – PRESCRIPTION

Prescription means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Prescription Drugs

For the HDHP Plans Only: certain prescription drugs are considered to be preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (*i.e.*, asymptomatic), or to prevent the reoccurrence of a disease from which a person has recovered. For example, the treatment of high cholesterol with cholesterol-lowering medications (*e.g.*, statins), or to prevent heart disease or the treatment of recovered heart attack or stroke victims with Angiotensin-converting Enzyme (ACE) inhibitors to prevent a reoccurrence, constitute preventive care. In addition, drugs used as part of procedures providing preventive care services specified in IRS Notice 2004-23. However, the preventive care safe harbor under IRS section 223(c)(2)(C) does not include any service or benefit intended to treat an existing Illness, Injury, or condition, including drugs used to treat an existing Illness, Injury or condition. Additional information about this section as well as a list of any qualified preventive care drugs will be given to Plan Participants at no cost and updated as needed. Covered Charges will be payable as shown in the Summary of Benefits.

Important Information for Medicare Part D Eligible Individuals

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a voluntary prescription drug benefit (Part D) to the Medicare program for certain individuals. Group health plans that provide prescription drug coverage to individuals who are eligible for coverage under Part D must provide a notice to such individuals whether coverage under the group health plan is "creditable." Such individuals will need this information to decide whether keeping the group health coverage will them allow them to delay enrolling in Medicare Part D and still avoid the Part D late enrollment penalty when they finally enroll in Part D. Medicare Part D Eligible Individuals will receive a separate creditable coverage notice at the appropriate time.

APPENDIX D

Delta Dental PPO plus Premier TEP Classified

SUMMARY OF BENEFITS

BENEFIT YEAR: January 1 through December 31

Benefit Year means the annual period specified in the Group Dental Contract for calculation of benefits, co-payment, and deductibles under This Contract.

DEDUCTIBLE: \$50 per Person, \$150 per Family

CALENDAR YEAR BENEFIT MAXIMUM: \$2,000 per Person, per Benefit Year

WHEN YOU RECEIVE SERVICES FROM A NONPARTICIPATING DENTIST, THE PERCENTAGES BELOW INDICATE THE PORTION OF DELTA DENTAL'S NONPARTICIPATING DENTIST FEE THAT WILL BE PAID FOR THOSE SERVICES. THE NONPARTICIPATING DENTIST FEE MAY BE LESS THAN WHAT THE DENTIST CHARGES AND YOU ARE RESPONSIBLE FOR THAT DIFFERENCE.

REFER TO THE DENTAL BENEFITS BOOKLET DESCRIPTION OF SERVICES FOR A MORE DETAILED DESCRIPTION INCLUDING LIMITATIONS AND EXCLUSIONS. BENEFITS SUBJECT TO ALL PROVISIONS, TERMS, & CONDITIONS OF THE GROUP DENTAL CONTRACT.

ROUTINE SERVICES (Deductible does not apply to these services) 100%

Preventive

- Exams, evaluations or consultations (Twice in a Benefit Year)
- Routine Cleanings (Twice in a benefit year)

BASIC SERVICES (Deductible does apply to these services) 80%

Diagnostic

- X-rays: Full Mouth/Panorex, or vertical bitewings (Once in a three (3) year period) Bitewings (Once in a Benefit Year).

Preventive

- Interim Caries Arresting Medicament - Treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament.
- Resin Restoration - Preventive resin restoration on permanent teeth for a moderate to high caries risk (Once in a three (3) year period)
- Sealants - Once per tooth in any three (3) year period for permanent molars & bicuspid.
- Topical Application of Fluoride - once in a benefit year.
- Space Maintainers (For missing posterior primary (baby) teeth) up to age nineteen (19). Re-cementation is not covered.

Restorative

- Fillings consisting of silver amalgam, or composite tooth color fillings.

Oral Surgery

- Simple Extractions. Surgical Extractions and Surgical Procedures limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than a 1/4 inch.
- General Anesthesia and Intravenous Sedation/Analgesia - As stated in the Covered Dental Services section of this benefit booklet.

