Post-65 Retiree Health Reimbursement Arrangement Program

January 1, 2020

PINNACLE WEST
CAPITAL CORPORATION

Contents

Plan Overview

Pinnacle West Capital Corporation ("Pinnacle West") established the Pinnacle West Capital Corporation Post-65 Retiree Health Reimbursement Arrangement (the "Plan") for the benefit of its retirees and the retirees of its participating affiliates. Pinnacle West and participating affiliates are collectively referred to herein as the "Company." The purpose of the Plan is to reimburse eligible retirees for certain medical expenses which are not otherwise reimbursed.

The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (the "Code"), as well as a health reimbursement arrangement ("HRA") as defined in IRS Notice 2002-45 and subsequent guidance. The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), but any insurance policies that you purchase using your HRA Account are not part of the Plan and are not subject to ERISA.

The material provisions of the Plan as of the Effective Date are summarized below, but this summary plan description ("SPD") is qualified in its entirety by reference to the full text of the formal plan document, a copy of which is available for inspection at the Company's offices. In the event of any conflict between the terms of this SPD and the terms of the Plan document, the terms of the Plan document will control.

Participants seeking to obtain additional information about the Plan should contact the Company's HR Service Team at (602) 250-3500, hrserviceteam@aps.com or 400 N 5th St, MS 8482 Phoenix, AZ 85004.

Note that "you," "your" and "my" when used in this SPD refer to you, the retiree, dependent, or surviving spouse, as applicable.

Participation Basics

Purpose

The purpose of the Plan is to reimburse Participants for Health Care Expenses and Catastrophic Prescription Drug Expenses ("Cat Rx Expenses") which are not otherwise reimbursed by any other plan or program. Reimbursements for Health Care Expenses and Cat Rx Expenses (collectively referred to as "Eligible Medical Expenses") paid by the Plan generally are excludable from the Participant's taxable income.

The Plan gives you the flexibility in how you spend your HRA Account – from helping pay for Individual Medicare Policies, prescription drug premiums, to dental, vision, and/or Medicare Part B premiums, as well as qualified out-of-pocket health expenses.

Eligibility

To be eligible for coverage under the Plan as an "Eligible Retiree," you must meet the following criteria:

- Retiree under the terms of the Pinnacle West Capital Corporation Retirement Plan
    - Age 65 with five years of service,
    - Age 60 with 10 years of service, or
    - Age 55 with 20 years of service
- You immediately collect pension benefits from the Pinnacle West Capital Corporation Retirement Plan, and
- You are covered under the Pinnacle West Capital Corporation Group Life & Medical Plan (the "Medical Plan") when you retire.

An Eligible Retiree or Eligible Dependent becomes a Participant in the Plan on the date that he or she has satisfied all of the following requirements:

- He or she becomes eligible for Medicare on account of attaining age 65;
- He or she obtains an Individual Medicare Policy through the Third Party Administrator; and
- He or she completes any enrollment forms or procedures required by the Plan Administrator.

An Individual Medicare Policy is a Medicare supplement plan (also known as Medigap) or a Medicare Advantage Plan (also known as Medicare Part C).

Eligibility for Your Dependents

Your "Eligible Dependents" under the Plan generally include your Spouse and your Handicapped Child, if any.

"Spouse" means an individual who is married to you, of the opposite or same sex, if the marriage was validly entered into a state whose laws authorize the marriage of the two individuals. For purposes of this definition, "state" means any domestic or foreign jurisdiction having the legal authority to sanction marriages. Spouse does not include an individual who you are legally separated from.

"Handicap Child" means your unmarried: (1) natural child, (2) stepchild, (3) adopted child, (4) child who is lawfully placed with you for legal adoption, (5) child or grandchild for whom you have legal guardianship and who receives over one-half of his or her support for the Plan Year from you and lives with you in a parent-child relationship, or (6) grandchild, but only if both the grandchild and the grandchild's parent live in the same household as you and the grandchild's parent is covered under the Plan as an Eligible Dependent.

