# PLAN DOCUMENT
# AND
# SUMMARY PLAN DESCRIPTION

RIVIAN, LLC
WELFARE BENEFIT PLAN

Restatement Effective as of January 1, 2023

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# Introduction

## Overview

The Rivian, LLC Welfare Benefit Plan (the "Plan") is an employer-sponsored health and welfare employee benefit plan. The purpose of the Plan is to provide Participants and Beneficiaries certain health and welfare benefits described herein. This Plan is intended to meet all applicable requirements of the Code and ERISA, as well as rulings and regulations issued or promulgated thereunder. Nothing in this Plan shall be construed as requiring compliance with Code or ERISA provisions to the extent not otherwise applicable.

A detailed list of benefit types provided under the Plan, along with contact information and more information about how to access Welfare Program Documents describing these benefits, can be found at Appendix A.

The terms and conditions of the Plan are set forth in this document ("Wrap Document") and the Welfare Program Documents. Together, the Wrap Document and the Welfare Program Documents constitute the written instrument under which the Plan is established and maintained (*i.e.*, Plan Document) for purposes of ERISA section 402(a) and the Summary Plan Description. An amendment to one of these documents constitutes an amendment to the Plan.

This Wrap Document should be read in connection with the applicable Welfare Program Documents provided by the Employer or the Insurers or Claims Administrators listed in Appendix A. Unless otherwise noted regarding insured benefits, if there is a conflict between a specific provision under this Wrap Document and a Welfare Program Document, this Wrap Document controls. If this Wrap Document is silent, then the applicable Welfare Program Document controls. However, with respect to fully insured benefits, the terms of the certificate of insurance coverage or Insurance Policy/Evidence of Coverage control when describing specific benefits that are covered or insurance-related terms. See Appendix A to determine whether a particular benefit is self-funded by the Employer or fully insured by the Insurer. Notwithstanding anything to the contrary, this Wrap Document shall control for purposes of determining which persons are eligible to participate in the Plan.

Neither this Wrap Document nor any of the benefits described herein is to be considered an employment contract or a limit on the Employer's right to terminate the employment of any Employee. Further, nothing contained herein shall operate or be construed to give any person any legal or equitable right against the Employer, except as expressly provided herein or as required by law. Rivian, LLC or its delegate reserves the right to change, amend, suspend, or terminate any or all of the benefits under the Plan, in whole or in part, at any time for any reason at its sole discretion.

## Plan Contact Information

Questions about this Plan can be directed to the Plan Administrator listed in the Administrative Information section or the applicable Insurer or Claims Administrator listed in Appendix A.

**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 45 for more details.**

**Administrative Information**

<table>
<tr><td>Plan Name & Number</td><td>Rivian, LLC Welfare Benefit Plan<br>Plan Number 501</td></tr>
<tr><td>Plan Sponsor</td><td>Rivian, LLC<br>14600 Myford Rd.<br>Irvine, CA 92606<br>888-748-4261</td></tr>
<tr><td>Employer Identification Number</td><td>84-4942307</td></tr>
<tr><td>Plan Administrator<br>& Agent for Service of Legal Process</td><td>The Rivian, LLC Employee Benefit Plan Committee<br>14600 Myford Rd.<br>Irvine, CA 92606<br>888-748-4261</td></tr>
<tr><td>Plan Year</td><td>January 1 – December 31</td></tr>
<tr><td>Plan Type</td><td>Welfare benefit plan providing the following health and welfare benefits: medical, dental, vision, health FSA, short-term disability, long-term disability, basic life, voluntary life, accidental death and dismemberment (AD&D), critical illness and group accident.<br><br>The Plan also provides adoption assistance/family planning benefits as set forth in Appendix B. These benefits are not subject to ERISA.</td></tr>
<tr><td>Administration & Funding</td><td>Self-funded benefits are administered by the Claims Administrators listed in Appendix A.<br><br>Insured benefits are administered by the Insurers listed in Appendix A. Fully insured benefits will be paid out of the Insurance Polices listed in Appendix A.</td></tr>
<tr><td>Source of Contributions</td><td>Contributions will be paid out of the Employer’s general assets and through contributions paid by Eligible Employees, in the amounts determined by the Employer in its discretion.</td></tr>
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**Glossary**

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| Benefits Booklet or Benefits Summary | The benefits booklets or summaries of benefits provided by the Claims Administrators listed at Appendix A that describe the benefits that are self-funded by the Employer. |
| Claims Administrator | A third party that makes claims determinations with respect to self-funded benefits under the Plan pursuant to a contractual arrangement with the Employer. These third-party administrators do not insure any benefits under the Plan. Appendix A lists the Claims Administrators and which benefits are self-funded by the Employer. |
| COBRA | The Consolidated Omnibus Budget Reconciliation Act, which provides continuation coverage for certain benefits when an Eligible Employee or Eligible Dependent has experienced a loss of coverage due to a qualifying event. |
| Dependent Child | A dependent child of the Eligible Employee who is:<br>• a natural child;<br>• an adopted child or a child placed for adoption;<br>• a stepchild;<br>• a foster child; or<br>• a child for whom an Eligible Employee has legal custody or legal guardianship, provided that (a) the child is related to the Eligible Employee or is living as a member of the Eligible Employee's household, (b) the Eligible Employee provides more than half of the child's support, and (c) for federal tax purposes, the child is not a dependent of a taxpayer other than the Eligible Employee.<br><br>In addition, Dependent Children are eligible for coverage through the end of the year in which they turn 26.<br><br>A Dependent Child also includes an unmarried child of any age, if the child is mentally or physically incapable of self-support, provided that (a) the child is related to the Eligible Employee or is living as a member of the Eligible Employee's household, (b) the Eligible Employee provides more than half of the child's support, and (c) for federal tax purposes, the child is not a dependent of a taxpayer other than the Eligible Employee. |
| Domestic Partner | A domestic partner within the meaning of the Insurance Policies/Evidence of Coverage.<br>• This may require that you attest to domestic partner status, demonstrate that you and your partner have registered your |

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| | domestic partnership in certain jurisdictions, or demonstrate that you otherwise meet certain criteria intended to show financial interdependence sufficient to indicate partnership status.<br>• Please also note that even if your partner qualifies as a domestic partner under the relevant Insurance Policies/Evidence of Coverage, in certain instances the coverage for your domestic partner may result in additional tax liability to you by reason of federal law. |
| Eligible Dependent | A person who is a Spouse, Domestic Partner, or a Dependent Child of an Eligible Employee. |
| Eligible Employee | Any person who is a common law employee of the Employer and who is:<br>• a full-time employee scheduled to work thirty (30) or more hours per week;<br>• a part-time employee hired or rehired on or after April 2, 2023 who is scheduled to work twenty (20) hours per week; or<br>• an otherwise Eligible Employee on short-term disability, in accordance with the terms of the short-term disability summary plan description.<br>You are not considered an Eligible Employee if the Employer classifies you as a leased employee, temporary worker, or an independent contractor, even if you are later reclassified by a court or agency as a common law employee.<br><br>Notwithstanding anything to the contrary, the Eligible Employee definition contained in this Wrap Document shall control for purposes of determining which persons are eligible to participate in this Plan or otherwise receive any specific benefits available under this Plan other than for the Rivian, LLC Severance Pay Plan. Eligibility for benefits under the Rivian, LLC Severance Pay Plan are set forth in that program's Summary Plan Description. |
| Employer | Rivian, LLC and all of Rivian, LLC's direct and indirect US subsidiaries |
| ERISA | The Employee Retirement Income Security Act of 1974, as amended from time to time. |
| HIPAA | The Health Insurance Portability and Accountability Act of 1996, as amended from time to time. |
| Insurance Policy | The policies provided by the Insurers listed at Appendix A that describe the fully insured benefits under the Plan. The terms of the Insurance Policies are described in an Evidence of Coverage. |