Periodontics

- Periodontal maintenance following periodontal treatment. (Two (2) in a benefit year; includes routine cleanings, periodontal maintenance, full mouth debridement, scaling and root planning. (After preventive benefit).
- Periodontics – surgical. (One per quadrant in any three (3) year period)

Endodontics

- Root Canal Treatment (Permanent Teeth); Pulpotomy (Primary (baby) Teeth) Once per tooth every two (2) years.

Emergency (Palliative Treatment)

- Emergency treatment for the relief of pain.

Other

- Oral Appliance for Treatment of Bruxism. (One device every five (5) year period)
- Treatment of Temporomandibular Joint Disorders, (TMJ). (Limited to office visits, consultations, diagnostic tests and x-rays)
- Injectable Antibiotic Drugs, one site per tooth per year.

MAJOR SERVICES (Deductible does apply to these services)

60%

Restorative

- Inlays and gold foil restorations.
- Cast Crowns - Onlays (five (5) year waiting period for replacement last performed).
- Stainless Steel Crowns - Once (1) per lifetime up to age fourteen (14).

Prosthodontics

- Implants are only a benefit to replace a single missing tooth. Covered up to a maximum of \$500 per tooth, per member; includes related services or treatment for complications of dental implants.
- Bridges -Does not provide for lost, misplaced or stolen bridges or dentures. Five (5) year waiting period for replacement last performed.
- Complete Dentures - Does not provide for lost, misplaced or stolen bridges or dentures. Five (5) year waiting period for replacement last performed; adjustments one per twelve (12) months if performed more than twelve (12) months after installation.
- Partial Dentures - Does not provide for lost, misplaced or stolen bridges or dentures. Five (5) year waiting period for replacement last performed.

Bridge and Denture Repair

- Repair of such appliances to their original condition, including relining and rebasing of dentures and partials.
- Precision attachments for removable dentures.

Predetermination recommended for services over \$250

ORTHODONTIC SERVICES (Deductible does not apply to these services)

60%

ORTHODONTICS: The program will pay (60%) of the Orthodontics Services for child(ren) age eight (8) up to age nineteen (19). Benefits are limited to a maximum of (\$1,500) per lifetime of the patient. This maximum is separate from the benefit year maximum for your other dental benefits.

**Delta Dental PPO plus Premier
FortisUS Inc., UNE, UNG, & TEP
Unclassified**

SUMMARY OF BENEFITS

BENEFIT YEAR: January 1 through December 31

Benefit Year means the annual period specified in the Group Dental Contract for calculation of benefits, co-payment, and deductibles under This Contract.

DEDUCTIBLE: \$100 per Person, \$300 per Family

CALENDAR YEAR BENEFIT MAXIMUM: \$2,000 per Person, per Benefit Year

WHEN YOU RECEIVE SERVICES FROM A NONPARTICIPATING DENTIST, THE PERCENTAGES BELOW INDICATE THE PORTION OF DELTA DENTAL'S NONPARTICIPATING DENTIST FEE THAT WILL BE PAID FOR THOSE SERVICES. THE NONPARTICIPATING DENTIST FEE MAY BE LESS THAN WHAT THE DENTIST CHARGES AND YOU ARE RESPONSIBLE FOR THAT DIFFERENCE.

REFER TO THE DENTAL BENEFITS BOOKLET DESCRIPTION OF SERVICES FOR A MORE DETAILED DESCRIPTION INCLUDING LIMITATIONS AND EXCLUSIONS. BENEFITS SUBJECT TO ALL PROVISIONS, TERMS, & CONDITIONS OF THE GROUP DENTAL CONTRACT.

ROUTINE SERVICES (Deductible does not apply to these services) 100%

Preventive

- Exams, evaluations or consultations (Twice in a Benefit Year)
- Routine Cleanings (Twice in a benefit year)
- Topical Application of Fluoride - once in a benefit year.

BASIC SERVICES (Deductible does apply to these services) 80%

Diagnostic

- X-rays: Full Mouth/Panorex, or vertical bitewings (Once in a three (3) year period) Bitewings (Once in a Benefit Year).

