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**Tucson Electric Power Company**

**Retiree Welfare Plan**

**Plan Document and Summary Plan Description**

**Effective January 1, 2021**

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## Section I –Introduction

Tucson Electric Power Company (the “Company” or “TEP”) previously established the Tucson Electric Power Company Retiree Medical Plan. Effective July 1, 2007, the name of the Tucson Electric Power Company Retiree Medical Plan was changed to the Tucson Electric Power Company Benefits By Design Grandfathered Retiree Medical Plan (the “Grandfathered Plan”) and the Company established the Tucson Electric Power Company Benefits By Design Retiree Medical Plan (the “Plan”). Effective August 1, 2009, the Grandfathered Plan was merged with and into the Plan. This 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, 2021 except as otherwise noted to: (1) rename the Plan the “Tucson Electric Power Company Retiree Welfare Plan”; (2) clarify the four classes of retirees eligible for benefits under the Plan; (3) clarify the Plan’s eligibility provisions; (4) incorporate the Component Program documents by reference; (5) make changes to ensure the Plan complies with applicable law; and (6) make various clarifying changes to the Plan.

The Plan is a “retiree-only” plan that covers fewer than two Participants who are current employees. The Plan offers various Component Programs to certain Eligible Retirees including medical, dental, vision, and life insurance. Some Component Programs are self-funded, while others are 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 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. It also serves as a ‘wrap plan.’ The purpose of maintaining a wrap plan is to consolidate the various Component Programs sponsored by the Company into one plan so that TEP can file one annual report (Form 5500) for all such Component Programs. 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 II – Component Programs

The Plan includes the Component Programs identified in the chart below. An individual's ability to participate in a Component Program depends on what Class the individual is a part of.

|  | <b>CLASS 1<br/>TEP<br/>RETIREEES</b><br><br>Unclassified<br>and Classified<br>Who Retired<br>Before or on<br>June 30, 2007 | <b>CLASS 2<br/>TEP<br/>RETIREEES</b><br><br>Unclassified<br>and<br>Classified<br>Who Retired<br>on or after<br>July 1, 2007 | <b>CLASS 3<br/>SES<br/>GRANDFATHERED<br/>RETIREEES</b><br><br>Appendix B | <b>CLASS 4<br/>UES<br/>GRANDFATHERED<br/>RETIREEES</b><br><br>Appendix C |
|--|--|---|--|--|
| <b>Retiree Indemnity<br/>Plan (including<br/>Pharmacy Drug Plan)</b> | <input checked="" type="checkbox"/>  |   |  |  |
| <b>PPO Plan (including<br/>Pharmacy Drug Plan)</b>                   |  | <input checked="" type="checkbox"/>   | <input checked="" type="checkbox"/>                                      | <input checked="" type="checkbox"/><br>(Unclassified PPO<br>Plan)        |
| <b>Self-funded Dental<br/>Plan</b>                                   | <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/>   | <input checked="" type="checkbox"/>                                      |  |
| <b>Dental Maintenance<br/>Organization*</b>                          | <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/>   | <input checked="" type="checkbox"/>                                      |  |
| <b>Vision Plan**</b>   |  | <input checked="" type="checkbox"/>   | <input checked="" type="checkbox"/>                                      |  |
| <b>Life Insurance Plan</b>   | <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/>   | <input checked="" type="checkbox"/>                                      | <input checked="" type="checkbox"/>                                      |
| <b>Medicare Supplement<br/>Plan***</b>                               | <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/>   |  |  |

\* Very limited network providers outside of Southern Arizona

\*\* Only available for persons who retire on or after 02/01/2009

\*\*\* Coverage under the Retiree Indemnity Plan and PPO Plan terminates when TEP Retirees turn 65 and become eligible for Medicare. Medicare Supplement coverage is only available for classified TEP Retirees who retire prior to December 31, 2021 and unclassified TEP Retirees who retire prior to January 1, 2002.

### Retiree Indemnity Plan

The benefits provided under the Retiree Indemnity Plan will be funded in part by TEP from its general assets and/or one or more trusts and in part by Retiree contributions. TEP will determine and periodically communicate to the Retirees their share of the cost of the benefits, and it may change that determination at any time.

The benefits that are provided by the Retiree Indemnity Plan are described in the medical benefits booklet incorporated by reference in Appendix A.

Coverage is conditioned on the Claims Administrator's determination that the benefits provided meet 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 PPO Plan**

The benefits provided under the PPO Plan will be funded in part by TEP or UES from their general assets and/or one or more trusts and in part by Retiree contributions. TEP will determine and periodically communicate to the Retirees their share of the cost of the benefits, and it may change that determination at any time.

The benefits that are provided by the PPO Plan are described in the medical benefits booklet incorporated by reference in Appendix A.

Coverage is conditioned on the Claims Administrator's determination that the benefits provided meet 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 from its general assets and/or one or more trusts and in part by Retiree contributions. TEP will determine and periodically communicate to the Retirees their share of the cost of the benefits, and it may change that determination at any time.

The benefits that are provided by the Self-funded Dental Plan are described in the medical benefits booklet incorporated by reference in Appendix A.

Coverage is conditioned on the Claims Administrator's determination that the benefits provided meet 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 Retirees are paid in part by TEP from its general assets and/or one or more trusts and in part by Retirees. TEP will determine and periodically communicate to the Retirees 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 benefits provided meet 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 are paid by the Retirees. TEP will periodically communicate to the Retirees their premiums, and it may change that determination at any time.

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 benefits provided meet 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.

### **Life Insurance Plan**

The Life Insurance Plan is fully insured. Insurance premiums are paid by TEP or UES from their general assets and/or one or more trusts.

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

Coverage is conditioned on the Insurance Company's determination that the benefits provided meet 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.

### **Medicare Supplement Plan**

The Medicare Supplement Plan is fully insured. Insurance premiums for Retirees are paid by TEP from its general assets and one or more trust and the Retirees, or entirely by the Retirees.

The benefits that are provided by the Medicare Supplement Plan are described in the Medicare Supplement Plan documents incorporated by reference in Appendix A.

Coverage is conditioned on the Insurance Company's determination that the benefits provided meet 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 III – Eligibility**

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 Chart in Section II and the eligibility provisions in this Section III.

An individual is eligible for the Life Insurance Component Program under the Plan if he or she satisfies the requirements in the Component Programs Chart in Section II and the eligibility provisions in the Life Insurance Plan certificates.

An individual is eligible for the Medicare Supplement Component Program under the Plan if he or she satisfies the requirements in the Component Programs Chart in Section II and the eligibility provisions in Section V.

#### **a. Eligible Classes of Retirees**

The individuals in the following four classes are Eligible Retirees:

##### **i. Class 1 Eligible Retirees**

Class 1 Eligible Retirees include all Employees of Tucson Electric Power Company (TEP), who retired on or before June 30, 2007 and at the time of their retirement from TEP, meet, or met, all of the following conditions:

- (a)** He or she was an Employee of TEP;
- (b)** He or she was eligible for an immediate retirement benefit as a result of attaining early, normal, or late retirement age under the Tucson Electric Power Company Salaried Employees Retirement Plan or the Pension Trust Plan for Employees of UNS Energy Corporation Company Represented by I.B.E.W. Local 1116;
- (c)** He or she was eligible for participation in the Active Plan and was either a participant in the Active Plan or had declined participation due to alternate medical coverage; and
- (d)** He or she is not eligible for medical coverage under Medicare on account of attainment of age 65.

Class 1 Eligible Retirees also include:

- (e)** An unclassified Employee who qualified for long-term disability benefits under Tucson Electric Power Company Long Term Disability insurance policy prior to July 1, 1996 and classified Employee who qualified for long-term disability benefits under the Tucson Electric Power Company Long Term Disability insurance policy prior to May 1, 2000.