The Handicapped Child must also be age 65 or older, and physically or mentally incapable of earning a living prior to attaining age 26, and who continues to be so handicapped.

No one in active military service of the United States or any other country is an Eligible Dependent.

For an Eligible Dependent to be covered under this Plan:

- You must be covered under this Plan, the Medical Plan, or TRICARE, or you die while covered under this Plan, the Medical Plan or TRICARE; and
- The Eligible Dependent must have been covered under the Medical Plan on your last day of active employment or was covered by the Medical Plan after your last day of active employment due to a special enrollment right under the Medical Plan.

Note that if, following your participation in this Plan, you are rehired by the Company and resume participation in the Medical Plan, any new dependents you add to your coverage under the Medical Plan while reemployed will not be Eligible Dependents under this Plan when you retire again and resume participation in this Plan.

If you are a Spouse of a deceased Eligible Retiree (a "Surviving Spouse"), you are eligible for coverage under the Plan if you had that coverage (or coverage under the Medical Plan) when your Spouse died.

You are required to provide proof of dependent status upon request by the Plan Administrator (or its designee). Failure to provide proof may result in a delay or cancellation of benefits provided under the Plan.

Qualified Medical Child Support Order

The Plan will honor a Qualified Medical Child Support Order ("QMCSO") for your Handicapped Child to the extent the QMCSO does not require coverage not otherwise offered under this Plan. Upon receipt of a medical child support order, the Plan Administrator will notify both you and the affected Handicapped Child of the order and of the Plan Administrator's determination as to whether the order is a QMCSO. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting the Plan Administrator.

Plan Features

HRA Account

Your HRA Account is a bookkeeping account to which Benefit Credits are added each year, which you may use to pay for be reimbursed for your Health Care Expenses. As a general rule, one joint HRA Account will be established for all Participants in your family. Benefit Credits for all Participants in your family will be credited to that joint HRA Account. However, if two members of a family are both Eligible Retirees and they each had primary coverage in the Medical Plan at the time of retirement, an individual HRA Account will be established for each Participant and Benefit Credits for each Participant will be credited to his or her individual HRA Account.

If no other members of your family are Participants, an individual HRA account will be established for you.

On January 1 each year, the Benefit Credits will be credited to HRA Accounts by the Employer. The amount of the Benefit Credits is set each year by the Employer, in its discretion, and may change from year-to-year. Benefit Credits will be pro-rated based on the month the Participant enrolls in an Individual Medicare Policy and funds will be credited when the Policy starts.

The HRA Accounts will be reduced from time to time by the amount of any Health Care Expenses for which you are reimbursed under the Plan. At any time, you may receive reimbursement for Health Care Expenses up to the amount in your HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts.

If you do not use all the amounts credited to your HRA Account during a Plan Year, those amounts will be carried over to subsequent Plan Years.

HRA Accounts are bookkeeping accounts only. They are not funded and do not bear interest or accrue earnings of any kind. Benefits under the Plan are paid from the Company's general assets, and/or plan assets held in trust.

Cat Rx Reimbursement

The Cat Rx Reimbursement feature of the Plan is separate from your HRA Account. If your Medicare Part D prescription drug expenses reach the TrOOP Maximum (defined below) during a Plan Year, you should contact the Third Party Administrator, at the number shown in the Plan and Administrative Details section to set up Cat Rx Reimbursement. In order to qualify for Cat Rx Reimbursement for a Plan Year, you must provide proof acceptable to the Claims Administrator, showing that you have met the TrOOP Maximum for the Plan Year.

The Plan will reimburse Participants for Medicare Part D prescription drug expenses incurred during the Plan Year in excess of the TrOOP Maximum, other than Cat Rx cost-sharing. Expenses eligible for reimbursement are called "Cat Rx Expenses." There is no annual or lifetime dollar limit on the amount that may be reimbursed for Cat Rx Expenses. Cat Rx expenses are reimbursed as you submit claims to the Claims Administrator.