Preventive

- Interim Caries Arresting Medicament - Treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament.
- Resin Restoration - Preventive resin restoration on permanent teeth for a moderate to high caries risk (Once in a three (3) year period)
- Sealants - Once per tooth in any three (3) year period for permanent molars & bicuspid.
- Space Maintainers (For missing posterior primary (baby) teeth) up to age nineteen (19). Re- cementation is not covered.
- Topical Application of Fluoride age 21 and over, once per year.

Restorative

- Fillings consisting of silver amalgam, or composite tooth color fillings.

Oral Surgery

- Simple Extractions. Surgical Extractions and Surgical Procedures limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than a 1/4 inch.

APPENDIX E

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT PLAN PARTICIPANTS MAY BE USED AND DISCLOSED AND HOW PLAN PARTICIPANTS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS EFFECTIVE ON AND AFTER JANUARY 1, 2023.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the self-funded health plan Component Programs of the Tucson Electric Power Company Benefits by Design Health Plans, the Tucson Electric Power Company Retiree Welfare Plan, and the Tucson Electric Power Medical Flexible Spending Account, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such self-funded health plan Component Programs are referred to herein as the "Plan."

The HIPAA Privacy Rule protects only certain medical information known as "protected health information" or "PHI." Generally, protected health information is individually identifiable health information, including demographic information, collected from Plan Participants or created or received by a health care provider, a health care clearinghouse, a health plan, or the Plan Sponsor on behalf of the Plan that relates to:

- (1) Plan Participants' past, present or future physical or mental health or condition;
- (2) the provision of health care to Plan Participants; or
- (3) the past, present or future payment for the provision of health care to Plan Participants.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant's PHI, and inform him/her about:

- (1) The Plan's disclosures and uses of PHI;
- (2) The Plan Participant's privacy rights with respect to his/her PHI;
- (3) The Plan's duties with respect to his/her PHI;
- (4) The Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
- (5) The person or office to contact for further information about the Plan's privacy practices.

Primary Uses and Disclosures of PHI

- (1) Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the Privacy Rule.
 - (a) Treatment. The Plan may use or disclose PHI to facilitate medical treatment or services by providers. The Plan may disclose medical information about a Plan Participant to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of the Plan Participant. For example, the Plan might disclose information about a Plan Participant's prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.
 - (b) Payment. The Plan may use or disclose PHI to determine a Plan Participant's eligibility for Plan benefits, to facilitate payment for the treatment and services a Plan Participant receives from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell a Plan Participant's health care provider about the Plan Participant's medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. The Plan may also share a Plan Participant's PHI with a utilization review or precertification service provider. Likewise, the Plan may share PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

- (c) Health Care Operations. The Plan may use and disclose PHI for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: (i) conducting quality assessment and improvement activities; (ii) underwriting, premium rating, and other activities relating to Plan coverage; (iii) conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; (iv) business planning and development such as cost management; and (v) business management and general Plan administrative activities. Notwithstanding the foregoing, the Plan will not use or disclose PHI that is genetic information for underwriting purposes.
- (2) Business Associates: The Plan contracts with individuals and entities (“Business Associates”) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management, or subrogation. Business Associates must agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant’s information.
- (3) Plan Sponsor. The Plan may disclose PHI to certain employees of the Plan Sponsor. However, those employees will only use or disclose that information as necessary to perform plan administrative functions or as otherwise required by HIPAA, unless a Plan Participant has authorized further disclosures. PHI cannot be used for employment purposes or for other benefits without a Plan Participant’s specific authorization.
- (4) Other Covered Entities: The Plan may disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

- (1) Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
- (2) Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
 - (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
 - (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
 - (c) locate and notify persons of recalls of products they may be using; or a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law; and
 - (d) a school, about a Plan Participant who is a student or prospective student if the PHI disclosed is limited to proof of immunization, the school is required by state or other law to have such proof of immunization prior to admitting the Plan Participant, and the Plan obtains and documents agreement to the disclosure from either a parent, guardian, or other person acting in loco parentis of the Plan Participant (if the Plan Participant is an unemancipated minor) or the Plan Participant (if the Plan Participant is an adult or emancipated minor).