In the following instances, a Dependent Spouse will be deemed to be a Class 1 Eligible Retiree:

- (f)** If an Employee meets requirements (a)-(d) or (e) above, except that the Employee is eligible for medical coverage under Medicare at the time of retirement, then the Dependent Spouse of such Employee will be deemed to be an Eligible Retiree unless the Spouse is also eligible for medical coverage under Medicare on account of attainment of age 65.
- (g)** The surviving Dependent Spouse of a deceased Eligible Retiree described above.

- (h) The surviving Dependent Spouse of a deceased Employee, if, at the time of the Employee's death, he or she would have been an Eligible Retiree meeting the requirements for participation set forth in (a)-(d) or (e) above assuming he or she had then elected to retire.

In regard to (f), (g), and (h) above, if the Dependent Spouse is an active Employee, he or she may not participate in the Plan while he or she is an active Employee. Instead, he or she may participate in the Active Plan. Then, when the Dependent Spouse is no longer an active Employee, he or she may participate in the Plan in accordance with (f), (g), and (h) above.

## ii. Class 2 Eligible Retirees

Class 2 Eligible Retirees include all Employees of TEP and Participating Affiliates (the "Employer") who retire on or after July 1, 2007 and at the time of their retirement from the Employer, meet, or met, all of the following conditions:

- (a) He or she was an Employee of the Employer (and for FortisUS, Inc. was a Transferred Employee);
- (b) He or she was eligible for an immediate retirement benefit as a result of attaining early, normal, or late retirement age under the Tucson Electric Power Company Salaried Employees Retirement Plan or the Pension Trust Plan for Employees of Tucson Electric Power Company Represented by I.B.E.W. Local 1116;
- (c) He or she was eligible for participation in the Active Plan and was either a participant in the Active Plan or had declined participation due to alternate medical coverage; and
- (d) He or she is not eligible for medical coverage under Medicare on account of attainment of age 65.

For purposes of this subsection, Participating Affiliates includes FortisUS, Inc. solely with respect to "Transferred Employees." Employees of FortisUS, Inc. who are not Transferred Employees are not eligible to participate in the Plan. A "Transferred Employee" for this purpose means an Employee who is transferred to FortisUS Inc. and immediately prior to his/her transfer to FortisUS Inc. was employed by TEP.

In the following instances, a Dependent Spouse will be deemed to be a Class 2 Eligible Retiree:

- (e) If an Employee meets requirements (a)-(d) above, except that the Employee is eligible for medical coverage under Medicare at the time of retirement, then the Dependent Spouse of such Employee will be deemed to be an Eligible Retiree unless the Spouse is also eligible for medical coverage under Medicare on account of attainment of age 65.
- (f) The surviving Dependent Spouse of a deceased Eligible Retiree described above.
- (g) The surviving Dependent Spouse of a deceased Employee, if, at the time of the Employee's death, he or she would have been an Eligible Retiree meeting the requirements for participation set forth in (a)-(d) above assuming he or she had then elected to retire.

In regard to (e), (f), and (g) above, if the Dependent Spouse is an active Employee, he or she may not participate in the Plan while he or she is an active Employee. Instead, he or she may participate

in the Active Plan. Then, when the Dependent Spouse is no longer an active Employee, he or she may participate in the Plan in accordance with (e), (f), and (g) above.

**iii. Class 3 Eligible Retirees**

Class 3 Eligible Retirees include all SES Grandfathered Employees who, at the time of retirement from SES, meet, or met, all of the following conditions:

- (a) He or she is an SES Grandfathered Employee listed in Appendix B;
- (b) He or she was eligible for an immediate retirement benefit as a result of attaining early, normal, or late retirement age under the Tucson Electric Power Company Salaried Employees Retirement Plan or the Pension Trust Plan for Employees of Tucson Electric Power Company Represented by I.B.E.W. Local 1116;
- (c) He or she was eligible for participation in the Active Plan and was either a participant in the Active Plan or had declined participation due to alternate medical coverage; and
- (d) He or she is not eligible for medical coverage under Medicare on account of attainment of age 65.

In the following instances, a Dependent Spouse will be deemed to be a Class 3 Eligible Retiree:

- (e) If an Employee meets requirements (a)-(d) above, except that the Employee is eligible for medical coverage under Medicare at the time of retirement, then the Dependent Spouse of such Employee will be deemed to be an Eligible Retiree unless the Spouse is also eligible for medical coverage under Medicare on account of attainment of age 65.
- (f) The surviving Dependent Spouse of a deceased Eligible Retiree described above.
- (g) The surviving Dependent Spouse of a deceased Employee, if, at the time of the Employee's death, he or she would have been an Eligible Retiree meeting the requirements for participation set forth in (a)-(d) above assuming he or she had then elected to retire.

In regard to (e), (f), and (g) above, if the Dependent Spouse is an active Employee, he or she may not participate in the Plan while he or she is an active Employee. Instead, he or she may participate in the Active Plan. Then, when the Dependent Spouse is no longer an active Employee, he or she may participate in the Plan in accordance with (e), (f), and (g) above.

**iv. Class 4 Eligible Retirees**

Class 4 Eligible Retirees include all UES Grandfathered Employees who, at the time of retirement from UES, meet, or met, all of the following conditions:

- (a) He or she is a UES Grandfathered Employee listed in Appendix C; Employees of UES, other than UES Grandfathered Employees listed in Appendix C, may not become Eligible Retirees under the Plan;
- (b) He or she is eligible for an immediate retirement benefit as a result of having attained his or her early, normal, or late retirement age under the Pension Plan for Employees of Unisource Energy Services; and

- (c) He or she was eligible for participation in the Active Plan and was either a participant in such Plan or had declined participation due to alternate medical coverage.

In the following instances, a Dependent Spouse will be deemed to be a Class 4 Eligible Retiree:

- (d) The surviving Dependent Spouse of a deceased Eligible Retiree described above.
- (e) The surviving Dependent Spouse of a deceased Employee, if, at the time of the Employee's death, he or she would have been an Eligible Retiree meeting the requirements for participation set forth in (a)-(c) above assuming he or she had then elected to retire.

In regard to (d) and (e) above, if the surviving Dependent Spouse is an active Employee, he or she may not participate in the Plan while he or she is an active Employee. Instead, he or she may participate in the Active Plan. Then, when the surviving Dependent Spouse is no longer an active Employee, he or she may participate in the Plan in accordance with (d) and (e) above.

**v. Coverage for Employees Who Transfer**

If an individual transfers to and then retires from a non-Participating Affiliate, the Employee shall be considered an Eligible Retiree if, at the time of the transfer, he or she would have qualified as an Eligible Retiree had he or she instead retired. An Employee who transfers to a non-Participating Affiliate shall not continue to accrue service while employed by the non-Participating Affiliate.

**vi. Miscellaneous – Eligible Retiree Information**

An individual may be covered as an Eligible Retiree under this Plan, or as a participant under the Active Plan, but not both.

An individual may be covered as an Eligible Retiree under this Plan or as a Dependent of an Eligible Retiree under this Plan, but not both.

**b. Dependent Eligibility**

For Class 1, 2, and 3 Eligible Retirees, a Dependent includes a Spouse or a Child. For Class 4 Eligible Retirees, a Dependent includes a Spouse only. A Dependent is only eligible for coverage under the Plan if he or she was a Dependent: (1) immediately prior to the Eligible Retiree's retirement; or (2) immediately prior to the Eligible Retiree's death if the Eligible Retiree died before retirement.

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

**i. Spouse Eligibility**

For purposes of this Plan, a "Spouse" shall mean the person recognized as the Eligible Retiree's husband or wife under the laws of the jurisdiction in which the marriage was performed or occurred. The term "Spouse" does not include the legally separated or divorced former Spouse of the Eligible Retiree. The Plan Administrator may require documentation proving a legal marital relationship.