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| Insurer | The insurance companies listed in Appendix A that the Employer has contracted with to provide insurance coverage. Insurers process your claims with respect to the Plan's fully insured benefits. These benefits are paid by the Insurer under the terms of the Insurance Policy. |
| Code | The Internal Revenue Code of 1986, as amended from time to time. |
| Open Enrollment | The annual enrollment opportunity designated by the Plan Administrator. |
| Participant | An individual who has satisfied the Plan's eligibility requirements and has timely elected to participate or has been automatically enrolled in a benefit under the Plan. |
| Plan | Rivian, LLC Welfare Benefit Plan. |
| Plan Administrator | The Rivian, LLC Employee Benefit Plan Committee. |
| Plan Document | This Wrap Document, and the Welfare Program Documents, together constitute the plan document for purposes of ERISA. |
| Plan Year | The twelve-month period beginning on January 1 and ending on December 31. |
| Qualified Medical Child Support Order (QMCSO) | A final court or administrative order requiring an Eligible Employee to provide health care coverage for a Dependent Child, usually following a divorce or child custody proceeding, as defined in section 609(a)(2)(A) of ERISA. |
| Spouse | An individual who is lawfully married to an Eligible Employee and who is not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following is true: (1) the individual was married in a state, possession, or territory of the United States and the individual is recognized as lawfully married by that state, possession, or territory of the United States; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the United States would recognize the individual as lawfully married. |
| Summary Plan Description (SPD) | This Wrap Document, and the Welfare Program Documents, together constitute the Summary Plan Description for purposes of ERISA. |
| Welfare Program Documents | Any and all Insurance Policies and certificates of insurance or other documents that set forth the terms and conditions of an insured benefit under this Plan, and any and all Benefits Booklets or Benefits Summaries for self-insured benefits. |

**A Special Note About Suspension of Outbreak Period Deadlines**

Beginning March 1, 2020, in accordance with joint guidance issued by the Department of Labor and Internal Revenue Service regarding the COVID-19 national emergency period, the following deadlines were temporarily extended:

- The 30-day (or, if applicable the 60-day) period to request a special enrollment during the Plan year;
- The 60-day period to elect COBRA coverage;
- The due date for COBRA premium payments;
- The date a COBRA qualified beneficiary must provide notice of a qualifying event or a disability determination;
- The date a claimant is required to file a claim for benefits;
- The date a claimant is required to file an appeal of an adverse determination of a claim for benefits; and
- The date by which a claimant is required to file a request for an external review (to the extent available)

The deadlines are extended until the earlier of:

- One year from the date the deadline would otherwise have occurred; or
- 60 days after the announced end of the COVID-19 national emergency period (this is referred to as the "Outbreak Period").

**The national emergency period is set to expire on May 11, 2023 and these deadline extensions will end accordingly. Unless further guidance is issued to the contrary, the Outbreak Period and any associated tolling periods applicable under the Plan, are anticipated to end on July 10, 2023, and the usual Plan deadlines will resume (we will notify you if this changes).**

Reminder: If you will lose health care coverage due to the end of this relief period, you may have other coverage options available, including the opportunity to enroll in a Health Insurance Marketplace. If you have concerns with respect to your coverage or meeting an applicable deadline under the Plan due to the COVID-19 national emergency, contact the Plan Administrator.

If you have concerns with respect to the end of the Outbreak Period, contact the Plan Administrator.

## Article 1

## Eligibility and Enrollment

### Eligibility Requirements

If you are a full-time Eligible Employee, as defined within the above "Glossary", you are eligible for benefits under the Plan on the first day of the month following the date you are hired.

If you are a part-time Eligible Employee, as defined within the above "Glossary", you are eligible for benefits under the Plan on the first day of the month coincident with or next following the completion of three (3) consecutive months of service with an Employer.

### Initial Enrollment

Newly hired Eligible Employees in the US must enroll for coverage within 14 days after their first day of employment. If you enroll within this 14-day period, your coverage will be effective as of your date of hire for full-time Eligible Employees, and on the first day of the month coincident with or next following the completion of three (3) consecutive months of service with an Employer for part-time Eligible Employees. If you do not enroll within this 14-day period, you will be automatically enrolled in employee-only medical coverage, and for all other benefits you will have to wait until the next Open Enrollment period to enroll, unless you experience an event allowing a mid-year change, as described below. Your elections (including default medical coverage enrollment) will remain in effect for the remainder of the Plan Year, unless you experience an event allowing a mid-year change, as described below.

For certain life coverage, you may have to show evidence of insurability if you do not enroll as a new hire. More information can be found in the Insurance Policies/Evidence of Coverage and Benefits Booklets/Summaries found on www.rivianbenefits.com.

### Open Enrollment

You may enroll or change elections during the Plan's annual Open Enrollment period, in accordance with procedures established by the Employer in its sole discretion. Your elections will remain in effect for the remainder of the Plan Year, unless you experience an event allowing a mid-year change, as described below.

### Dependents

You must enroll your Eligible Dependents within the same timeframes for electing coverage as a new hire or during Open Enrollment. Your Eligible Dependents can be enrolled in medical, dental, and vision coverage only if you also are enrolled.

### Mid-Year Changes: Qualified Medical Child Support Orders

You may enroll an Eligible Dependent Child mid-year if required to do so through a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order that requires you to provide health coverage to your children. You may obtain a copy of the Employer's procedures for QMCSO determinations, free of charge, by contacting the Plan Administrator.

**Mid-Year Changes (Medical, Dental, and Vision Benefits): HIPAA Special Enrollment Events**

If you decline enrollment for medical, dental, or vision benefits for yourself or your Eligible Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Eligible Dependents in the medical, dental, and vision benefits under this Plan mid-year if you or your Eligible Dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your Eligible Dependents' other coverage). However, you must request enrollment within 30 days after your Eligible Dependents' other coverage ends (or after the other employer stops contributing toward the other coverage). Your election change will be effective as soon as practicable after the date the Plan receives your request for special enrollment.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll both yourself and any Eligible Dependents within 30 days after the marriage, birth, adoption, or placement for adoption. For a new spouse or dependent acquired by marriage, your election change will be effective as soon as practicable after the date the Plan receives your request for special enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, your election change will be effective retroactively as of the date of the birth, adoption, or placement for adoption.

You also may enroll in medical benefits mid-year if you or your Eligible Dependents no longer are eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, or if you or your Eligible Dependents become eligible for a state's premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. Your election change will be effective as soon as practicable after the date the Plan receives your request for special enrollment.
To request enrollment under these HIPAA special enrollment rules or to obtain more information, contact the Plan Administrator.

**Mid-Year Changes: Change in Status Events**

This section applies only to changes to elections for medical, dental, and vision benefits.

You also may change certain elections mid-year if you experience a change in status event listed below. You must notify the Plan Administrator within 30 days in order to make a change in your election during the year. The notice must be in writing, on the form required by the Employer, with supporting documentation. **Where applicable, the changes you make to your coverage must be consistent with and "on account of and correspond with" the event.** For example, if your child no longer is eligible for medical benefits, you may cancel medical coverage only for that child, not yourself or your Spouse.

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a Spouse, legal separation, and annulment.
- **Number of Eligible Dependents:** Any event that changes your number of Eligible Dependents including birth, death, adoption, legal guardianship, and placement for adoption.
- **Employment status:** Any event that changes your or your Eligible Dependents' employment status that results in gaining or losing eligibility for coverage.
- **Dependent Status:** Any event that causes your Eligible Dependents to become eligible or ineligible for coverage because of age, disability, or similar circumstances.

- **Residence:** A change in the place of residence for you or your Eligible Dependents if the change results in you or your Eligible Dependents living outside the network service area of your medical, dental, or vision coverage.
- **HIPAA Special Enrollment Event:** The events listed above as HIPAA Special Enrollment events.
- **Entitlement to Medicare or Medicaid:** If you or your Eligible Dependents become entitled to or lose entitlement to Medicare or Medicaid.
- **Judgment, Decree, or Order:** If a judgment, decree, or order, such as a QMCSO, requires your Dependent Child to be covered under this Plan (or another plan).

For HIPAA Special Enrollment events, your election change will be effective on the dates set forth earlier in the section "Mid-Year Changes: HIPAA Special Enrollment Events." For all other events, your election change will be effective as soon as practicable after the date the Plan receives your election change request (including any required supporting documentation).

## Article 2

## Employee Contributions

You and the Employer share the cost of your benefits. Information describing your share of the cost for each option will be available at enrollment and each open enrollment.

**Important Domestic Partner Tax Considerations**

Under current law, your Domestic Partner is only considered your Eligible Dependent for federal tax purposes if your Domestic Partner: (1) has the same principal place of abode as you and is a member of your household; (2) receives over half of his or her support from you; (3) is not anyone's qualifying child; and (4) is a U.S. citizen or resident or resident of the United States or a country contiguous to the United States.

As a result, unless your Domestic Partner is your dependent for federal tax purposes, your contributions toward your Domestic Partner's medical coverage will be withheld on a post-tax basis rather than a pre-tax basis. In addition, the Employer-paid portion of that coverage is taxable to you and treated as imputed income. These amounts will be reflected on your paychecks throughout the year and will be reported on your Form W-2 at the end of each calendar year.

We advise you to consult with your tax advisor to determine if your Domestic Partner and his or her dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner benefit coverage.