- (3)** Victims of Abuse, Neglect, or Domestic Violence: The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (2) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- (4)** Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
- (5)** Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
- (6)** Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
- (7)** To Coroners, Funeral Directors or Medical Examiners:: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.
- (8)** Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.
- (9)** To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
- (10)** Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- (11)** Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.
- (12)** Organ and Tissue Donation: If a Plan Participant is an organ donor, the Plan may release the Plan Participant's PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- (13)** Inmates: If a Plan Participant is an inmate of a correctional institution or is in the custody of a law enforcement official, the Plan may disclose the Plan Participant's PHI to the correctional institution or law enforcement official if necessary: (a) for the institution to provide the Plan Participant with health care; (b) to protect the Plan Participant's health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.

Required Disclosures of PHI

- (1) **Disclosures to Plan Participants:** The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant state law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

- (2) **Disclosures to the Secretary of the U.S. Department of Health and Human Services:** The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Disclosures to Others Involved with a Plan Participant's Care

- (1) **To Persons Involved With a Plan Participant's Care.** The Plan may disclose PHI to a person involved in a Plan Participant's care in the following circumstances: (a) the person is the parent of the Plan Participant who is a minor child, subject to certain state law requirements; (b) the Plan Participant is present and consents; or (c) the Plan Participant is not present or an opportunity to agree or object is not practicable (e.g., the Plan Participant is incapacitated) and the PHI is directly relevant to the person's involvement with the Plan Participant's care.
- (2) **Disclosures Involving Decedents:** The Plan may also disclose PHI to a decedent's family members and others involved with the decedent's care or payment for care, unless doing so would be inconsistent with any prior request for confidential communications and the Plan agreed to the request.
- (3) **Explanations of Benefits.** With only limited exceptions, the Plan will send all explanations of benefits or EOBs to the employee who is covered under the Plan. This includes EOBs relating to the employee's spouse and other family members who are covered under the Plan, and includes information on the use and/or denial of Plan benefits by the employee's spouse and other family members. If a Plan Participant has requested Restrictions or Confidential Communications (see below under "Rights to Individuals"), and if the Plan has agreed to the request, the Plan will send EOBs as provided by the request for Restrictions or Confidential Communications.

Other Uses and Disclosures of Protected Health Information Pursuant to an Authorization

Other uses or disclosures of PHI not described in this Notice will only be made with a Plan Participant's written authorization. For example, in general and subject to certain conditions, the Plan will not use or disclose a Plan Participant's psychotherapy notes without the Plan Participant's written authorization. In addition, the Plan will not use or disclose a Plan Participant's PHI for marketing purposes and will not sell a Plan Participant's PHI, unless the Plan Participant gives us a written authorization. Any authorizations obtained for marketing purposes or to sell protected health information must state that such disclosure will result in payment to the Plan.

A Plan Participant may revoke his/her written authorization at any time, so long as the revocation is in writing. Once the Plan receives a written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving the written revocation.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

- (1) Request Restrictions:** The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

To request restrictions, a Plan Participant must make his/her request in writing to the Privacy Official identified on the last page of this Notice. In the request, the Plan Participant must indicate: (a) what information the Plan Participant wants to limit; (b) whether the Plan Participant wants to limit the Plan's use, disclosure, or both; and (c) to whom the Plan Participant wants the limits to apply.

- (2) Right to Receive Confidential Communication:** The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing to the Privacy Official and must include how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests if the Plan Participant clearly provides information that the disclosure of all or part of his/her PHI could endanger the Participant.
- (3) Copy of this Notice:** The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Official.
- (4) Accounting of Disclosures:** The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information.

The first accounting a Plan Participant requests within a 12-month period will be provided free of charge. For additional accountings, the Plan may charge the Plan Participant the costs of providing the accounting. The Plan will notify the Plan Participant of the cost involved and the Plan Participant may choose to withdraw or modify his/her request at that time before any costs are incurred.

If the Plan Participant wishes to make a request, please contact the Privacy Official.

- (5) Access:** The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the information requested is maintained electronically, and the Plan Participant requests an electronic copy, the Plan will provide a copy in the electronic form and format requested, if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, the Plan will work with the Plan Participant to come to an agreement on a form and format. If an electronic form and format cannot be agreed upon, the Plan will provide the Plan Participant with a paper copy.