## ii. Child Eligibility

A Child shall mean, with respect to an Eligible Retiree:

- A natural child;
- An adopted child or child placed with an Eligible Retiree in anticipation of adoption. The phrase "child placed with an Eligible Retiree in anticipation of adoption" refers to a child whom the Eligible Retiree intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Eligible Retiree 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;
- A step child who resides in the Eligible Retiree's household as long as a natural parent remains married to the Eligible Retiree and also resides in the Eligible Retiree's household; or
- An alternate recipient under a qualified medical child support order ("QMCSO"). A Participant in this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

In order to qualify as a Dependent Child eligible for the Plan the Child must meet all of the following requirements:

- The Child is unmarried;
- The Child meets one of the following age limits:
  - is less than 19 years of age;
  - is age 19-23 years of age and is a full-time student at an accredited school;
  - is 19 or older, is not eligible for Medicare, and was continuously covered prior to attaining the age limits described above and is currently, and was prior to attaining age 19 or 23 if a full-time student at an accredited school, mentally or physically incapable of sustaining his or her own living. The Eligible Retiree must apply for coverage and submit proof of incapacity within 31 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. BCBSAZ will determine whether a Child meets disability criteria in its sole and absolute discretion and will provide a copy of the criteria used to make this decision upon request. An Eligible Retiree must inform BCBSAZ if the Child's disability ceases. Cessation of the Child's disability or dependency will terminate the Child's coverage a Dependent under the Plan.
- The Child must be primarily dependent upon the Eligible Retiree for support and maintenance which means that the Child must be dependent upon the Eligible Retiree for over one-half of his support during the Plan Year. However, a special rule applies in the case of a Child of divorced parents, legally separated parents, or parents who lived apart at all times of the year or during the last six months of the Calendar Year. In those instances, the Child will be considered dependent upon the Eligible Retiree

for over one-half of his support if the Child is in the custody of the Eligible Retiree and/or the other parent for more than one-half of the year and the Child is dependent upon one and/or both parents for more than one-half of his support for the year. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

### **Special Rules for Dependent Children**

Also, in order to be eligible for coverage, a Dependent Child must have been a Dependent Child immediately prior to the Eligible Retiree's retirement or the Eligible Retiree's death if the Eligible Retiree died before retirement.

If both mother and father are Eligible Retirees covered under the Plan, their Children will be covered as Dependents of the mother or father, but not of both.

If two Eligible Retirees (husband and wife) are covered under the Plan and the Eligible Retiree who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Eligible Retiree as long as coverage has been continuous.

### **Newborn Children**

If an Eligible Retiree or Eligible Retiree's Spouse is pregnant at the time of retirement, the Eligible Retiree is not able to add the unborn child after birth as this child is considered to be acquired after the Eligible Retiree's retirement from the Company and therefore is not eligible to receive Dependent coverage.

The benefit is limited to charges for inpatient nursery care for the newborn child while hospital confined as a result of the child's birth. Facility charges for covered inpatient nursery care and healthy newborn physician care for the newborn will be applied toward the Plan of the covered parent.

### **iii. Other Dependent Eligibility Rules**

#### **Exclusions**

These persons are excluded as Dependents:

- other individuals living in the Eligible Retiree's home, but who are not eligible as defined;
- any person who is on active duty in any military service of any country; or
- any person who is eligible for coverage under the Active Plan, unless the person is married to an Eligible Retiree.

#### **Changes from Eligible Retiree to Dependent Status**

If a person covered under this Plan changes status from Eligible Retiree to Dependent or Dependent to Eligible Retiree, 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 applied to maximums.

### **Special Rules for Dependents Deemed to be Eligible Retirees**

As explained in more detail in (a. **Eligible Classes of Retirees**), in certain instances a Dependent Spouse is deemed to be an Eligible Retiree under the Plan. If a Dependent Spouse is deemed to be an Eligible Retiree, such individual may not enroll his or her Dependents in the Plan, unless his or her Dependents were the Eligible Retiree's Dependents immediately prior to the Eligible Retiree's retirement, or death (if the Eligible Retiree died before retirement).

For example, if a Class 2 Eligible Retiree participating in the Plan dies, his Spouse is deemed to be an Eligible Retiree. If such Spouse (who is deemed to be an Eligible Retiree) remarries, she cannot enroll her new spouse in the Plan. However, if the deceased Eligible Retiree and Spouse (who is deemed to be an Eligible Retiree) had a Dependent Child prior to the Eligible Retiree's death, the Spouse (who is deemed to be an Eligible Retiree) may enroll that Dependent Child in the Plan.

#### **c. Effective Date of Coverage**

##### **i. Eligible Retiree**

All new Eligible Retirees (and their Dependents, as applicable) will be eligible for coverage on the Eligible Retiree's date of retirement provided that proper enrollment has been timely completed.

If an Eligible Retiree fails to elect coverage or waives coverage, he or she may elect coverage during a subsequent Open Enrollment Period and such coverage shall commence as of the first day of the Plan Year for which the Open Enrollment Period was held. Alternatively, an Eligible Employee may elect coverage if he or she qualifies during a Special Enrollment Period.

If an Eligible Retiree participates in the Plan and fails to make an election during an Open Enrollment Period, his or her coverage election with respect to the preceding Plan Year shall remain in effect for the current Plan Year.

### **Special Rule for Class 4 Eligible Retirees**

Prior to July 1, 2007, UES Grandfathered Employees were covered under a plan now known as the Tucson Electric Power Company Benefits By Design Grandfathered Retiree Medical Plan. Effective July 1, 2007, those UES Grandfathered Employees are automatically covered under this Plan and do not need to enroll in this Plan.

##### **ii. Dependent**

Except as provided in the "Special Enrollment and Disenrollment Rights" subsection, Dependent coverage will generally begin on the same day as the Eligible Retiree, provided that the Dependent satisfies the requirements for Dependent coverage and proper enrollment has been made.

If a person who is otherwise eligible to become an Eligible Retiree dies while employed by the Employer, his or her eligible surviving Dependents will be covered on the date of death provided that proper enrollment is completed within the first 31 days following the death.

#### **d. Enrollment**

An Eligible Retiree may enroll in the Plan during: (1) Initial Enrollment; (2) Open Enrollment; or (3) Special Enrollment. An Eligible Retiree must enroll for coverage by timely filling out and signing an enrollment application. The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If the Eligible Retiree does not enroll for coverage within 31 days after he or she first

becomes eligible, he or she will not be enrolled in the Plan but may elect to enroll in the Plan during a subsequent Open Enrollment Period or Special Enrollment Period as explained in more detail below.

An Eligible Retiree may enroll his or her Dependents for coverage under the Plan.

**e. Reinstatement of Coverage**

If coverage terminates because the Eligible Retiree returns to work for the Company and becomes eligible for coverage under the Active Plan, the Eligible Retiree and his or her Dependents as applicable will be eligible for coverage in the Plan as of the Eligible Retiree's subsequent retirement date provided that proper enrollment has been timely completed.

**f. Enrollment Elections**

Elections made pursuant to this document shall include an agreement to contribute any Participant contributions required under the Plan, at such time and in such manner as the Plan Administrator shall determine. In addition, the following rules shall apply to Participant elections hereunder:

- i. Elections shall specify whether the Participant elects the Plan or waives coverage because of other health insurance coverage, with respect to the Participant and his or her Dependents.
- ii. Elections must be evidenced in writing by a completed approved enrollment form and timely received by the Plan Administrator or its delegate. An election made pursuant to this document shall remain in effect until it is subsequently modified during an annual Open Enrollment Period or Special Enrollment Period.
- iii. If a newly retired Eligible Retiree, or Dependent Spouse who is deemed to be an Eligible Retiree (as applicable), fails to make a timely election to participate in this Plan, then such Eligible Retiree will not be enrolled in the Plan for the remainder of the Plan Year. However, the Eligible Retiree may elect to participate in the Plan in a subsequent Plan Year or pursuant to a Special Enrollment event.