When you hit the TrOOP maximum, you remain responsible for paying Cat Rx cost-sharing. For 2020, your Cat Rx cost-sharing is the greater of:

- $3.60 for generic drugs, and $8.95 for brand-name drugs, or
- 5% of the total drug cost.

TrOOP Maximum

The "TrOOP Maximum" stands for "true out-of-pocket maximum." The TrOOP Maximum for 2020 is $6,350 and is subject to change from year to year.

Prescription expenses that count toward your TrOOP Maximum include deductibles, coinsurance and copayments that you pay as well as payments made by pharmaceutical manufacturers toward the cost of your prescription drugs. Premiums and payments made by your insurance carrier do not count toward meeting your TrOOP Maximum.

Health Care Expense

A "Health Care Expense" for purposes of the Plan means premiums for Individual Medicare Policies obtained through the Third Party Administrator, premiums for prescription drug coverage, premiums for dental coverage, premiums for vision coverage, and premiums for Medicare Part B coverage, and other expenses incurred by you or any Eligible Dependent for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease).

Some common examples of expenses that qualify under Code Section 213(d) include:

- Dental expenses;
- Dermatology;
- Physical therapy
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Over-the-counter drugs and medicines
- Menstrual care products; and
- Wheelchairs.

Some examples of common items that do not qualify under Code Section 213(d) include:

- Baby-sitting and child care;
- Long-term care services;

- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items do and do not qualify under Code Section 213(d), consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement arrangement. If you need more information regarding whether an expense is eligible for reimbursement under the Plan, contact the Third Party Administrator, as provided in the Plan and Administrative Details section.

Only Health Care Expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Similarly, only Health Care Expenses incurred while your Eligible Dependent is a Participant in the Plan may be reimbursed from his or her HRA Account. Health Care Expenses are "incurred" when the medical care is provided, not when you or your Eligible Dependent are billed, charges or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

- prescription drug expenses;
- premiums for long-term care coverage;
- expenses incurred for qualified long term care services;
- expenses incurred prior to the date that you became a Participant in the HRA:
- expenses incurred after the date that you cease to be a Participant in the HRA;
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- Overpayments of otherwise permissible premiums (such as premiums for Individual Medicare Policies after a Participant's death).

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied).

Taxable Benefits

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. If an Eligible Dependent is not your dependent for tax purposes, the Eligible Medical Expenses reimbursed for such individual will be imputed as income to you. The Company cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Reimbursement Process

You must complete a reimbursement form and mail or fax it to the Claims Administrator as provided in the Plan and Administrative Details section, along with a copy of your insurance premium bill, an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred.

You can obtain a reimbursement form online at my.viabenefits.com/aps or by calling Via Benefits at (844) 256-0920. Your claim is deemed filed when it is received by the Claims Administrator.

Via Benefits

PO Box 2396

Omaha, NE 58103-2396

Fax: (855) 321-2605

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Administrator.

Claim Denial

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Administrator receives your claim. If the Claims Administrator determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-days period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information.

Any notice of denial will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Administrator, you may file a written appeal. You should file your appeal with the Claims Administrator at the address provided in the Plan and Administrative Details section no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary to complete your claim, and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Claims Administrator receives your request to appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Administrator.

Note that you cannot file suit in Federal court until you have exhausted these appeals procedures. If you bring any legal action, you must do so within one year of the date you are notified of our final decision on your appeal, or you lose any rights to bring your action against the Company or the Third Party Administrator.

Overpayments

If it is later determined that you or your Eligible Dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your Eligible Dependent will be required to refund the overpayment or erroneous reimbursement to the Company.

If you do not refund the overpayment or erroneous payment, the Company reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

When Benefits End

If you are an Eligible Retiree, you will cease being a Participant in the Plan on the earlier of:

- The date you cease to be an Eligible Retiree for any reason, including death;
- The date you are rehired by the Company as an active employee;
- The date you cease to be eligible for Medicare or fail to meet the eligibility requirements of an Eligible Retiree;
- The effective date of any amendment terminating your eligibility under the Plan; or
- The date the Plan is terminated.