The Plan Participant may request that the Plan transmit the copy of his/her electronic PHI directly to another person, provided that the Plan Participant's request is in writing, is signed by the Plan Participant, clearly identifies the person to whom the electronic PHI should be sent, and where to send the information.

If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Official. In very

limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

- (6) Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. To request an amendment, the request must be in writing and must include a reason that supports the Plan Participant's request. Submit the request to the Privacy Official. The Plan may deny the Plan Participant's request in certain cases, including if it is not writing or if he/she does not provide a reason for the request. If the Plan denies the Plan Participant's request, the Plan Participant has the right to file a statement of disagreement with the Plan and any future disclosures of the disputed information will include the Plan Participant's statement
- (7) Notification of a Breach: The Plan Participant has the right to be notified in the event the Plan (or a Business Associate) discovers a Breach of Unsecured PHI.

Changes to the Notice

The Plan reserves the right to change the terms of this Notice and to make new provisions regarding PHI that it maintains, as allowed or required by law. If the Plan makes any material change to this Notice, Plan Participants will be provided with a copy.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Privacy Official. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Kris Page-Iverson
Director, Compensation & Benefits
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COMPLIANCE WITH GINA

Notwithstanding any provision of the Plan to the contrary, the Plan will comply with the requirements of Title II of the Genetic Information Nondiscrimination Act of 2008 ("GINA") effective as of November 21, 2009, and Title I of GINA effective as of January 1, 2010.

APPENDIX F

COVID-19 Addendum

I. Free COVID-19 Vaccines (Effective through the end of the COVID-19 Public Health Emergency¹)

The Plan covers 100% of your expenses for covered “COVID-19 Preventive Services” provided by both in-network and out-of-network providers, even if you have not met your deductible. “COVID-19 Preventive Services” include items, services, and immunizations intended to prevent or mitigate COVID-19.

The Plan is required to cover COVID-19 Preventive Services within 15 business days after the service is (1) recommended by the United States Preventive Services Task Force (“USPSTF”) as an evidence-based item or service with an “A” or “B” rating, or (2) recommended by the Advisory Committee on Immunization Practices (“ACIP”) of the Centers for Disease Control and Prevention (the “CDC”) and adopted by the CDC.

If you receive a COVID-19 vaccine that is a COVID-19 Preventive Service, the Plan will cover 100% of the cost of the vaccine upon its recommendation by the USPSTF or the ACIP as described above. You will not be required to pay a copayment, cost share, or coinsurance for the COVID-19 vaccine. As the USPSTF and/or the ACIP approve additional COVID-19 vaccines, the Plan will cover them at 100%. The Plan’s coverage may change if either the USPSTF or the ACIP revises its recommendation on the covered COVID-19 Preventive Services (e.g., if the COVID-19 vaccines are recommended for younger age groups).

See COVID-19 ACIP Vaccine Recommendations here: <https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html>.

See CDC COVID-19 Immunization Schedules here: <https://www.cdc.gov/vaccines/schedules/index.html>.

II. Free COVID-19 Testing (Effective March 11, 2020 – the End of the COVID-19 Public Health Emergency)

The Plan covers 100% of your expenses for covered COVID-19 diagnostic testing provided by both in-network and out-of-network providers, even if you have not met your deductible. This means that items and services for diagnostic testing for COVID-19, that are “medically appropriate”, will be free of charge to you. Your attending health care provider, not the Plan, decides if COVID-19 testing is medically appropriate. The Plan’s normal medical necessity rules do not apply to free COVID-19 testing.

A COVID-19 test must be “ordered or administered” during a health care provider office visit (including in-person and virtual visits), urgent care center visit, or emergency room visit to be free of charge. If you go to a health care provider for a COVID-19 test, but a COVID-19 test is not ordered or administered during the visit, no portion of the visit is free under these rules.

More than just the COVID-19 diagnostic test itself can be free under these rules. Related facility fees, other tests or services to determine whether a COVID-19 test is appropriate (such as a flu test or chest x-ray), and physician fees are also free.

The Plan will cover more than one COVID-19 test (and related fees and services) for free, if each test meets the above requirements for a free test.

¹ For more information regarding the Public Health Emergency, see: <https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx>.