**g. Open Enrollment**

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

If a new Eligible Retiree does not timely enroll when first eligible, the individual may elect to participate in the Plan during any subsequent Open Enrollment Period in which he or she continues to be an Eligible Retiree.

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 family status during the year (death, divorce, legal separation, a person ceasing to be a Dependent, coverage under a plan with a coverage period other than the Calendar Year) or loss of coverage due to loss of a Spouse's employment. An election to change coverage must be made within 31 days of the event.

A Plan Participant who fails to make an election during Open Enrollment will automatically retain his or her present coverages. In the event that the Plan Participant's present coverage is no longer available the Participant will be advised that he/she must make an election or waive coverage.

Eligible Retirees will receive detailed information regarding Open Enrollment from the Employer.

## **h. Special Enrollment and Disenrollment Rights**

An Eligible Retiree and/or Dependent may be eligible to enroll in the Plan outside of the Plan's Initial Enrollment or Open Enrollment periods under some circumstances described in more detail below.

### **i. Special Enrollment for Individuals Who Lose Coverage Under a Group Health Plan or Health Insurance.** If an Eligible Retiree declines enrollment for the Eligible Retiree or a Dependent because of other health plan or health insurance coverage, the Eligible Retiree may subsequently enroll himself or herself, and a Dependent(s), in the Plan, provided he or she satisfies the following requirements:

- (a)** The individual was covered under a group health plan or had health insurance at the time the individual was most recently eligible to participate in the Plan;
- (b)** The individual moves out of the coverage area reasonably available under such plan or insurance or the individual's other coverage under such plan or insurance ceases because:
  - i. the individual had exhausted his or her rights to continuation coverage;
  - ii. employer contributions for such other coverage ceased;
  - iii. the individual, whose other coverage was not pursuant to continuation coverage requirements, was no longer eligible for such other coverage;
  - iv. the individual remains eligible for such other coverage but there is a significant change in benefits and/or cost of coverage; or
  - v. the Dependent changes coverage elections under his or her employer's health plan that permits mid-year changes, where the other plan's coverage period does not correspond to the Plan's Plan Year;
- (c)** The Eligible Retiree's election for such individual is received by the Plan Administrator or the Plan Administrator's designee no later than 31 days after the individual's coverage under such group health plan or health insurance ceases and coverage shall begin no later than the first day of the calendar month following the date the Plan Administrator receives the enrollment form; and
- (d)** In the case of a Dependent, the related Eligible Retiree must elect, or have elected, coverage for himself or herself under the Plan (except in certain instances when the Dependent Spouse is deemed to be the Eligible Retiree).

If the Eligible Retiree 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.

### **ii. Disenrollment for the Loss of a Dependent or Due to the Commencement of Other Coverage.** An Eligible Retiree may elect out of coverage under the Plan for the Eligible Retiree and/or his or her covered Dependents outside of an enrollment period, provided he or she satisfies the following requirements:

- (a)** The Eligible Retiree loses a covered Dependent due to divorce, legal separation or death, or a covered Dependent Child ceases to be eligible because he or she marries, reaches the limiting age, is no longer a full-time student, ceases to be

disabled, becomes covered by Medicare, or the Eligible Retiree or covered Dependent becomes covered under another employer health plan or health insurance that permits mid-year changes, where the other plan's coverage period does not correspond to the Plan's Plan Year; and

- (b) The Eligible Retiree's election for such individual is received by the Plan Administrator or the Plan Administrator's designee no later than 31 days after the date the Eligible Retiree loses such covered Dependent or the individual's coverage under such other group health plan or health insurance commences.

**iii. Special Enrollment for Individuals Who Lose Medicaid or State Children's Health Insurance Program (SCHIP)**

- (a) If an Eligible Retiree has declined enrollment in the Plan for himself or herself, or his or her Dependents (including a Spouse) because of coverage under a Medicaid plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act, or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. A written request for enrollment must be made no later than sixty (60) days after the government-provided coverage ends.

**iv. Special Enrollment for Individuals Who Become Eligible for a State Premium Assistance Subsidy from Medicaid or SCHIP**

- (a) If an Eligible Retiree has declined enrollment in the Plan for himself or herself, or his or her Dependents (including a Spouse), and such Eligible Retiree or Dependent later becomes eligible for state assistance with respect to coverage under the Plan through a Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), then there may be a right to enroll in this Plan. However, a written request for enrollment must be made no later than sixty (60) days after the determination of eligibility for the state assistance.

| <b>High Level Summary of Special Enrollment and Disenrollment Circumstances and Options</b> |   |
|---|---|
| <b>If you...</b>  | <b>You can...</b>                         |
| <b>lose other coverage</b>  | <b>enroll in coverage</b>                 |
| <b>have a Dependent who loses coverage</b>  | <b>enroll that Dependent in coverage</b>  |
| <b>lose a Dependent</b>   | <b>cancel coverage for that Dependent</b> |
| <b>gain other coverage</b>  | <b>disenroll in coverage</b>              |
| <b>have a Dependent who gains other coverage</b>  | <b>cancel coverage for that Dependent</b> |

Any election described above shall be made in the manner prescribed by the Plan Administrator and shall be consistent with the event giving rise to such election. Coverage election under this "Special Enrollment" subsection shall become effective on the first day of the calendar month following the date the election is received by the Plan Administrator or the Plan Administrator's designee.

If an individual enrolls during a Special Enrollment Period, any period before such Special Enrollment Period is not treated as a waiting period.

To request special enrollment or obtain more detailed information of these provisions, contact the Plan Administrator.

**i. Termination of Coverage**

Notwithstanding anything herein to the contrary, in the event that a Participant ceases to participate in the Plan because of a qualifying event, such Participant may be entitled to continuation coverage in accordance with the COBRA. The rules regarding COBRA continuation coverage are contained in Section X.

- i. When Eligible Retiree Coverage Terminates.** An Eligible Retiree's coverage shall cease on the earliest of:
- (a)** Midnight on the date that this Plan is terminated;
  - (b)** Midnight on the date preceding the date the Eligible Retiree becomes eligible for medical coverage under Medicare on account of attainment of age 65;
    - i. This applies to Participants in the Retiree Indemnity Plan.
    - ii. This applies to Participants in the PPO Plan.
    - iii. This does not apply to UES Grandfathered Employees.
  - (c)** Midnight on the day the Eligible Retiree elects out of coverage under the Plan, including an election to waive coverage because of other health insurance coverage;
  - (d)** Midnight on the date of the Eligible Retiree's death;
  - (e)** Midnight on the date preceding the effective date of coverage under the Active Plan if the Eligible Retiree returns to employment with the Company and is eligible to participate in the Active Plan;
  - (f)** Midnight on the date preceding the date the Eligible Retiree enters military service with any country;
  - (g)** Midnight on the last day of the month in which the Eligible Retiree fails to make a contribution required under the Plan;
  - (h)** The earliest date the Eligible Retiree has a claim that is denied in whole or in part because the Eligible Retiree has met or exceeded a lifetime limit on all benefits;
  - (i)** The date coverage under this Plan commenced if such coverage was obtained through the Participant's submission of fraudulent information, and such coverage would have been denied if accurate information had been submitted; or
  - (j)** In the case of an Eligible Retiree who is an unclassified Employee who qualified for long-term disability benefits under Tucson Electric Power Company Long Term Disability insurance policy prior to July 1, 1996 or a classified Employee who qualified for long-term disability benefits under the Tucson Electric Power Company Long Term Disability insurance policy prior to May 1, 2000, the date he or she ceases to be eligible for long-term disability benefits under such plan(s), unless he or she otherwise qualifies as a Class 1 Eligible Retiree.