If you are an Eligible Dependent, you will cease being a Participant in the Plan on the earlier of:

- The date you cease to be an Eligible Dependent for any reason, including death;
- The date the Eligible Retiree ceases to be covered under this Plan, the Medical Plan, or TRICARE for any reason other than death;
- The date the Eligible Retiree is rehired by the Company as an active employee;
- The date you cease to be eligible for Medicare or fail to meet the eligibility requirements of an Eligible Dependent;

- In the case of an Eligible Dependent spouse, the date you divorce or legally separate from the Eligible Retiree;
- In the case of a Handicapped Child, the date he or she ceases to be a Handicapped Child;
- The effective date of any amendment terminating your eligibility under the Plan; or
- The date the Plan is terminated.

You may not obtain reimbursement of any Health Care Expenses or Cat Rx Expenses incurred after the date your participation ends, nor will you be credited with any additional Benefit Credits after your participation ends. You have 180 days after your participation ends, however, to request reimbursement of Health Care Expenses or Cat Rx Expenses you incurred before your eligibility ceased.

In addition, your Eligible Dependents may be eligible to continue coverage under the Plan beyond the date that their coverage would otherwise end if coverage is lost for certain reasons. Reference the Continuation Coverage Rights section for further information.

In addition, you or your Eligible Dependent's coverage under the Plan may be terminated retroactively if you and/or your Eligible Dependent performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, such as enrolling an individual who does not meet the Plan's eligibility requirements.

Coverage in the Event of Your Death

Joint HRA Accounts

When a Participant covered by a joint HRA Account dies, the HRA Account shall continue. However, no further Benefit Credits will be made to the joint HRA Account on behalf of the deceased Participant. The remaining Participant(s) may continue to submit claims for Health Care Expenses incurred by the deceased Participant before his or her death. Such claims must be submitted within 180 days of his or her death.

The other Participants covered by the joint HRA Account may continue to submit claims for their own Health Care Expenses and will continue to receive any applicable Benefit Credits. When the last Participant covered by the joint HRA Account dies, his or her estate or representative may submit claims for Health Care Expenses incurred by the deceased Participant before his or her death. Such claims must be submitted within 180 days of his or her death. After that, all Benefit Credits remaining in the HRA Account are forfeited.

Individual HRA Accounts

When a Participant covered by an Individual HRA Account dies, no further Benefit Credits will be made to the Individual HRA Account on behalf of the deceased Participant. The deceased Participant's estate or representative may submit claims for Health Care Expenses incurred by the deceased Participant before his or her death. Such claims must be submitted within 180 days of his or her death. After that, all Benefit Credits remaining in the HRA Account are forfeited.

Cat Rx Reimbursement

When a Participant eligible for Cat Rx Reimbursement dies, the other Participants, or the deceased Participant's estate or representative, may submit claims for Cat Rx Expenses incurred by the deceased Participant before his or her death. Such claims must be submitted within 180 days of his or her death.

Continuation Coverage Rights

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Eligible Dependents under the Plan who are the Spouse, former Spouse, or Handicapped Child of a Participant (collectively called "Qualified Beneficiaries") may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, a Participant's death, or a Handicapped Child ceasing to be a Handicapped Child. Such events are called "Qualifying Events."

Note that the Eligible Dependents are required to notify the Plan Administrator in writing of a divorce or legal separation, death, or a Handicapped Child losing dependent status within 60 days of the event or they will lose the right to continue coverage under the Plan.

If an Eligible Dependent elects to continue coverage, he or she is entitled to the level of coverage under the Plan in

effect immediately preceding the Qualifying Event. He or she may also be entitled to an increase in his or her HRA Account equal to the amounts credited to the HRA Accounts of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, the Qualified Beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify the Qualified Beneficiaries of the applicable premium at the time of a Qualifying Event.

Coverage may continue for up to 36 months following the Qualifying Event, but will end earlier upon the occurrence of any of the following events:

- The date the Qualified Beneficiary's HRA Account is exhausted;
- The date the Qualified Beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the Qualified Beneficiary's election to continue coverage, that he or she becomes covered under another group health plan; or
- The Company ceases to provide any group health plan.