III. Free COVID-19 Over-the-Counter Tests (Effective January 15, 2022 – the End of the COVID-19 Public Health Emergency)

The Plan will reimburse up to eight OTC at-home rapid COVID-19 tests per covered individual per month that are purchased after January 15, 2022, and are FDA approved or have emergency use authorization.²

IV. COVID-19 Treatment Subject to Applicable Deductible and Cost Sharing

COVID-19 treatment, or other medical treatment that you receive during a COVID-19 testing visit is not free under these rules. For example, if you are diagnosed with COVID-19 during an emergency room visit and receive medically appropriate COVID-19 treatment for your symptoms during the visit, the COVID-19 treatment expenses will be subject to the Plan's normal deductible and cost sharing requirements.

V. No Copays/Coinsurance for BlueCare AnyWhere Telehealth Program (Effective March 11, 2020 – November 14, 2021)

The Plan offers BCBSAZ's BlueCare Anywhere Telehealth Program. BlueCare Anywhere connects you to BCBSAZ's network of board-certified doctors by live video and is available at any time, not just during business hours. BlueCare Anywhere is available at BlueCareAnywhereAZ.com. There also is a BlueCare Anywhere telehealth app available for download. You can access BlueCare Anywhere providers using your computer, tablet, or mobile device.

From March 11, 2020 – November 14, 2021, the Plan waived all copays and coinsurance for BlueCare Anywhere, even if you had not met your deductible. This applied to both medical and behavioral telehealth visits under the BlueCare Anywhere program. All other telemedicine services outside of the BlueCare Anywhere Telehealth Program were subject to the Plan's normal deductible and cost sharing requirements.

VI. Additional Reimbursements Under the Health Flexible Spending Account ("FSA") and Health Savings Account ("HSA") (Effective January 1, 2020)

You can use your health FSA or HSA to purchase or get reimbursed for certain over-the-counter drugs and medications, like aspirin and other pain medications, allergy medications, etc., without a doctor's prescription. You can also use your health FSA or HSA to purchase feminine care products and personal protective equipment for the primary purpose of preventing the spread of COVID-19 including masks, hand sanitizer, and sanitizing wipes.

VII. COVID-19 Deadline Extensions (Effective through 60 days after the COVID-19 National Emergency, But No Longer Than One Year)

Pursuant to DOL and IRS guidance, ERISA health and welfare and retirement plans must extend various deadlines during the "outbreak period." The outbreak period generally means the earlier of: (1) one year from the date an individual is first eligible for relief; and (2) 60 days after the announced end of the COVID-19 National Emergency. The deadlines that are currently extended include:

- 1) the 60-day deadline for an individual to elect COBRA coverage;
- 2) the 45-day deadline for an individual to make an initial COBRA premium payment;
- 3) the 30-day deadline for an individual to make a subsequent monthly COBRA premium payment;
- 4) the 60-day deadline for an individual to notify the plan of certain COBRA qualifying events (i.e., divorce or a dependent child ceasing to be a dependent child);

² View a list of FDA-approved EUA tests here: https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas-antigen-diagnostic-tests-sars-cov-2?utm_source=marketing_cloud&utm_medium=email&utm_campaign=AH_2022-01-18_MembersCom_OTCAtHomeCovidTest&utm_term=View+a+list+of+FDA-approved+or+EUA+tests&utm_id=231563&sfdc_id=17020130.

- 5) the deadline for a COBRA qualified beneficiary to notify the plan of a determination of disability;
- 6) the 14-day deadline for plan administrators to provide COBRA election notices to qualified beneficiaries;
- 7) the 30-day special enrollment period for individuals who lose health coverage;
- 8) the 30-day special enrollment period for individuals who gain new dependents;
- 9) the 60-day special enrollment period for individuals who lose or gain eligibility for Medicaid or children's health insurance program;
- 10) the deadline for an individual to file a benefit claim under ERISA's claim procedures;
- 11) the deadline for an individual to appeal an adverse determination under ERISA's appeal procedures;
- 12) the 4-month deadline for an individual to request an external review after receipt of an adverse benefit determination or final internal adverse benefit determination; and
- 13) the 4-month deadline (or, if later, 48 hours following receipt of notice of an incomplete request) for an individual to file information to perfect a request for external review of a benefit determination upon learning the request was incomplete.