**NOTE:** If an Eligible Retiree's coverage is terminated for any of the foregoing reasons, other than because he or she elected to waive coverage under the Plan because of other health coverage (i.c), because he or

she became covered by the Active Plan (i.e.), or because of military service (i.f.), the Retiree will not be able to recommence coverage under the Plan.

- ii. **When Dependent Coverage Terminates.** Dependents of an Eligible Retiree shall cease to participate in the Plan on the earliest of:
  - (a) Midnight on the date that the Plan or Dependent coverage under the Plan is terminated;
  - (b) Midnight on the date preceding the date the Dependent becomes eligible for medical coverage under Medicare on account of attainment of age 65;
    - i. This applies to Participants in the Retiree Indemnity Plan.
    - ii. This applies to Participants in the PPO Plan.
    - iii. This does not apply to a UES Grandfathered Employee's Dependent Spouse.
  - (c) Midnight on the date the Eligible Retiree elects that coverage of a Dependent be terminated, provided that such election is made at such time and in such manner as the Plan Administrator shall determine;
  - (d) Midnight on the date prior to the date the Dependent Child ceases to be a Dependent as defined by the Plan.
  - (e) With respect to a Dependent Spouse, midnight on the day in which the Dependent Spouse and Eligible Retiree's divorce or legal separation becomes effective;
  - (f) Midnight on the date of the Eligible Retiree's death unless the Dependent is deemed to be an Eligible Retiree due to the death of the Eligible Retiree;
  - (g) Midnight on the date the Eligible Retiree ceases to participate in the Plan for any reason other than becoming eligible for medical coverage under Medicare on account of attainment of age 65, except to the extent that a Dependent is deemed to be an Eligible Retiree due to the death of an Eligible Retiree;
  - (h) Midnight on the date preceding the effective date of coverage under the Active Plan if the Eligible Retiree returns to employment with the Company and is eligible to participate in the Active Plan;
  - (i) Midnight on the date preceding the date the Eligible Retiree or Dependent enters military service with any country;
  - (j) Midnight on the last day of the month in which the required contribution under the Plan has not been made;
  - (k) The earliest date the Dependent has a claim that is denied in whole or in part because the Dependent has met or exceeded a lifetime limit on all benefits;
  - (l) The date coverage under this Plan commenced if such coverage was obtained through the submission of fraudulent information, and such coverage would have been denied if accurate information had been submitted;

- (m) If a Dependent is deemed to be an Eligible Retiree, the Dependent's coverage will also terminate upon the occurrence of any event described above "When Eligible Retiree Coverage Terminates";
- (n) In the case of a totally disabled adult Dependent Child, the date the totally disabled adult Dependent Child becomes eligible for medical coverage under Medicare for any reason.

**NOTE:** If a Dependent's coverage is terminated for any of the foregoing reasons, other than because he or she elected to waive coverage under the Plan because of other health coverage (ii.(g)), because he or she became covered by the Active Plan (ii.(h)), or because of military service (ii.(i)), the Dependent will not be able to recommence coverage under the Plan.

#### Section IV – CareHere Clinic

CareHere is an on-site clinic operated and staffed by an independent health care provider. All Participants in the Retiree Indemnity and PPO Plans 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 Retiree Indemnity Plan or PPO Plan 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 Retiree Indemnity or PPO Plan – for example when an individual's coverage under either Plan is terminated, or when a Participant stops receiving regular benefits and starts receiving Medicare Supplement coverage. 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, neither 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.

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

## **Section V – Medicare Supplement**

The Medicare Supplement group coverage is fully insured. A Participant should refer to the AARP Medicare Supplement Plan Guide and enrollment materials to obtain additional information about the Medicare Supplement benefit, effective date of coverage, enrollment, and termination of coverage.

### **Class 1 and Class 2 Eligible Retirees**

When a Class 1 or Class 2 Eligible Retiree or Dependent Spouse turns 65 and becomes eligible for Medicare, coverage under the Retiree Indemnity Plan and PPO Plan terminates. Upon termination of such coverage, certain Eligible Retirees and Dependent Spouses shall be eligible for Medicare Supplement group coverage under the Plan. Those Eligible Retirees include: (1) classified TEP Eligible Retirees who retire prior to December 31, 2021; and (2) unclassified TEP Eligible Retirees who retire prior to January 1, 2002.

### **Class 3 Eligible Retirees**

When a Class 3 Eligible Retiree or Dependent Spouse turns 65 and becomes eligible for Medicare, coverage under the PPO Plan terminates. Upon termination of such coverage, Class 3 Eligible Retirees and their Dependent Spouses are not eligible for Medicare Supplement group coverage under the Plan.

### **Class 4 Eligible Retirees**

Class 4 Eligible Retirees do not lose coverage under the PPO Plan when they turn 65 and become eligible for Medicare. Therefore, Class 4 Eligible Retirees and their Dependent Spouses are not eligible for the Medicare Supplement group coverage under the Plan.

## Section VI – 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 Plan** means the Tucson Electric Power Benefits by Design Health Plans.

**BCBSAZ** means Blue Cross Blue Shield of Arizona.

**Calendar Year** means January 1 through December 31.

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

**Child** has the meaning set forth in Section III. Eligibility.

**Claims Administrator** means the entity that administers claims for benefits under the Plan. The Plan has various Claims Administrators identified in Section XVI. 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 X. 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 and welfare benefits offered under the Plan (e.g., medical, dental, and vision benefits), as identified in Appendix A.

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

**Dependent Child** has the meaning set forth in Section III. Eligibility.

**Dependent Spouse** has the meaning set forth in Section III. Eligibility.

**Eligible Retiree** or **Retiree** means an individual in one of the four classes of Retirees identified in Section III. Eligibility.

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

**Employee** means an individual who is a common-law employee of the Employer as determined by the Employer. 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. The Employer's classification shall be binding for purposes of determining eligibility under this Plan.

**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.

**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** 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.

**Life Insurance Plan** means the Component Program that provides life insurance benefits as identified in Appendix A.

**Medicare Supplement** means the Component Program that provides Medicare Supplement benefits as identified in Section V. Medicare Supplement and Appendix A.

**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 III. Eligibility.

**Participant** or **Plan Participant** means any Eligible Retiree or Dependent who is covered under this Plan.

**Participating Affiliate** means a company related to TEP that has adopted the Plan. As of January 1, 2021, the only related company that has adopted the Plan, other than TEP, is FortisUS, Inc. (solely with respect to "Transferred Employees"). Southwest Energy Solutions was previously a Participating Affiliate, but such participation ceased as of December 31, 2020. The related companies that have adopted the Plan may be modified at any time by the Plan Administrator without necessity of adopting a formal amendment.

**Plan** means the Tucson Electric Power Company Retiree Welfare Plan as described in this document.

**Plan Administrator** means the Committee.

**Plan Sponsor** means Tucson Electric Power Company.

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

**PPO Plan** means one of the Plan's Component Programs that provides medical benefits.

**Retiree Indemnity or Retiree Indemnity Plan** means one of the Plan's Component Programs that provides medical benefits.

**SES** means Southwest Energy Solutions, Inc.

**SES Grandfathered Employees** means the closed class of SES Grandfathered Employees who are eligible to participate in the Plan.

**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 III. Eligibility.

**Spouse** has the meaning set forth in Section III. Eligibility.

**TEP** means Tucson Electric Power Company.

**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.

**UES Grandfathered Employees** means the closed class of UES Grandfathered Employees that are eligible to participate in the Plan.