## Article 3

## When Your Coverage Ends

### When Coverage Ends

Unless otherwise provided in the applicable Insurance Policy/Evidence of Coverage, coverage under the Plan will end on the earlier of:

- You or the Employer has failed to pay premiums within 30 days of when premiums are due. Coverage will terminate as of the last day for which premiums were paid.
- The end of the month that you are no longer an Eligible Employee.
- Upon your death, coverage will terminate unless you have coverage for Eligible Dependents. If you have coverage for Eligible Dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.
- For Spouses in cases of divorce, the end of the month following the date of the divorce.
- For Dependent Children, until the end of the year in which the Dependent Child turns 26 years of age.
- For all other Eligible Dependents, the end of the month in which the Eligible Dependent ceases to be eligible.
- The end of the month during which you or the Employer provides written notice to the Insurer requesting termination of coverage, or on such later date requested for such termination by the notice.
- The date that the applicable Insurance Policy or the Plan is terminated.

Under some circumstances, you or your Eligible Dependents may continue coverage through COBRA continuation coverage. See the COBRA section.

### Rescission in Event of Fraud

Any act, practice, or omission by a Plan Participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the Plan, and the Plan may rescind coverage retroactively as a result in accordance with applicable law. Any such fraudulent statements, including on Plan enrollment forms and in electronic submissions, may invalidate any payment or claims for services and may be grounds for rescinding coverage.

### Coverage During Leave of Absence

Unless otherwise provided in the applicable Insurance Policy/Evidence of Coverage or Benefits Booklet/Summary if you are on an approved leave of absence and are receiving pay directly from the Employer, your elections and salary reduction contributions will continue in accordance with the elections you made.

If you are on an approved leave where you are not receiving pay directly from the Employer, the Employer will continue your coverage for the duration of time required under the Family and Medical Leave Act (FMLA) or other applicable law.

**Military Leave**

If you are absent from employment for more than 30 days by reason of service in the Uniformed Services, you may elect to continue Plan coverage for you and your Eligible Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, Army National Guard, and Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, if possible, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on your behalf. If your Military Service is for a period of time less than 31 days, you may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

You may continue Plan coverage under USERRA for up to the lesser of:

- the 24-month period beginning on the date of your absence from work; or
- the day after the date on which you fail to apply for, or return to, an employed position.

Regardless of whether you continue health coverage, if you return to a position of employment within five years, your health coverage and that of your Eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your Eligible Dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

## Article 4

## COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides for continuation of medical, dental, and vision coverage for "qualified beneficiaries" who lose their coverage due to a "qualifying event." You (or your Eligible Dependent) must be offered the same medical, dental, vision coverage that you had the day before the qualifying event that caused you to lose coverage. (Note the COBRA provisions applicable to the health FSA and limited purpose health FSA are contained in the applicable Welfare Program Documents.)

You are required to pay up to 102 percent of the applicable premium for COBRA coverage. When you enroll, you will receive a separate notice that gives more information on your COBRA rights. You also will receive an election notice if you experience a qualifying event. For more information, please contact the Plan's COBRA administrator.

### When You May Elect COBRA Coverage

You may continue coverage for yourself and your covered Eligible Dependents for up to 18 months (or longer if required by state law), if your medical, dental, or vision coverage ends for one of the following reasons:

- You separate from service with the Employer (for reasons other than gross misconduct on your part); or
- Your hours are reduced so that you are no longer eligible for the Plan.

If you—or any of your Eligible Dependents—are determined to be disabled (for Social Security benefit purposes) when your coverage ends, or within the first 60 days of COBRA coverage, coverage for your entire family may continue for a total of 29 months.

Your covered Eligible Dependents may elect to continue coverage for up to 36 months if coverage ends for one of the following reasons:

- Your death
- Your divorce or legal separation
- Your eligibility for Medicare during a COBRA continuation period
- Your covered Dependent Child no longer meets the eligibility requirements under the Plan

Please note that Domestic Partners may be eligible to continue coverage in the same way and to the same extent as a Spouse; however, whether this is the case will depend on the underlying insurance contract to the extent the coverage is insured through a third party. If you or your Domestic Partner have questions about whether continuation coverage is available, please contact the Plan's COBRA administrator.

### Applying for COBRA Coverage

When your coverage ends, you or your Eligible Dependents have 60 days to elect continued coverage. The 60 days is counted from the day your active benefits end or the date your COBRA notice is mailed,

whichever is later. If you lose coverage due to separation from service or a reduction in work hours, you will automatically receive a notice of your COBRA rights.

In the case of a divorce, legal separation, dissolution of a domestic partnership, or when a child no longer qualifies for dependent coverage, you or your Eligible Dependent must notify the COBRA administrator within 60 days. Your dependents will not be eligible for COBRA coverage unless you notify the COBRA administrator that they have lost eligibility for coverage.

**Early Termination of COBRA Coverage**

COBRA coverage will end prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- The Employer stops providing coverage for all employees
- You or your Eligible Dependents do not pay your premiums on time
- You or your Eligible Dependents become covered by another group health plan or the Health Insurance Marketplace
- You or your Eligible Dependents become covered by Medicare
- You or your Eligible Dependents extended COBRA coverage to 29 months due to disability, but are no longer considered disabled

## Article 5

## Filing Claims and Appeals

**Claim for Eligibility: Initial Claims**

These procedures apply to claims for eligibility for coverage under the Plan or enrollment in the Plan, to the extent those determinations have not been delegated to a Claims Administrator. A claim regarding your eligibility may overlap with a claim for benefits (described below). That is, you may be denied a benefit because you are shown as not eligible to participate in the coverage that denied your benefit.

If you believe that you or your dependent is eligible for coverage under the Plan, you may file a claim in writing with the Plan Administrator or its delegate at the following address (please include your full name, employee ID and details regarding your claim for eligibility):

The Rivian, LLC Employee Benefit Plan Committee
14600 Myford Rd.
Irvine, CA 92606
888-748-4261

**Claim for Eligibility: Initial Claim Decision**

When an eligibility or enrollment claim is received, the Plan Administrator or its delegate must notify you of its determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. You will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected. The Plan Administrator or its delegate will send you a written notice of an adverse determination.

A denial of a claim will include:

- the reason(s) for the denial;
- references to the specific Plan provisions on which the decision was based;
- a description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- a description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal.

**Claims for Eligibility: Appeals**

If you believe that a denial is incorrect, you may request a full review by the Plan Administrator or its delegate (at the address above) within 60 days after your receipt of the denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge).

The Plan Administrator or its delegate will furnish you with a written decision providing the final determination of the appeal. The decision of the Plan Administrator or its delegate on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the Plan Administrator or its delegate will notify you in writing of the extension within 60 days of receiving your appeal. The decision of the Plan Administrator or its delegate on review will be final and binding on you, your dependents and any other interested party.

Your appeal notice will include:

- the specific reason or reasons for the appeal decision;
- reference to the specific Plan provisions on which the determination is based;
- a statement that you have the right to request access to and copies of all relevant Plan documents free of charge; and
- a statement that you have the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal.

**Claims for Benefits: Deadline to File Claims**
Unless otherwise provided in the applicable Insurance Policy/Evidence of Coverage or Benefits Booklet/Summary, you must file a claim for benefits within 120 days following the date the service was rendered. You should file your claim for benefits with the applicable Insurer or Claims Administrator listed at Appendix A.

**Claims for Benefits: Initial Claims**

Unless otherwise provided in the applicable Insurance Policy/Evidence of Coverage or Benefits Booklet/Summary, your claim for benefits will be processed under the procedures described below. Insured benefits will be decided by the Insurer listed at Appendix A. Self-funded benefits will be decided by the Claims Administrator listed at Appendix A.