Your ERISA Rights

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's corporate office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. 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 Plan Coverage

Continue Plan coverage for yourself, Spouse or Handicapped Child if there is a loss of coverage under the Plan as a result of a Qualifying Event. You, your Spouse or your Handicapped Child may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other the Plan Participants and beneficiaries. No one, including your employer , your union 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 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 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 should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator or the Third Party 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 of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave NW, Washington, DC 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.

The Role of the Plan Administrator

The Pinnacle West Capital Corporation Benefit Administration Committee (the "Committee") is the Plan Administrator. As the Plan Administrator, the Committee is responsible for satisfying certain legal requirements under ERISA with respect to the Plan, for example, distributing SPDs.

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan.

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities. The Plan Administrator has delegated the day-to-day administration of the Plan to the HR Service Team and the Third Party Administrator. In Addition, the Claims Administrator has responsibility for deciding claims under the Plan.

To the fullest extent permitted by law, the Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of the Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

Legal Notices

Newborns' and Mothers' Health Protection Act

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Women's Health and Cancer Rights Act

To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is

receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

Health Plan Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Review it carefully. It is effective as of October 20, 2017.

Why This Notice is Being Issued

This notice is required by law under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, you have a right to know all the ways that your health information may be used. You also have the right to access your health information. All of the health plans to which this notice applies are listed below. Collectively, these plans will be referred to as the "Plans" in this notice.

Plans Covered by This Notice

The following plans are required by law to protect the privacy of your individually identifiable health information and to abide by the terms outlined in the Privacy notice.

- Pinnacle West Capital Corporation Group Life & Medical Plan
- Pinnacle West Capital Corporation Group Dental Plan
- Pinnacle West Capital Corporation HealthCare Spending Account Plan
- Pinnacle West Capital Corporation HealthMatters Screening Program
- Pinnacle West Capital Corporation Employee Assistance Program
- Pinnacle West Capital Corporation Post-65 Retiree Health Reimbursement Arrangement

Protected Health Information ("PHI")

Under HIPAA, PHI is information:

- in any form such as oral, written, electronic, that is
- created or received by the Plans that
- relates to your past, present or future physical or mental health conditions; and
- that individually identifies you or which could reasonably identify you.

PHI includes information of persons living or persons who have been deceased for 50 or fewer years.

Reasons for Which Your Health Information May Be Used and Disclosed Without Your Authorization

To Obtain Treatment

Use or disclosure may be made to coordinate or manage your health care with a provider.

To Make or Obtain Payment

Use or disclosure may be made to pay or collect payment from third parties, such as providers or other health plans for the care you receive, or to assist the third party to receive payment for treatment they provided to you. The Plans may also use or disclose your PHI to obtain in refunds of overpayments made by the Plans or to determine third party liability. For example, the Plans may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations

Use or disclosure may be made to administer the Plans and as necessary to provide coverage and services to Participants. The Plans will disclose your PHI to third party administrators or vendors, such as the medical claims or prescription drug administrators, so they may perform services for the Plans. Other uses and disclosures include sharing information among the Plans, customer service, resolution of grievances, auditing, legal services, business planning and contacting you about treatment alternatives. The Plans will not use or disclose your genetic information for underwriting purposes.

For Disclosure to the Plan Sponsor

The Plans may disclose your PHI to the Plan Sponsor for administrative functions that the Plan Sponsor performs on behalf of the Plans in accordance with Plan amendments. The Plans will not disclose your PHI for any employment-related decision or for any other plan. The Plans do not consider your annual enrollment form to be PHI. Your

enrollment form is needed for overall enrollment and payroll purposes. It will be used by the Plans described in this notice and by other plans the Company offers that do not provide health benefits, such as life insurance. The Plans will not disclose your PHI for any employment-related decision or for any other plan.

When Legally Required

The Plans will disclose your PHI when they are required to do so by any federal, state or local law. This may include disclosures for civil or criminal investigations, judicial or administrative proceedings, court orders, subpoenas, discovery request or other lawful process.