## **Section VII – 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 Plan 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 a 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:

|   |  |
|---|--|
| <b>Initial benefit determination:</b>   | The claimant will be notified within 72 hours.   |
| <b>If the claimant fails to follow the Plan's procedure for filing a claim:</b> | The claimant will be notified of the failure, orally or in writing, and the proper procedures within 24 hours.   |
| <b>If the claim is insufficient:</b>  | <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>  |
| <b>Appeal of an adverse benefit determination:</b>                              | <p>1. The claimant may file a written appeal within 180 days of receipt of an adverse benefit determination.</p> <p><b>Expedited Appeals</b></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:

|   |  |
|---|--|
| <b>If the pre-approved period of time or number of treatments is reduced or terminated:</b> | 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. |
|---|--|

|  |  |
|--|--|
| <p><b>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:</b></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><b>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:</b></p> | <p>The claimant will be notified according to the normal pre-service or post-service timetables, as applicable to the claim.</p>   |
| <p><b>Adverse benefit determination appeals related to reduction or termination of the pre-approved period of time or number of treatments:</b></p>  | <ol style="list-style-type: none"> <li>1. The claimant may file a written appeal within the period specified in the adverse benefit determination notice.</li> <li>2. Notification of an adverse benefit determination will be provided before the reduction or termination of the benefit.</li> </ol>   |
| <p><b>Adverse benefit determination appeals related to requests to extend the pre-approved period of time or number of treatments:</b></p>   | <ol style="list-style-type: none"> <li>1. The claimant may file a written appeal within 180 days of receipt of an adverse benefit determination.</li> <li>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.</li> </ol>                             |

### 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><b>Initial benefit determination:</b></p>   | <p>The claimant will be notified within 15 days.</p>  |
| <p><b>If the claimant fails to follow the Plan's procedure for filing a claim:</b></p> | <p>The claimant will be notified of the failure, orally or in writing, and the proper procedures within 5 days.</p>   |
| <p><b>If the claim is insufficient:</b></p>  | <ol style="list-style-type: none"> <li>1. The claimant will be notified of the specific insufficient information within 15 days.</li> <li>2. The claimant must respond within 45 days of receiving notice of the insufficient claim.</li> </ol> |

|  |  |
|--|--|
|  | 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. |
| <b>If an extension is necessary due to matters beyond the control of the Plan:</b> | 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.  |
| <b>Adverse benefit determination on appeal:</b>                                    | 1. The claimant may file a written appeal within 180 days of receipt of an adverse benefit determination.<br><br>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:

|   |   |
|---|---|
| <b>Initial benefit determination:</b>   | The claimant will be notified within 30 days.   |
| <b>If the claimant fails to follow the Plan's procedure for filing a claim:</b> | 1. The claimant will be notified of the specific insufficient information within 30 days.<br><br>2. The claimant must respond within 45 days of receiving notice of the insufficient claim.<br><br>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. |

|   |  |
|---|--|
| <p><b>If an extension is necessary due to matters beyond the control of the Plan:</b></p> | <p>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.</p> |
| <p><b>Adverse benefit determination on appeal:</b></p>                                    | <p>1. The claimant may file a written appeal within 180 days of receipt of an adverse benefit determination.</p> <p>2. Notification of the benefit determination will be provided within 60 days of receipt of the appeal.</p>   |

**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:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) 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.
- (4) A description of any applicable Plan review procedures and the time limits applicable to such 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.
- (5) 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”).
- (6) 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.
- (7) If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
- (8) 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.

- (9) 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:

- (1) was relied upon in making the benefit determination;
- (2) 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;
- (3) 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
- (4) 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.

## **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.

## **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 Plan Participant or Dependent on whose behalf such payment was made.

A Plan 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 Plan 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 Plan 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 Plan Participant, provider or other person or entity to enforce the provisions of this Section, then that Plan Participant, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan 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 Plan 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:

- (1) In error;
- (2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- (3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- (4) With respect to an ineligible person;
- (5) In anticipation of obtaining a recovery if a Plan Participant fails to comply with Section IX "Third Party Recovery Provision - Subrogation and Reimbursement Provisions"; or
- (6) 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 (6) 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 Plan Participant or by any of his covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan 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 plan participant for any outstanding amount(s).

## **Section VIII – Coordination of Benefits**

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 Spouse is covered by this Plan and by another plan or the couple's covered Children are covered by this Plan and another plan, the Plan 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 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 network provider, or the usual and customary and reasonable charge of non-network providers, 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:

- (1) any primary payer besides the Plan;
- (2) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) any policy of insurance from any insurance company or guarantor of a third party;

- (4) worker's compensation or other liability insurance company; or
- (5) 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, retiree, 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 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 VII, 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 the Section VII 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 Plan Participant under the Plan.

## Section IX – Third Party Recovery Provision - Subrogation and Reimbursement Provisions

### a. Payment Condition

- i. The Plan, in its sole discretion, may elect, but is not required, 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 a third party, or the acts or omissions of Participants or their Dependents, beneficiaries, estates, heirs or assigns (collectively referred to hereinafter in this Section as “Plan Beneficiary”), where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorists and medical payment provisions (collectively “Coverage”).
- ii. Plan Beneficiary, his or her attorney, and /or Legal Guardian of a minor or incapacitated individual agrees, by acceptance of the Plan’s payment of medical benefits is constructive notice of this provision in its 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 and without dissipation except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits under the Plan, the Plan Beneficiary agrees that the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney, if any, from any source and shall be held in trust until such time as the obligation under this provision is fully satisfied.
- iii. In the event a Plan Beneficiary settles, recovers or is reimbursed by any third party or Coverage, 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.

### b. Subrogation

- i. As a condition to participating in and receiving benefits under this 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 to any Coverage to which the Plan Beneficiary is entitled, regardless of how classified or characterized.
- ii. 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.
- iii. The Plan may in its own name or in the name of the Plan Beneficiary or his/her personal representative 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 extended by the Plan.
- iv. If the Plan Beneficiary fails to make a claim against 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 or personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
  - (c) any policy or contract 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 coverings;

then 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 sources listed above.

**c. Right of Reimbursement**

- i. 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, and without regard to whether the Plan Beneficiary is fully compensated by his/her recovery from all sources. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment specifically designates the recovery of 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.
- ii. The Plan's equitable subrogation lien specifically supersedes all common law or statutory rules and doctrines such as the "make whole doctrine" the "common fund doctrine" and the law of any state prohibiting any assignment of rights, which interferes with or compromises in any way the Plan's equitable subrogation lien.
- iii. The Plan will not be responsible for any expenses, attorney's fees, costs or other monies incurred by the attorney for the Plan Beneficiary or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
- iv. The Plan's right of subrogation and reimbursement shall not be reduced or affected as a result of any fault or claim on the part of the Plan Beneficiary or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
- v. 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 or caused the applicable sickness, injury, disease or disability.

**d. Excess Insurance**

- i. If at the time of injury, sickness, disease or disability there is available, or potentially available (based on information known or provided to the Plan, or to the Plan Beneficiary) any other Coverage (including but not limited to Coverage resulting from judgment at law or settlements) the benefits under this Plan shall apply only as excess insurance over such 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.

**e. Separation of Funds**

- i. 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.

**f. Wrongful Death Claims**

- i. 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 still apply.

**g. Obligations**

- i. It is the Plan Beneficiary's obligation to:
  - (a) cooperate with the Plan or any representatives of the Plan in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in trial in order to preserve the Plan's subrogation 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 right of subrogation and reimbursement;
  - (e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
  - (f) To not settle or release, without the prior consent of the Plan, any claim that the Plan Beneficiary may have against any legally responsible party or Coverage to the extent the Plan is or may be entitled to any part of such settlement proceeds.
- ii. Failure to comply with any of these requirements by the Plan Beneficiary, his or her attorney, or guardian 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 this Plan may be withheld until the Plan Beneficiary satisfies his or her obligation. If the Plan Beneficiary fails to reimburse the Plan all of the 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.