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| **Medical, Dental, and Vision**<br>***Urgent Claims***<br>Any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. | Notice of the Plan's determination will be sent as soon as possible taking into account the medical exigencies, and in no case later than 72 hours after receipt of the claim.<br><br>You may receive notice orally, in which case a written notice will be provided within three days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request. |
| **Medical, Dental, and Vision** | If your pre-service claim is improperly filed, you will be sent |

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| ***Pre-Service Claims***<br>A claim for services that have not yet been rendered and for which the Plan requires prior authorization. | notification within five days of receipt of the claim.<br><br>If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim.<br><br>If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information. |
| **Medical, Dental, and Vision**<br>***Post-Service Claims***<br>A claim for services that already have been rendered, or where the Plan does not require prior authorization. | Notice of the Plan's determination will be sent within a reasonable time period but no later than 30 days from receipt of the claim.<br><br>If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information. |
| **Medical, Dental, and Vision**<br>***Concurrent Care Claims***<br>A claim that arises when there is a reduction or termination of ongoing care. | You will be notified if there is to be any reduction or termination in coverage for ongoing care in the timeframes specified above, depending on if the claim is urgent or non-urgent. If the claim is a request for an urgent extension of concurrent care and request is made within 24 hours of the end of period or number of treatments, you will be notified as soon as possible, but no later than 24 hours. |

| Short-Term Disability and Long-Term Disability Claims | Notice of the Plan's determination will be sent within a reasonable time period, but no later than 45 days from receipt of the claim.<br><br>If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended for two additional 30-day periods. You will receive notice prior to each extension that indicates the circumstances requiring the extension, the date by which the Insurer or Claims Administrator expects to render a determination, the standards on which entitlement to a benefit is based, and the unresolved issues that prevent a decision on the claim. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 30 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information. |
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| **Life, AD&D, Critical Illness and All Other Claims** | Notice of the Plan's determination will be sent within a reasonable time period, but no later than 90 days from receipt of the claim.<br><br>If the Insurer or Claims Administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 90 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. |

**Claims for Benefits: Appeals**

Unless otherwise provided in the applicable Insurance Policy/Evidence of Coverage or Benefits Booklet/Summary, your appeal will be processed under the procedures described below.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will have access to all documents that are relevant to your claim. Review of your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, the Insurer or Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Insurer or Claims Administrator will provide

you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

In the case of an urgent care claim, you may request an expedited appeal of an adverse benefit determination either orally or in writing, and all necessary information, including the Plan's benefit determination on appeal, will be transmitted by telephone, fax, or other available expeditious method.

A final decision on appeal will be made within the time periods specified below.

| **Medical, Dental, and Vision** <br> ***Urgent Claims*** | You must submit your appeal within 180 days of the date of your initial denial notice. <br><br> You will be notified of the determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. |
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| **Medical, Dental, and Vision** <br> ***Pre-Service Claims*** | You must submit your appeal within 180 days of the date of your initial denial notice. <br><br> You will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 30 days from the date your request is received. |
| **Medical, Dental, and Vision** <br> ***Post-Service Claims*** | You must submit your appeal within 180 days of the date of your initial denial notice. <br><br> You will be notified of the determination within a reasonable period of time, but no later than 60 days from the date your request is received. |
| **Medical, Dental, and Vision** <br> ***Concurrent Care Claim*** | You must submit your appeal within 180 days of the date of your initial denial notice. <br><br> You will be notified of the determination before treatment ends or is reduced, where the determination is a decision to reduce or terminate concurrent care early. |
| **Short-Term Disability and Long-Term Disability Claims** | You must submit your appeal within 180 days of the date of your initial denial notice. <br><br> You will be notified of the determination within a reasonable period of time, but no later than 45 days from receipt of the request for review. <br><br> If the Insurer or Claims Administrator determines that an extension is necessary due to special circumstances, this time |

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| | may be extended for an additional 45 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 45 days from the date it receives your information, or, if earlier, the deadline to submit your information. |
| **Life, AD&D, Critical Illness and All Other Claims** | You must submit your appeal within 60 days of the date of your initial denial notice.<br><br>You will be notified of the determination within a reasonable time, but no later than 60 days from receipt of the request for review.<br><br>If the Insurer or Claims Administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. |

**Claims for Benefits: Notice of Determination**

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will, where applicable:

- state specific reason(s) for the adverse determination;
- reference specific Plan provision(s) on which the benefit determination is based;
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only);
- describe the Plan's claims review procedures and the time limits applicable to such procedures (initial claim only);
- include a statement of your right to bring a civil action under section 502(a) of ERISA following appeal (for appeals of claims for disability benefits, this statement will also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action and the calendar date on which the contractual limitations period expires for the claim);
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (appeal

only);

- describe any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures (appeal only);
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);
- include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount (for medical claims);
- include the denial code and corresponding meaning (for medical claims);
- include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning (for medical claims);
- describe the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for medical claims);
- describe the external review process, if applicable (for medical claims);
- include a statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for medical claims);
- include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration (for disability claims and appeals for disability claims); and
- include either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist (for disability claims and appeals for disability claims).

**Claims for Benefits: External Review**

For medical benefits, you may have the right to request an independent review with respect to any claim that involves medical judgment or a rescission of coverage. Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of

receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. See your Benefits Booklet/Summary or Insurance Policy/Evidence of Coverage for more information.

**Deadline to Bring Legal Action**

You may not bring a lawsuit to recover benefits under this Plan until you have exhausted the administrative process described in this section and as listed in your Insurance Policy/Evidence of Coverage or Benefits Booklet/Summary. No action may be brought at all unless brought no later than one year following a final decision on your claim for benefits, unless a shorter period is provided in your Insurance Policy/Evidence of Coverage or Benefits Booklet/Summary (in which case that time period controls). Any such court action must be brought in the U.S. District Court for the Central District of California, where the Plan is administered.

## Article 6

## Coordination of Benefits

If there is a conflict between the coordination of benefits provision in an Insurance Policy/Evidence of Coverage and the rules set forth below, the coordination of benefits provision in the Insurance Policy/Evidence of Coverage will govern.

### In General

The Plan has the right to coordinate its payment of Plan benefits with "other plans" under which a Participant or Eligible Dependent are covered so that the total medical or dental benefits paid by the Plan together with other plans does not exceed the level of benefits that would otherwise be paid by the Plan. When a Participant or Eligible Dependent is covered by more than one plan, under this coordination of benefits rule, one plan is designated the primary plan. The primary plan will pay benefits first and will not take into account benefits payable under other plans when determining the benefits it pays. Any other plan that pays benefits after the primary plan is designated the secondary plan. A secondary plan reduces its benefits by those benefits payable under other plans and may limit the benefits it pays. These rules apply whether or not a claim is made under the other plan. If a claim is not made, benefits under the Plan will be pended or denied until documentation is received showing a claim made with the primary plan. For purposes of this coordination of benefits rule, "other plans" is defined to include the following types of medical and health care benefits:

- Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation
- Group insurance or other coverage for a group of individuals, including coverage under another employer plan or student coverage obtained through an educational institution
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans
- Any coverage under governmental plans, such as Medicare, but not including a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private insurance, nongovernmental program;
- Any private or association policy or plan of medical expense reimbursement which is group or individual rated
- Any excess insurance policy
- Any retiree medical plan

### Determining When the Plan is Primary and When it is Secondary

A plan without a coordination of benefits provision is always primary. The Plan has a coordination of benefits provision. If all plans have a coordination of benefits provision the following will apply:

(1) With respect to no-fault coverage, personal injury protection, and medical payment coverage, the Plan is always secondary. This provision shall permit the Plan to pay first and then seek reimbursement in the case of no-fault coverage.

(2) The plan covering the participant for whom the claim is made, other than as a dependent, pays first and the other plan pays second.

(3) For dependent children's claims, the plan of the parent whose birthday occurs earlier in the calendar year is primary.

(4) When the birthdays of both parents are on the same day, the plan that has covered the dependent for the longer period of time is primary.

(5) When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary.

(6) When the parent with custody has remarried, that parent's plan is primary, the stepparent's plan pays second, and the plan of the parent without custody pays last.

(7) When there is a court decree that establishes financial responsibility for the health care expenses of the child, the plan that covers the parent with financial responsibility is primary.

(8) When a person is covered under a right of continuation coverage pursuant to federal or state law (such as COBRA) and also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary.

(9) When none of the above establishes an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time will be primary.

**Medicare**

In general, the Social Security Act requires that the Plan be the primary payer if a Participant or Eligible Dependent is eligible or enrolled in Medicare and meets certain requirements. To the extent permitted by law, in certain limited circumstances the Plan will pay benefits secondary to Medicare.

## Article 7

## Right to Reduction, Reimbursement, and Subrogation

If there is a conflict between the reduction, reimbursement, and subrogation provision in an Insurance Policy/Evidence of Coverage and the rules set forth below, the reduction, reimbursement, and subrogation provision in the Insurance Policy/Evidence of Coverage will govern.

### In General

The Plan has the right to reduce or deny benefits otherwise paid by the Plan, and recover or subrogate 100% of the medical or dental benefits paid by the Plan for a Participant or Eligible Dependent, to the extent of any and all of the following: (i) any judgment, settlement, or payment made or to be made because of an accident or malpractice, including but not limited to other insurance, (ii) any automobile or recreational vehicle insurance coverage or benefits, including but not limited to uninsured or underinsured motorist coverage, (iii) any business medical and/or liability insurance coverage or payments, and (iv) any attorney's fees. The Plan's right to reimbursement applies when the Plan pays benefits, and a judgment, payment, or settlement is made on behalf of the Participant or Eligible Dependent for whom the benefits were paid. Reimbursement to the Plan of 100% of these charges shall be made at the time any such payment is received by a Participant, Eligible Dependent or their representative or any other entity. The Plan's right to reduction, reimbursement and subrogation is based on the terms of the Plan in effect at the time of judgment, payment or settlement.