When Legally Permitted

The Plans may disclose your PHI to a governmental authority, law enforcement official and others as permitted by law.

For Workers' Compensation

The Plans may release your PHI to the extent necessary to comply with laws related to workers' compensation or similar programs, but only as authorized by and to the extent necessary to comply with laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Disclosure to Family Members and Others

The Plans may disclose your PHI when such disclosure is in your best interest, to your spouse, parent, legal guardian or any other individual involved with your health care. The Plans will use professional judgment and common practice in determining who or what information will be released on your behalf. The Plans will disclose only the minimum information necessary based on the situation. You may request that the Plans limit these disclosures as set forth below in "Your Rights Under HIPAA." In addition, if the Plans are notified of your death while covered by the Plans, this information will be released to the following departments: payroll, life insurance, savings plan, pension plan and disability.

Authorization to Use or Disclose Health Information

The Plans will only disclose your PHI without your authorization for the reasons stated above. The Plans will not disclose your PHI for any other reason unless you have given your written authorization. If you authorize the Plans to use or disclose your PHI, you may revoke that authorization in writing at any time. However, the Plans will not honor your revocation for information already disclosed if disclosure was based on a valid authorization.

In general, and subject to specific conditions, the Plans will not do any of the following without your written authorization: (1) use or disclose your psychotherapy notes; (2) use or disclose your PHI for marketing purposes; and (3) sell your PHI. Any authorizations obtained for marketing purposes or to sell PHI must state that such disclosure will result in payment to the Plans.

In addition, from time to time, one or more of the health plans' third party claims payers may use or disclose your PHI for certain research purposes, such as research relating to how diseases are spread or which treatments are effective. In this situation, the third party claims payer will first obtain from you any consent or authorization required by law for its research activities.

How Much Information is Disclosed

The Plans and employees involved in the administration of the Plans will use and/or disclose only the minimum amount of information necessary to accomplish the activity at hand. For example, if you call for assistance in getting a bill paid for the surgeon who operated on your back, and you happen to mention to the person taking your call that you are a diabetic, your diabetes is not necessary information relating to your back surgery and would not be mentioned to anyone in connection with getting the bill paid unless it became a relevant factor for some reason. This "minimum necessary" policy does not apply when you or a provider request information, when information disclosure is required by law or when you authorize the disclosure.

Information Not Regulated by HIPAA

There is some health-related information, which is not covered by HIPAA, that your employer may require from you in order for you to be eligible for certain benefits. The health-related information not covered by HIPAA is any information related to dependent care spending account plan benefits, short-term and long-term disability benefits, life insurance, the Family and Medical Leave Act (FMLA), the Americans with Disabilities Act (ADA), Workers' Compensation, the Health Clinics, and any regulatory testing or Fitness for Duty testing. While this information is not covered by HIPAA, it is treated with the utmost respect and confidentiality.

Your Rights Under HIPAA

You have the following rights regarding your PHI that the

Plans maintain. You must exercise these rights, in writing, by contacting the Privacy Official identified below.

- You may request, in writing, restrictions on certain uses and disclosures of your PHI. You have the right to request a limit on the Plans' disclosure of your PHI to someone involved in the payment of your care. However, the Plans are not required to agree to your request.
- You have the right to request, in writing, that the Plans communicate with you in a confidential way if you feel the disclosure of your PHI could endanger you. For example, you may ask that the Plans only communicate with you at a certain telephone number or by email.
- You have the right to inspect and copy your PHI. If the information you request is maintained electronically, and you request an electronic copy, the Plans will provide a copy in the electronic form and format you request 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 Plans will work with you to come to an agreement on a form and format. If we cannot agree on an electronic form and format, the Plans will provide you with a paper copy. You may also request that the Plans transmit your electronic PHI that is contained in a designated record set directly to another person If you request a copy of the information, the Plans may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.
- If you believe that your PHI records are inaccurate or incomplete, you may request that the Plans amend the records. The Plans may deny your request if they did not create your PHI records; if the PHI you are requesting to amend is not part of the Plans' records; if the PHI you wish to amend falls within an exception to the PHI you are permitted to inspect and copy; or if the Plans determine the records containing your PHI are accurate and complete.
- You have the right to request an accounting of certain disclosures of your PHI made by the Plans after April 14, 2003.
- You have the right to be notified in the event that the Plans (or a Business Associate) discover a breach of unsecured PHI.
- You have a right to request and receive a paper copy of this Notice at any time.