**h. Offset**

- i. 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 forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Plan Beneficiary satisfies his or her obligation.

**i. Minor Status**

- i. 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 requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
- ii. If the minor's parents or court-appointed guardian fail or refuse 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.

**j. Language Interpretation**

- i. 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/reimbursement rights.

**k. Severability**

- i. 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 valid or illegal language had never been inserted in the Plan.

## **Section X – Continuation Coverage Rights Under COBRA**

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Retirees 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, 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 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 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") at group rates. 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 a loss of coverage, is covered under a Plan by virtue of being on that day either a Retiree, the Spouse of a Retiree, or a Dependent Child of a Retiree. 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 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.

An individual is not a Qualified Beneficiary if the individual's status as a Retiree 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 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:

- (1) The death of a Retiree.
- (2) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).
- (3) The divorce or legal separation of a Retiree from the Retiree's Spouse. If the Retiree reduces or eliminates the Retiree's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) The institution of a bankruptcy proceeding under Title 11 of the United States Code with respect to the Company that results in a substantial elimination of coverage under the Plan for a Retiree or a covered Dependent within one year before or after the institution of such a proceeding. This may only be a Qualifying Event for Retirees who retired on or before the date of substantial elimination of coverage and any other Plan Participant who, on the day before the Qualifying Event was the Retiree's Spouse, surviving Spouse or Dependent Child. To the extent permitted by law, a Participant entitled to COBRA due to a bankruptcy proceeding who had individual coverage at the time of the Qualifying Event will not be permitted to change to family coverage, or add new Dependents after the Qualifying Event, except to the extent such Participant could have added a Dependent if he or she was still covered under the Plan.
- (5) The Retiree or the Retiree's Spouse entitlement to Medicare.

If the Qualifying Event causes the Retiree, or the covered Spouse or a Dependent Child of the Retiree, 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.

**What factors should be considered when determining to elect COBRA continuation coverage?** In considering whether to elect continuation coverage, you should take into account that 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.

**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 no 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 Retiree 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 is responsible for notifying the COBRA Administrator within 30 days of the occurrence of the following events:

- (1) the Retiree dies;
- (2) the Employer commences a bankruptcy proceeding; and
- (3) the Retiree become entitled to Medicare based on age.

**IMPORTANT:**

For the other Qualifying Events (death, divorce, or legal separation of the Retiree 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 or email your notice to:

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 Retiree 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.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

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. Retirees may elect COBRA continuation coverage for their Spouses, and Retirees 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 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).
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (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). This rule does not apply to a person who becomes a Qualified Beneficiary due to a bankruptcy proceeding.

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 death, divorce, legal separation, covered Retiree becoming entitled to Medicare benefits, or a Dependent Child ceasing to be a Dependent, the maximum coverage period ends 36 months after the loss of coverage.
- (2) In the case of a Qualifying Event that is the institution of a bankruptcy proceeding, the maximum coverage period, for a Qualified Beneficiary who is the retired employee, ends on the date of his or her death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent Child of the retired employee ends on the earlier of:
  - (a) the date of the Qualified Beneficiary's death: or
  - (b) the date that is 36 months after the date of the Retiree's death.

**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. 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, Retirees 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 Company and the entity that provides Plan benefits on the Company's behalf, the Company 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.

## **IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, 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](http://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 COBRA Administrator and 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 COBRA Administrator and Plan Administrator.

## **Section XI – 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 XVI. The Committee delegates claims administration of the Plan’s insured Component Programs to the applicable Insurance Company identified in Section XVI.

### **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 Retirees 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 XII – 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 Benefits by Design Health Plans, 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:

- HR Benefits Services;
- Employee & Labor Relations;
- HR Training;
- 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 (PrognoCIS);

- 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 XIII – 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, on a monthly basis 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 Retiree Indemnity Plan, PPO 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 and/or plan assets that are held in trust for the benefit of Eligible Retirees and their Dependents. Benefits are paid directly from the Plan through the Claims Administrator.

### **Insured Benefits**

The benefits provided under the DMO, Vision Plan, Life Insurance Plan, and Medicare Supplement Policy are insured. The Employer collects the premiums (except for Medicare Supplement Policy) and pays its portion of the premium from its general assets and/or plan assets that are held in trust for the benefit of Eligible Retirees and their Dependents.

### **Trusts**

Effective September 1, 2009, the Company established two trusts to hold plan assets, the Tucson Electric Power Company Retiree Medical Benefit Trust for Classified Employees (the "VEBA Trust") and the Tucson Electric Power Company Retiree Medical Benefits Trust for Unclassified Employees and UES Employees (the "Taxable Trust").

## **Section XIV – Miscellaneous Provisions**

### **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.

## **Section XV – 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 XVI – General Plan Information

### Type of Administration

The Plan is composed of various Component Programs that are self-funded or 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 one or more trusts and in part by Retiree (or Dependent) contributions. The insured benefit programs are administered by the Insurance Company. Insurance premiums are paid in part by the Company from its general assets and one or more trusts and in part by Retiree (or Dependent) contributions.

|  |   |
|--|---|
| <b>Name of Plan:</b>   | Tucson Electric Power Company Retiree Welfare Plan  |
| <b>Plan Sponsor:</b>   | Tucson Electric Power Company<br>Benefit Services<br>P.O. Box 711<br>Tucson, Arizona 85702  |
| <b>Plan Administrator<br/>(Named Fiduciary):</b>   | Tucson Electric Power Company<br>Employee Welfare Benefits Committee<br>Benefit Services<br>P.O. Box 711<br>Tucson, Arizona 85702   |
| <b>Plan Sponsor ID No. (EIN):</b>  | 86-0062700  |
| <b>Source of Funding:</b>  | Self-funded (Retiree Indemnity Plan, PPO Plan, Self-funded Dental)<br><br>Insured (DMO, Vision, Life Insurance, Medicare Supplement)<br><br>Tucson Electric Power Company Retiree Medical Benefit Trust for Classified Employees<br><br>Tucson Electric Power Company Retiree Medical Benefits Trust for Unclassified Employees and UES Employees |
| <b>Plan Year:</b>  | January 1 – December 31   |
| <b>Plan Number:</b>  | 509   |
| <b>Plan Type:</b>  | Medical (Prescription Drug, CareHere Clinic)<br>Dental<br>Vision<br>Medicare Supplement<br>Life Insurance   |
| <b>Third Party Administrator/<br/>Claims Administrator for<br/>Retiree Indemnity Plan, PPO<br/>Plan:</b> | Blue Cross Blue Shield of Arizona<br>P.O. Box 13466<br>Phoenix, AZ 85002-3466<br>(855) 818-0239   |

**Third Party Administrator/  
Claims Administrator for  
Prescription Drugs:**

Express Scripts Inc.  
PO Box 66587  
St. Louis, MO 63166-6587  
Attn: Admin Appeals Department  
800-946-3979

**Third Party Administrator/  
Claims Administrator for  
Self-funded Dental Plan:**

Delta Dental of Arizona  
P.O. Box 43000  
Phoenix, Arizona 85080-3000  
(602) 938-3131  
(800) 352-6132

**Adopting Employer:**

Tucson Electric Power Company

**Participating Affiliate(s):**

FortisUS Inc. (solely with respect to "Transferred Employees")

**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

**Medicare Supplement  
Insurance Carrier/Claims  
Administrator:**

UnitedHealthcare Insurance Company  
P.O. Box 30607  
Salt Lake City, UT 84130-0607

**Life Insurance Carrier/Claims  
Administrator:**

The Hartford  
Group Benefits Division, Customer Service  
P.O. Box 2999  
Hartford, CT 06104-2999  
1-800-523-2233

**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 XVII – 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, 2021, hereby amends and restates the Tucson Electric Power Company Retiree Welfare Plan (the “Plan”), which was originally adopted by the Company, effective July 1, 2007.