### First Priority Right

The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation. The Plan has the right to recover interest on the amount paid by the Plan. The Plan has the right to 100% reimbursement in a lump sum. The Plan is not subject to any state laws or equitable doctrines, including, but not limited to, the common fund doctrine, which could otherwise require the Plan to reduce its recovery by any portion of a Participant or Eligible Dependent's attorney's fees or costs. The Plan is not responsible for the Participant or Eligible Dependent's attorney's fees, expenses, or costs. The Plan's right applies regardless of whether any payments to a Participant or Eligible Dependent are designated as payment for, but not limited to, (i) pain and suffering, or (ii) medical benefits. This applies regardless of whether a Participant or Eligible Dependent has been fully compensated for injuries. The Plan's right to reduction, reimbursement, and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any Participant or Eligible Dependent. The Plan's first priority right shall not be reduced due to the negligence of the Participant or Eligible Dependent.

### Cooperation

The Plan requires a Participant or Eligible Dependent, and their representatives, to cooperate in efforts to obtain reimbursement to the Plan from third parties. To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, Participants, Eligible Dependents and their representatives must, at the Plan's request and at its discretion (i) take any action, (ii) give information, and (iii) sign documents as required by the Plan. Failure to aid the Plan and to comply with such requests may result in the Plan's withholding or recovering benefits, services, payments, or credits due or paid under the Plan to a Participant or Eligible Dependent under the Plan. A Participant or Eligible Dependent and/or their representatives may not do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by a Participant, Eligible Dependent or their representatives.

**Right to File an Action**

The Plan has the right to file suit on behalf of a Participant or Eligible Dependent for the claim related to the Plan expenses in order to recover benefits paid or to be paid by the Plan.

## Article 8

## Plan Administration

### Plan Administrator

For purposes of ERISA, and unless otherwise delegated by the Plan Administrator, the Plan Administrator shall be the "administrator" with respect to the general administration of the Plan.

### Discretion to Interpret Plan

The Plan Administrator, and Insurer if so delegated, shall have absolute discretion to construe and interpret any and all provisions of the Plan and the Welfare Program Documents, including, but not limited to, the discretion to resolve ambiguities, inconsistencies, or omissions conclusively; provided, however, that all such discretionary interpretations and decisions shall be applied in a uniform and nondiscriminatory manner to all Participants and Eligible Dependents similarly situated. The decisions of the Plan Administrator, and Insurer to the extent delegated final decision-making authority, upon all matters within the scope of its authority shall be binding and conclusive upon all persons.

### Powers and Duties

In addition to the powers described in this Article and all other powers specifically granted under the Plan, the Plan Administrator, and Insurer if so delegated, shall have all powers necessary or proper to administer the Plan and to discharge its duties under the Plan, including, but not limited to, the following powers:

(1) To make and enforce such rules, regulations, and procedures as it may deem necessary or proper for the orderly and efficient administration of the Plan;

(2) To enter into an administrative services agreement or insurance policy with an individual or entity to perform services with respect to one or more benefits under the Plan;

(3) In its discretion, to interpret and decide all matters of fact in granting or denying benefits under the Plan, its interpretation and decision thereof to be final and conclusive on all persons claiming benefits under the Plan;

(4) In its discretion, to determine eligibility under the terms of the Plan, its decision thereof to be final and conclusive on all persons;

(5) In its discretion, to authorize the payment of benefits under the Plan, its decision thereof to be final and conclusive on all persons;

(6) To prepare and distribute information explaining the Plan;

(7) To obtain from the Employer, Eligible Employees, and Eligible Dependents such information as is necessary for the proper administration of the Plan;

(8) To appoint an Insurer to review, determine, and authorize payment of requests for distribution under the Plan, to direct and supervise the payment of benefits, to review appeals of the denial of requests for distribution under the Plan, and to perform any other actions or duties the Plan Administrator may delegate to it;

(9) To sue or cause suit to be brought in the name of the Plan and to compromise and settle claims brought against, by, or on behalf of the Plan;

(10) To administer or pay benefits, or provide or receive any communications under the Plan, in electronic form, in accordance with applicable law; and

(11) To take any other action necessary or advisable to carry out its duties with respect to the Plan.

**Right to Delegate**

The Plan Administrator may from time to time allocate to one or more of the Employer's officers, employees, or agents, and may delegate to any other person or organization, any of its powers, duties, and responsibilities with respect to the operation and administration of the Plan, including, without limitation, the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claims, and the discretion to decide matters of fact and interpret Plan provisions, and may employ and authorize any person to whom any of its fiduciary responsibilities have been delegated to employ persons to render advice with regard to any fiduciary responsibility held hereunder. Upon such designation and acceptance, the Plan Administrator shall have no liability for the acts or omissions of any such designee. All allocations and delegations of fiduciary responsibility shall be terminable upon such notice as the Plan Administrator in its discretion deems reasonable and prudent, under the circumstances.

**Reliance on Reports, Certificates, and Participant Information**

The Plan Administrator shall be entitled to rely conclusively upon all tables, valuations, certificates, opinions, and reports which will be furnished by an actuary, accountant, controller, counsel, insurer, or other person who is employed or engaged for such purposes. Moreover, the Plan Administrator and Employer shall be entitled to rely upon information furnished to the Plan Administrator or Employer by a Participant or Eligible Dependent, including such person's current mailing address.

**Named Fiduciary**

For purposes of ERISA, the Plan Administrator shall be the Plan's "named fiduciary" and may designate other named fiduciaries.

**Plan Expenses**

All fees and expenses incurred in connection with the operation and administration of the Plan, including, but not limited to, legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of Plan assets to the extent that it is legally permissible for these fees and expenses to be so paid. The Employer may, but is not required, to pay such fees and expenses directly. The Employer may also advance amounts properly payable by the Plan and then obtain reimbursement from the Plan for these advances. If the Employer elects to pay any expense that may otherwise be paid from the Plan, such payment shall be deemed to be an unsecured, interest-free advance to the Plan that will be reimbursed by the Plan unless the Employer fails to request reimbursement within 60 days after the end of the Plan Year in which the Employer made such advance. The Plan Administrator shall review and approve any request for reimbursement by the Employer made under this section.

## Article 9

## HIPAA Compliance

### Disclosures to Plan Sponsor

The Plan may disclose participant information to the Plan Sponsor, as permitted under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose protected health information to the Plan Sponsor as necessary to allow the Plan Sponsor to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

### Use of Protected Health Information

The Plan will not use or disclose protected health information that is genetic information for underwriting purposes.

### Access to Medical Information

The following employees or individuals under the control of the Plan Sponsor shall have access to the Plan's protected health information to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

(1) Benefits personnel at the Plan's claims processing locations;

(2) Members of the Legal, Audit, and People Partner Departments to the extent they perform functions with respect to the Plan; and

(3) Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

### Plan Sponsor Agreement to Restrictions

The Plan will not disclose protected health information to the Plan Sponsor until the Plan Sponsor has certified to the Plan that it agrees to:

(1) Not use or disclose protected health information other than as permitted or required by law or as specified above;

(2) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(3) Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which the Plan Sponsor becomes aware;

(4) Make protected health information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;

(5) Allow the subject individuals to amend or correct their protected health information and incorporate any amendments to protected health information in accordance with the HIPAA Privacy Regulations;

(6) Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;

(7) Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or, if not feasible, restrict access and uses to those that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;

(9) Ensure that any agents, including a subcontractor, of the Plan Sponsor to whom the Plan Sponsor provides protected health information shall also agree to these same restrictions;

(10) Ensure that adequate separation between the Plan Sponsor and Plan is established as required under the HIPAA Privacy Regulations and restrict access to protected health information to those classes of employees or individuals identified above under "Access to Medical Information"; and

(11) Restrict the use of protected health information by those employees or individuals identified above under "Access to Medical Information" for plan administration functions within the meaning of the HIPAA Privacy Regulations.

**Permitted Disclosure to Plan Sponsor**

Notwithstanding the foregoing, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor the following types of information:

(1) Summary health information may be disclosed to the Plan Sponsor if 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.

(2) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(3) Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulations.

(4) De-identified information, as defined under the HIPAA Privacy Regulations.

**Noncompliance**

In the event of noncompliance with the restrictions herein by a designated Business Associate or other entity or person receiving protected health information on behalf of the Plan Sponsor, the employee or other individual shall be subject to discipline in accordance with the Plan Sponsor's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Officer.

**HIPAA Security Standards**

(1) Safeguards. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 C.F.R. Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

(2) Agents. The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

(3) Security Incidents. The Plan Sponsor shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

(4) Adequate Separation. The Plan Sponsor shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Plan Sponsor, in support of the requirements described herein.