Duties of Health Plan

The Plans are required by law to maintain the privacy of your PHI as outlined in this Notice and to provide this Notice to you. The Plans are required to abide by the terms of this Notice, which may be amended from time to time. The Plans reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that it maintains. If the Plans make any material change to this Notice, the Plans will provide you with a copy of the revised Notice by posting it on its website by the effective date of the material change and providing you with a copy of the revised Notice (or information about the material change and how to obtain the revised Notice) in the Plans next annual mailing.

Contact Person

If you have any questions, concerns or complaints about this Notice or the privacy of your PHI, contact the following office by telephone or mail at Pinnacle West Capital Corporation HIPAA Privacy Officer, PO Box 53999 MS 8467, Phoenix, AZ 85072-3999, Telephone: 602-250-3500; Fax: 602-250-3027.

You may also file a complaint within 180 days of the date you know or should have known about an act or omission with the Secretary of the Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or contact the Privacy Officer for more information.

No one at the Company will retaliate or take any action against you for filing a complaint.

Plan and Administrative Details

Name of Plan

Pinnacle West Capital Corporation Post-65 Retiree Health Reimbursement Arrangement

Plan Number

531

Effective Date of this Summary

January 1, 2020

Third Party Administrator

All reimbursement forms, and supporting documentation, must be provided to the Claims Administrator. Forms should not be mailed to the Third Party Administrator.

Via Benefits

10975 South Sterling View Drive

Suite A-1 South

Jordan, UT 84905

(844) 256-0920

my.viabenefits.com/aps

Claims Administrator

All reimbursement forms, and supporting documentation, must be provided to the Claims Administrator. Forms should not be mailed to the Third Party Administrator.

Via Benefits

PO Box 2396

Omaha, NE 68103-2396

Fax: (855) 321-2605

The Claims Administrator has been hired to process claims under the Plan. It does not serve as an insurer, but merely a claims processer.

Plan Sponsor

Pinnace West Capital Corporation

400 N 5th Street, MS 8482

Phoenix, AZ 85004

(602) 250-3500

Plan Sponsor's Employer Identification Number

86-0512431

Plan Administrator

Benefit Administration Committee

400 N 5th Street, MS 8482

Phoenix, AZ 85004

(602) 250-3500

Agent for Service of Legal Process

CT Corporation System

3800 N Central Ave, Ste 460

Phoenix, AZ 85012

Service of legal process may also be made on the Plan Administrator.

Plan Year

January 1 through December 31

Plan Funding

Benefits are paid from the Company's general assets, the Retiree Healthcare Account under the Pinnacle West Capital Corporation Retirement Plan, and/or the Pinnacle West Capital Corporation Union Health Benefits Master Trust.

Future of the Plan

The Company expects to continue the Plan but reserves the right to amend or terminate it at any time. The Company's decision to change or terminate a benefit plan or program may be due to changes in federal or state laws governing benefits, the requirements of the Code or ERISA, or any other reason. Amendments may be retroactive or prospective, but no change may be made that would result in the reduction of any benefits already incurred but unpaid under the Plan. In the event the Plan is terminated, only the expenses that have been incurred before the termination date will be eligible for reimbursement under the Plan.

If the Plan is terminated, or if there is a transfer of assets and debts or a plan split-up, you will not be vested in any Plan benefits or have any further rights, except for payment of any benefits to which you became entitled before the Plan ended. The amount and form of any final benefit you may receive will depend upon plan assets, any contract affecting the Plan, and Company decisions. Contributions to the Plan will stop on the date the Plan ends.