### **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.

### **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.

On December 31, 2021, TEP’s Board of Directors, the Plan Sponsor, has caused this Plan document and summary plan description to be executed by Unanimous Written Consent.

## **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 Indemnity Design Retiree Plan Benefit Book (Effective January 1, 2021)
2. Delta Dental of Arizona, Inc. Summary of Benefits – UNE, UNG, & TEP Unclassified (Effective January 1, 2021)
3. Delta Dental of Arizona, Inc. Summary of Benefits – TEP Classified (Effective January 1, 2021)
4. 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)
3. AARP Medicare Supplement Plan Guide insured by UnitedHealthcare Insurance Company and enrollment materials
4. UniSource Energy Services Grandfathered Retiree Group Life Policy GL-681819 issued by Hartford Life and Accident Insurance Company (Effective January 1, 2021)
5. Tucson Electric Power Retiree (Classified) Group Life Policy GL-681819 issued by Hartford Life and Accident Insurance Company (Effective January 1, 2021)
6. Tucson Electric Power Retiree (Unclassified) Group Life Policy GL-681819 issued by Hartford Life and Accident Insurance Company (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**

| <b>Name</b>   | <b>Birth Date</b> | <b>Hire Date</b> | <b>Retirement Date</b> |
|---|-------------------|------------------|------------------------|
| <b>Southwest Energy Solutions, Inc.<sup>1</sup></b> |                   |                  |                        |
| Polansky, Paula                                     | 10/26/63          | 02/21/89         | 04/01/19               |

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<sup>1</sup> Southwest Energy Solutions, Inc. was previously a Participating Affiliate in the Plan, but such participation ceased as of December 31, 2020. Employees of Southwest Energy Solutions, Inc. who retired and qualified for benefits under the Plan on or before December 31, 2020, shall be eligible to participate in the Plan as SES Grandfathered Retirees.

**APPENDIX C<sup>2</sup>**

| <b>Name</b>                    | <b>Birth Date</b> | <b>Hire Date</b> | <b>Retirement Date</b> |
|--------------------------------|-------------------|------------------|------------------------|
| <b>ARIZONA GAS<sup>3</sup></b> |                   |                  |                        |
| Broughton, Carol A.            | 07/08/42          | 11/05/68         | 04/01/07               |
| Bursley, Robert (Deceased)     | 09/29/19          | 06/14/76         | 10/30/92               |
| Bursley, Irene (Spouse)        | 11/14/20          | N/A              | N/A                    |
| Butrymowicz, Donald M.         | 02/26/37          | 01/24/77         | 02/01/02               |
| Carroll, Richard G. (Deceased) | 10/21/38          | 10/09/61         | 06/01/04               |
| Carroll, Judith (Spouse)       | 07/23/41          | N/A              | N/A                    |
| Duey, Daniel J.                | 08/14/40          | 08/15/77         | 04/01/04               |
| Felix, Esthela                 | 02/09/44          | 12/03/80         | 01/31/06               |
| Fetterman, Marvin J.           | 04/19/40          | 03/09/81         | 06/01/04               |
| Fischer, Donald J.             | 07/06/36          | 12/04/91         | 07/31/02               |
| Hines, James W.                | 07/29/40          | 03/21/60         | 09/01/04               |
| Jenkins, David G.              | 06/21/42          | 10/01/62         | 07/01/07               |
| Newman, Dale                   | 05/11/42          | 05/07/73         | 08/01/99               |
| Orr, Jackie C.                 | 07/26/36          | 07/13/56         | 07/31/95               |
| Rousselle, Sonja H.            | 10/18/36          | 05/29/90         | 07/31/95               |
| Smith, John W.                 | 01/19/43          | 06/29/81         | 03/01/06               |
| Triggs, Margaret               | 10/25/34          | 07/15/63         | 04/30/94               |
| Valasquez, Hector (Deceased)   | 09/20/38          | 01/29/79         | 10/01/00               |
| Valasquez, Maria (Spouse)      | 01/08/47          | N/A              | N/A                    |
| Walsh, Almeda                  | 10/11/40          | 11/22/82         | 12/31/96               |
| Warren, James (Deceased)       | 04/25/39          | 02/05/68         | 07/31/00               |
| Warren, Karen (Spouse)         | 04/03/40          | N/A              | N/A                    |
| West, Billy M. (Deceased)      | 04/13/33          | 09/15/64         | 07/31/95               |
| West, Geraldine (Spouse)       | 08/10/35          | N/A              | N/A                    |
| Wisdom, William                | 09/16/32          | 05/01/74         | 08/01/95               |

<sup>2</sup> This Appendix C was last updated 7/19/2021.

<sup>3</sup> Asset Purchase Agreement by and between Citizens Communications Company, as Seller, and UniSource Energy Corporation, as Buyer, Dated October 29, 2002 (Relating to the Purchase by Buyer of Seller's Gas Utility Business in the State of Arizona – Schedule 6.12(d)(iii)(D), updated 7/10/2003.

| Name                                | Birth Date | Hire Date | Retirement Date |
|-------------------------------------|------------|-----------|-----------------|
| <b>ARIZONA ELECTRIC<sup>4</sup></b> |            |           |                 |
| Canez, Rosa                         | 11/21/43   | 02/01/69  | 03/01/99        |
| Dierich, Ernest R.                  | 01/04/39   | 08/01/77  | 10/31/94        |
| Duran, Humberto                     | 03/15/40   | 11/01/70  | 11/11/96        |
| Favro, Arlene                       | 07/24/37   | 03/15/76  | 08/14/98        |
| Finley, Jon (Deceased)              | 07/29/37   | 05/29/79  | 01/31/99        |
| Finley, Lorene (Spouse)             | 06/30/29   | N/A       | N/A             |
| Ibarra, Roberto S.                  | 12/31/36   | 05/22/67  | 09/18/95        |
| Kuntz, Andrew L.                    | 10/26/27   | 03/01/72  | 10/01/89        |
| Litzinger, Robert L.                | 03/02/26   | 09/05/73  | 05/31/90        |
| Millermon, Donald H.                | 09/19/33   | 12/03/79  | 07/31/95        |
| Moody, Jane E.                      | 09/09/32   | 06/20/67  | 07/31/95        |
| Moore, Gerald (Deceased)            | 06/26/32   | 02/23/70  | 06/30/93        |
| Moore, Carol Lea (Spouse)           | 09/16/35   | N/A       | N/A             |
| Parada, Cesar F.                    | 10/27/34   | 08/16/61  | 08/11/95        |
| Richards, Walter (Deceased)         | 08/05/36   | 08/12/74  | 02/01/03        |
| Richards, Mary Ann (Spouse)         | 05/03/36   | N/A       | N/A             |
| Rodriguez, Gilberto S.              | 03/20/35   | 05/22/67  | 10/02/95        |
| Rosas, Eduardo V. (Deceased)        | 05/05/33   | 09/04/56  | 08/01/95        |
| Rosas, Maria (Spouse)               | 12/15/37   | N/A       | N/A             |
| Russell, Jerome T.                  | 12/03/39   | 05/15/61  | 08/01/05        |
| Serrano, Martin                     | 02/02/36   | 06/01/71  | 02/21/98        |
| Stutz, Jacqueline A.                | 06/17/42   | 06/10/85  | 06/01/04        |
| Woodhouse, John A.                  | 06/03/40   | 03/29/66  | 07/01/05        |

<sup>4</sup> Asset Purchase Agreement by and between Citizens Communications Company, as Seller, and UniSource Energy Corporation, as Buyer, Dated October 29, 2002 (Relating to the Purchase by Buyer of Seller's Electric Utility Business in the State of Arizona – Schedule 6.12(d)(iii)(D), updated 7/10/2003.