**Application**

The provisions of this Article shall only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

## Article 10

## Other Legal Information

### Applicable Law

The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA, HIPAA, and the Code to the extent applicable, and to the extent not preempted by ERISA, the laws of Michigan, without giving effect to its conflicts of laws provision. The Plan may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

### Plan Amendment & Termination

The Employer has the right to amend or terminate the Plan at any time. This reservation of the right to amend or terminate benefits applies to benefits for current employees and their dependents and also to retired or terminated employees and their survivors or dependents. Nothing in this document or other communication from the Employer or its delegee with respect to the Plan shall be deemed to create or imply a continuing obligation by the Employer to provide or fund benefits to current employees or their dependents, or retired or terminated employees or their dependents or survivors.

All amendments to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

### Merger or Consolidation

In the event of any dissolution, merger, consolidation, or reorganization of the Employer in which the Employer is not the survivor, the Plan shall terminate with respect to the Employer and its Eligible Employees unless the Plan is continued by the successor to the Employer and such successor agrees to be bound by the terms and conditions of the Plan.

### Assignment of Benefits

Except as required by law, Participants may not transfer or assign any benefit or right under the Plan. Any such assignment shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by the Participant, but only as a convenience to Participants. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants under any circumstances.

### Right to Recover Overpayment

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any Participant. Failure to comply with this request will entitle the Plan to withhold benefits due a Participant. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful.

## Missing Persons

If a benefit check is uncashed by the payee or the Plan Administrator, Insurer, or Claims Administrator cannot locate an individual covered under the Plan or his or her beneficiary, the Plan Administrator, Insurer, or Claims Administrator, as applicable, shall utilize reasonable due diligence efforts to locate the payee, including by giving written notice addressed to the individual's last known address as shown by the records of the Plan Administrator, Insurer, or Claims Administrator. If the Plan benefit remains unclaimed after the expiration of one year from the date as of which it was originally directed to be distributed, it shall be treated as a forfeiture under the Plan. Any such forfeiture shall be and remain assets of the Plan, until paid or distributed in accordance with the provisions of the Plan, and in no event shall any such forfeiture escheat to, or otherwise be paid to, any governmental unit under any escheat or unclaimed property law. If the intended distributee of an unclaimed amount, e.g., a Participant or his or her beneficiary, subsequently appears and files a valid claim for the forfeited benefit, it shall be restored. The restored benefit shall be the dollar value of the benefit that was forfeited, determined as of the date the forfeiture occurred, without any interest, earnings or adjustment in value occurring after the date of forfeiture.

## Keeping Your Plan Account(s) Secure

Be sure to log into your Plan account(s) regularly. Frequent monitoring of your account(s) helps to prevent fraud, cyber threats and other unauthorized activity. It is important that you protect your Plan account(s) and personal information with respect to any Plan or vendor websites. Do not share your log-in credentials with anyone and use strong passwords. You are responsible for maintaining the security of your log-in credentials. If you believe your log-in credentials have been compromised, you should immediately notify the Plan Administrator. Neither the Plan nor the Plan Administrator is responsible for any losses or costs that may be incurred or suffered as a result of security incidents involving identity theft or your failure to protect your benefits, personal information or log-in credentials.

## Consent to Be Contacted Telephonically

You expressly consent to receive phone calls, faxes, text messages, and ringless voicemails placed by or on behalf of Rivian, LLC or its vendors, affiliates, agents or partners, using an automatic telephone dialing system or autodialer, or prerecorded or automated voice to any cellular, facsimile or residential land line number that you have provided to Rivian, LLC or its affiliates, regardless of whether it is on a state or national Do-Not-Call registry. You also consent to receive phone calls, faxes, text messages, and ringless voicemails from Rivian, LLC regarding your employment or any services you provide or work you perform for Rivian, LLC or its affiliates, any health care or wellness plans or programs offered by Rivian, LLC as well as any communications sent for commercial, sales, telemarketing or advertising purposes. You understand that your cellular, landline or facsimile line carrier may charge you for such calls, faxes, text messages or ringless voicemails and you agree to accept full responsibility for any such charges.

## Article 11

## Legal Notices

### Newborns’ & Mothers’ Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

* * *

**Statement of ERISA Rights**

If you are a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

<u>Receive Information About the Plan</u>

- Examine, without charge, at the Plan Administrator’s office and at other specified locations all documents governing the Plan, including, if applicable, insurance contracts, collective bargaining agreements, and a copy of the latest annual report 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, if applicable, insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of a summary annual report, if any.

<u>Prudent Actions by Plan Fiduciaries</u>

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

<u>Enforce Your Rights</u>

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 the Plan or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored; in whole or in part, and you have appealed all adverse determinations, you may file suit in a state or Federal court. Any such suit must be brought no later than 180 days following a final decision on the claim for benefits. If you believe that the fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. 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.

*   *   *

## Premium Assistance Under Medicaid and theChildren's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premiumassistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact yourState Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependentsmight be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligiblefor premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more informationon eligibility –

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website:<br>Health Insurance Premium Payment (HIPP) Program<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |

| COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) | FLORIDA – Medicaid |
| --- | --- |
| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **GEORGIA – Medicaid** | **INDIANA – Medicaid** |
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: (678) 564-1162, Press 2 | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>Phone 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website: https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website: http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-766-9012 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) |

| MAINE – Medicaid | MASSACHUSETTS – Medicaid and CHIP |
|---|---|
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: (617) 886-8102 |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website:<br>http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 | Website:<br>https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 |

| PENNSYLVANIA – Medicaid and CHIP | RHODE ISLAND – Medicaid and CHIP |
|---|---|
| Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://www.coverva.org/en/famis-select<br>https://www.coverva.org/en/hipp<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since January 31, 2023, or for more information onspecial enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencis/ebsa
1-866-44-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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**Women's Health and Cancer Rights Act**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related

benefits, coverage will be provided, in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan.

* * *

**Important Notice from Rivian, LLC About**
**Your Prescription Drug Coverage and Medicare**

Please read this Notice carefully and keep it where you can find it. This Notice has information about your current prescription drug coverage with Rivian, LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Rivian, LLC has determined that the prescription drug coverage offered by the Plan, on average for all plan participants, is expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current Plan prescription drug coverage will not be affected. Those individuals who elect Part D coverage can continue their prescription drug coverage under the Plan.

If you do decide to join a Medicare drug plan and drop your current Plan prescription drug coverage, be aware that you and your dependents will be able to get this coverage back due to a qualifying life event or during open enrollment.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current Plan prescription drug coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage**

For further information, contact **Collective Health at 855-429-6354. You can also sign into your Collective Health account and use Messages to communicate with a Member Advocate directly.** NOTE: You'll get this Notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan changes. You also may request a copy of this Notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium ( a penalty).**

* * *

## Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of January 1, 2019.
Please provide this Notice to your family.

This Notice applies to the health benefits provided under the Rivian, LLC Welfare Benefit Plan (the "Plan") sponsored by Rivian, LLC.
The references to "we" and "us" throughout this Notice mean the Plan. This Notice has been drafted to comply with the "HIPAA Privacy Rules" under federal law. Any terms that are not defined in this Notice have the meaning specified in the HIPAA Privacy Rules.

### How We Protect Your Privacy

The Plan will not disclose protected health information without your authorization unless it is necessary to provide your health benefits and administer the Plan, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality.

### How We May Use and Disclose Your Protected Health Information

The Plan will not use or disclose any of your protected health information for marketing purposes, make any disclosures that constitute the sale of your protected health information, or use or disclose your psychotherapy notes, without your written authorization. Any other uses and disclosures not specified in this Notice require your authorization. We will not use or disclose your protected health information without your written authorization, except for the following purposes, or as otherwise permitted by law. You may revoke an authorization that you previously have given by sending a written request to the People Partner Department, but not with respect to any actions we already have taken. When required by law, we will restrict disclosures to the Limited Data Set, or if necessary, to the minimum necessary information to accomplish the intended purpose.

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| **Treatment** | We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing. |

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| **Payment** | We may use or disclose your protected health information to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your protected health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the services provided to you. We may use and disclose your protected health information to adjudicate your claims. Also, we may disclose your protected health information to other health care providers or entities who need your protected health information to obtain or provide payment for your treatment. |
| **Health Care Operations** | We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan. |
| **Disclosures to Sponsor of Plan** | Rivian, LLC is the sponsor of the Plan. We may disclose your protected health information to employees of the sponsor only to the extent necessary to administer the Plan. The sponsor is not permitted to use protected health information for any purpose other than the administration of the Plan. The sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plan, it will restrict access to your protected health information to those individuals whose job it is to administer the Plan, and it will not use protected health information for any employment-related actions or decisions. |
| **Disclosures to Business Associates** | We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We |

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| | require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management. |
| **Disclosures to Family Members or Others** | Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends. |

**Other Uses and Disclosures**

The law allows us to disclose protected health information without your prior authorization in the following circumstances:

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| **Required by law** | We may use and disclose your protected health information to comply with the law. |
| **Public health activities** | We will disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse. |
| **Reports about victims of abuse, neglect, or domestic violence** | We will disclose your protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree. |
| **To health oversight agencies** | We will provide protected health information as requested to government agencies that have the authority to audit or investigate our operations. |
| **Lawsuits and disputes** | If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested. |
| **Law enforcement** | We may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to |

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| | criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances). |
| **Organ procurement** | We may disclose protected health information to facilitate organ donation and transplantation. |
| **Coroners, medical examiners and funeral directors** | We may disclose protected health information to facilitate the duties of these individuals. |
| **Medical research** | We may disclose protected health information for medical research projects, subject to strict legal restrictions. |
| **Serious threat to health or safety** | We may disclose your protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public. |
| **Special government functions** | We may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State. |
| **Workers' compensation or similar programs** | We may disclose your protected health information when necessary to comply with workers' compensation laws. |
| **Genetic information** | The Plan is prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. |

**Stricter State Privacy Laws**

Under the HIPAA privacy and security rules, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter).

**Your Individual Rights**

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| **Breach Notification** | The Plan is required by law to notify you should a breach of your unsecured protected health information occur. |
| **Who to contact to exercise your individuals rights** | You have important rights with respect to your protected health information as described below. Your enrollment and eligibility information originates with and is maintained by Rivian, LLC, and requests regarding that information must be in writing and directed to the People Partner Department. However, most of your protected health information originates with and is maintained by the Insurers or Claims Administrators for the Plan. Requests relating to your claims information must be in writing and should be directed to the Insurer or Claims Administrator for the particular benefit. |

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| **Right to inspect and copy your protected health information** | Except for limited circumstances, you may review and copy your protected health information. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.<br><br>If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance. |
| **Right to correct or update your protected health information** | If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.<br><br>We may deny your request if you ask us to amend information that:<br>• Was not created by us, unless the person who created the information is no longer available to make the amendment;<br>• Is not part of the protected health information we keep about you;<br>• Is not part of the protected health information that you would be allowed to see or copy; or<br>• Is determined by us to be accurate and complete.<br><br>If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your protected health information. |
| **Right to obtain a list of the disclosures** | You have the right to get a list of protected health information disclosures, which is also referred to as an accounting.<br><br>The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include disclosures we have made for national security purposes or law enforcement personnel or disclosures made before April 14, 2004.<br><br>The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12- |

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| | month period will be free. You may be charged for providing any additional lists within a 12-month period. |
| **Right to choose how we communicate with you** | You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger. |
| **Right to request additional restrictions on health information** | You may request restrictions on our use and disclosure of your protected health information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict disclosure of your protected health information for payment or health care operations purposes if you paid for these services in full, out of pocket. |
| **Right to receive a paper copy** | You have the right to receive a paper copy of this Notice, even if you have agreed to receive this Notice electronically. |

**Questions and Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us or the U.S. Department of Health and Human Services Office for Civil Rights. To file a complaint with us, put your complaint in writing and mail or email to your People Partner Department. The Plan will not retaliate against you for filing a complaint. You may also contact the Company's HIPAA Privacy Officer, Jim Gregoire, if you have questions or comments about our privacy practices:

**Jim Gregoire**: jgregoire@rivian.com

To file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights, you may send a letter to 200 Independence Avenue, S.W., Washington D.C., 20201, or call 1-877-696-6775, or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

**Future Changes to Our Practices and This Notice**

The Plan is required by law to maintain the privacy of your protected health information and to provide you with a notice of its legal duties and privacy practices with respect to your protected health information. The Plan is required to abide by the terms of this notice.

We reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the People Partner Department.

This Notice is intended as an overview of certain benefits-related requirements. More information is available from the People Partner Department.

**Appendix A**

**Benefits under the Plan & Contact Information**

This Wrap Document should be read in connection with the applicable Insurance Policy/Evidence of Coverage or Benefits Booklet/Summary provided by the Insurers or Claims Administrators listed below.

If you have general questions regarding the Plan, please contact **Ellie Warner, Manager, Benefits, at 313-205-2776 or ewarner@rivian.com**. However, if you have questions concerning claims and appeals or the amount of benefits payable under the Plan, please refer to the applicable Insurer or Claims Administrator listed below.

| MEDICAL BENEFITS | |
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| **Collective Health** | • Third Party Administrator for Blue Shield of California, Delta Dental, EyeMed, and VSP<br>• Claims Administrator:<br>1557 W Innovation Way, Suite 125<br>Lehi, UT 84043<br>my.collectivehealth.com<br>855-429-6354 |
| **Blue Shield of California PPO 500** | • Self-Funded<br>• Group Number: W8000021<br>• For details, see Summary Plan Description/Booklet<br>• Claims Administrator:<br>Collective Health<br>1557 W Innovation Way, Suite 125<br>Lehi, UT 84043<br>my.collectivehealth.com<br>855-429-6354 |
| **Blue Shield of California PPO HSA 1500** | • Self-Funded<br>• Group Number: W8000021<br>• For details, see Summary Plan Description /Booklet<br>• Claims Administrator:<br>Collective Health<br>1557 W Innovation Way, Suite 125<br>Lehi, UT 84043<br>my.collectivehealth.com<br>855-429-6354 |
| **Blue Shield of California PPO HSA 3500** | • Self-Funded<br>• Group Number: W8000021<br>• For details, see Summary Plan Description /Booklet |

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| | • Claims Administrator:<br>Collective Health<br>1557 W Innovation Way, Suite 125<br>Lehi, UT 84043<br>my.collectivehealth.com<br>855-429-6354 |
| **Blue Shield of California PPO HSA 6530** | • Self-Funded<br>• Group Number: W8000021<br>• For details, see Summary Plan Description /Booklet<br>• Claims Administrator:<br>• Collective Health<br>1557 W Innovation Way, Suite 125<br>Lehi, UT 84043<br>my.collectivehealth.com<br>855-429-6354 |
| **Kaiser Permanente HMO 500** | • Fully insured<br>• Group Number: 234288- Southern CA 606151-Northern CA<br>• For details, see Insurance Policy/Evidence of Coverage<br>• Insurer:<br>Kaiser Permanente<br>3100 Thornton Avenue<br>4th Floor #4120<br>Burbank, CA 91504<br>https://healthy.kaiserpermanente.org/<br>800-464-4000 |
| **FERTILITY BENEFIT COMPONENT OF MEDICAL BENEFITS** | |
| **Kindbody** | • Self Insured<br>• For details, see Appendix C, Supplement to Medical Program Summary Plan Description/Booklet<br>• Claims Administrator:<br>KBI Services, Inc.<br>120 Fifth Avenue, 5th Fl<br>New York, New York 10011<br>http://kindbody.con/rivianbenefits<br>844-956-1655<br>employeebenefits@kindbody.com |
| **DENTAL BENEFITS** | |
| **Delta Dental of California** | • Self Insured<br>• Group Number: 21596<br>• For details, see applicable Insurance |

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| | Policy/Evidence of Coverage<br>• Claims Administrator:<br>Delta Dental of California<br>PO Box 997330<br>Sacramento, CA 95899-7330<br>https://www1.deltadentalins.com/<br>1-800-765-6003 |
| **VISION BENEFITS** | |
| **EyeMed** | • Self Insured<br>• Group Number: 1034967<br>• For details, see applicable Insurance Policy/Evidence of Coverage<br>• Claims Administrator: EyeMed Vision Care<br>Attn: OON Claims<br>P.O. Box 8504<br>Mason, OH 45040-7111<br>https://member.eyemedvisioncare.com/member/en<br>844-225-3107 |
| **Vision Service Plan (VSP)** | • Self Insured<br>• Group Number: 30104763<br>• For details, see applicable Insurance Policy/Evidence of Coverage<br>• Claims Administrator:<br>Vision Service Plan, Attention Claims Services<br>PO Box 385018 Birmingham, AL 35238-5018.<br>https://www.vsp.com/<br>800.877.7195 |
| **DISABILITY BENEFITS** | |
| **Short-Term Disability** | • Hourly Benefit: Fully Insured<br>• Salary Benefit: Self-Funded<br>• Group Number: G000B9JF<br>• For details, see applicable Insurance Policy/Evidence of Coverage<br>• Insurer:<br>Unum Group<br>1 Fountain Square<br>Chattanooga, TN 37402<br>www.unum.com<br>866-679-3054 |
| **Long-Term Disability** | • Fully Insured<br>• Covered by ERISA<br>• Group Number: G000B9JF<br>• For details, see applicable Insurance Policy/Evidence of Coverage |

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| | • Insurer:<br>Unum Group<br>1 Fountain Square<br>Chattanooga, TN 37402<br>www.unum.com<br>866-679-3054 |
| **LIFE AND AD&D BENEFITS** | |
| **Life Insurance** | • Fully Insured<br>• Group Number: G000B9JF<br>• For details, see applicable Insurance Policy/Evidence of Coverage<br>• Insurer:<br>Unum Group<br>1 Fountain Square<br>Chattanooga, TN 37402<br>www.unum.com<br>866-679-3054 |
| **Accidental Death & Dismemberment (AD&D) Insurance** | • Fully Insured<br>• Group Number: G000B9JF<br>• For details, see applicable Insurance Policy/Evidence of Coverage<br>• Insurer:<br>Unum Group<br>1 Fountain Square<br>Chattanooga, TN 37402<br>www.unum.com<br>866-679-3054 |
| **FLEXIBLE SPENDING BENEFITS** | |
| **Health Flexible Spending Account** | • Self-Funded<br>• For details, see Rivian, LLC Flexible Benefits Plan and Rivian, LLC Health Flexible Spending Account Plan SPD<br>• Claims Administrator:<br>Infinisource, Inc.<br>15 E. Washington St.<br>P.O. Box 488<br>Coldwater, MI 49036-0488<br>www.infinisource.com<br>866-350-3040 |
| **Limited Purpose Health Flexible Spending Account** | • Self-Funded<br>• For details, see Rivian, LLC Flexible Benefits Plan and Rivian, LLC Health Limited Purpose Flexible Spending Account Plan SPD<br>• Claims Administrator:<br>Infinisource, Inc.<br>15 E. Washington St. |

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| | P.O. Box 488<br>Coldwater, MI 49036-0488<br>www.infinisource.com<br>866-350-3040 |
| **OTHER BENEFITS** | |
| **Employee Assistance Program** | • Fully Insured<br>• 1-800-854-1446<br>• Toll-free 24/7 Access<br>• www.unum.com/lifebalance |
| **Adoption Assistance/Family Planning Program Kindbody** | • Self-funded<br>• 1-844-956-1655<br>• http://kindbody.con/rivianbenefits<br>• employeebenefits@kindbody.com |
| **Severance Pay Plan** | • Self-Funded<br>• For details, see Summary Plan Description |
| **Global Wellness Program** | • Fully-insured<br>• Covered by ERISA<br>• For details, see the Cigna Summary<br>• Cigna Health and Life Insurance Company1-800-441-2668 or 1.302.797.3100<br>• Claims Administrator:<br>Cigna<br>P.O. Box 15050<br>Wilmington, DE 19850-5050<br>www.CignaEnvoy.com |
| **Critical Illness** | • Fully-insured<br>• Covered by ERISA<br>• For details, see the Unum Certificate |

## Appendix B

## Adoption Assistance/Family Planning Program

The Adoption Assistance/Family Planning Program provides you with assistance in paying eligible expenses incurred in connection with child adoption, surrogacy, or donor services. The Adoption Assistance/Family Planning Program provides $10,000 per eligible enrollee per lifetime for Third Party Reproduction services (egg donor, sperm donor, adoption or surrogacy services) administered through Kindbody.

As you read about the Adoption Assistance/Family Planning Program, keep the following in mind:

- The program is designed to help you pay eligible expenses associated with one-time expenses related to child adoption, surrogacy, or donor services.
- The Adoption Assistance/Family Planning Program is a reimbursement program. Under the program, you are reimbursed for eligible expenses only after you pay the expenses and only after the adoption, surrogacy, or donor service is completed. The program does not advance you money to pay outstanding bills. Reimbursement for eligible expenses are reviewed and approved by Kindbody.
- An "eligible enrollee" for purposes of this program is any Rivian employee who is a full-time active associate at the time of reimbursement.
- The reimbursement received may be taxable to you and it may reduce any tax credits available. You should consult your own tax professional for advice.
- This program is not subject to ERISA.

**How to Use the Adoption Assistance/Family Planning Program**

- *Legally and successfully utilize an adoption, surrogacy, or donor service* - The program does not assist you with the process of securing an adoption, surrogate, or donor. Any reimbursement for eligible expenses is subject to the completion of the adoption, surrogacy, or donor service. To receive any adoption-related reimbursement, you must provide Kindbody with the legal custody authorization which indicates that you have completed a legal adoption of an eligible child.
- *Incur eligible expenses* - The program is a reimbursement program. You are reimbursed only for expenses you actually incur. You must provide written proof that you have paid all eligible expenses. So, be sure to get receipts for all eligible expenses. The program will not reimburse you for any expense you incurred before you became an eligible associate, after you ended your employment with Rivian, before the effective date of this program, or after the termination of the program.
- *Receive reimbursement* - You must submit a program claim form, that you can obtain from Kindbody, an itemized listing of all expenses you are claiming, receipts for all expenses you are claiming, and, for adoption-related expenses, the legal custody authorization to Kindbody.

## Program Coverage

### Eligible Child

You and your spouse/partner may use the Adoption Assistance/Family Planning Program only if you adopt an eligible child. A child is an "eligible child" if s/he is under the age of 18.

### Eligible Expenses

The term "eligible expenses" means expenses incurred by you in connection with the adoption, surrogacy, or donor services for an eligible child adoption that are approved by Kindbody. Eligible expenses include, but are not limited to, adoption agency fees, placement fees, legal fees, court costs, and foster care charges. If you have a question about whether an expense is an eligible expense reimbursable under the program, please contact Kindbody.

### Expenses Not Covered

The program does not reimburse you for certain expenses. For example, the term "eligible expenses" does not include costs incurred before you become an eligible associate, after you end your employment with Rivian, before the effective date of this program, or after the termination of the program.

## Applying for Reimbursement

You can be reimbursed under the Adoption Assistance/Family Planning Program only after:

- The service or item for which you are seeking has been performed
- You have paid for the service or item
- Completion of the legal adoption, surrogacy, or donor service

To apply for reimbursement, you must file the following with Kindbody:

- A program claim form
- An itemized listing of the expenses you are claiming
- Receipts for all the expenses you are claiming
- For adoption-related expenses, the legal custody authorization

## Filing a Claim

- You may file a claim only after completion of the adoption, surrogacy, or donor services for an eligible child. You must submit a claim no later than 90 days after the date the services becomes final. Claim forms can be obtained from Kindbody.
- If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if an informal resolution is not made, you may appeal a decision to the Plan Administrator by sending a written request for review. The Plan Administrator will review your request and notify you in writing of its decision and the reasons for it. See the claim review procedures described in Article 5 of the Rivian Plan Document and Summary Plan Description for "All Other Claims."

**Tax Considerations**

Pursuant to Section 137 of the Internal Revenue Code, in many cases the adoption-related expenses reimbursed to you are not subject to federal income taxes. In many cases, the adoption-related expenses reimbursed to you are not subject to state and local income taxes either. They are, however, subject to social security (FICA) taxes. If your adjusted gross income is more than a certain amount ($239,230 in 2023), some or all of your reimbursement will be subject to federal income taxes. If you think this rule applies, you should consult a tax advisor.

Reimbursement for surrogacy-related and donor-related expenses is not tax-free under Section 137 of the Internal Revenue Code and will be considered taxable to you.

Rules vary, and state and local laws are subject to frequent change. Rivian may be required to withhold taxes on any reimbursement and will do so if it determines that the law requires it.

**Learn more about the program benefits by contacting Kindbody through any of the following:**

- http://kindbody.com/rivianbenefits
- EmployeeBenefits@kindbody.com or (844) 956-1655

## Appendix C
## Supplement to Medical Program Summary Plan Description / Booklet
## Fertility & Family Planning Benefit Program

**As a full time benefits eligible employee, you have access to comprehensive fertility coverage through Kindbody.**

The Kindbody program provides:

- Coverage for two Kindcycles cycles, including medication
- Access to end-to-end fertility services, including standard gynecological care
- Dedicated Care Navigation Team and personalized patient portal
- Up to 5 covered virtual coaching sessions for prepartum to postpartum care
- Network access to partner clinics in locations near Rivian and your home

Learn more about the program benefits by contacting Kindbody through any of the following:

- http://kindbody.com/rivianbenefits,
- EmployeeBenefits@kindbody.com or (844) 956-1655