Rivian, LLC Welfare Benefit Plan

Summary Plan Description*

**This document, together with the Certificate(s) and SPD Booklet(s) for the Benefit Program(s) in which you are enrolled, constitutes your Summary Plan Description for the Rivian, LLC Welfare Benefit Plan.*

2026

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Introduction

The **Rivian, LLC Welfare Benefit Plan** ("Plan") sponsored by Rivian, LLC ("Company") is designed to help you and your covered family members by offering the types of coverage listed below. The various types of coverages available under the Plan are referred to in this Summary Plan Description ("SPD") as "Benefit Programs."

Summary Plan Description

This SPD contains key administrative information about the Plan and Benefit Programs as in effect on January 1, 2026. If you have any questions about the information in this SPD, contact the Plan Administrator, whose contact information appears in the "**Administrative Information**" section.

This SPD supplements each certificate of insurance (or evidence of coverage) produced by the Insurers (the "Certificate") and each summary plan description booklet ("SPD Booklet") provided by the Claims Administrator and the Company for each Benefit Program, and the current annual enrollment materials—***together, these documents constitute your SPD for the Plan***. This SPD provides details about the administration of the Plan and your rights under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other applicable laws.

Please read the SPD carefully and keep it with other information about your Company welfare benefits. In the event that there is a conflict between this SPD and the underlying Certificate, SPD Booklet or annual enrollment materials, the underlying Certificate, SPD Booklet or annual enrollment materials will control with respect to the benefits provided. If there is a conflict between the Summary Plan Description and the Plan document, the terms of the Plan generally will control, except as needed to give effect to applicable federal or state law.

Please be aware that Plan rights and benefits generally may not be assigned or transferred.

Benefit Programs

You may not be eligible for all of the Benefit Programs available under the Plan -- eligibility for a particular Benefit Program may depend on certain factors, such as where you live. The Benefit Programs which may be available to you under the Plan include:

- Medical Program
- Prescription Drug
- Dental Program
- Vision Program
- Employee Assistance Program
- Wellness Program
- Short Term Disability Program*

- Short Term Disability Program
- Long Term Disability Program
- Life Insurance Program
- Dependent Life Insurance Program
- Accidental Death and Dismemberment Program
- Health Savings Account*
- Dependent Care Spending Account*
- Limited Health Care Spending Account
- Health Care Spending Account
- Health Reimbursement Account
- Critical Illness
- Group Accident
- Severance
- Onsite Clinic

* Indicates Benefit Programs that are not subject to ERISA and is not required to be included in this SPD.

Keep in mind that you and your doctor always make the final decision regarding your healthcare and treatment. The Plan only determines whether benefits will be paid by the Plan, not whether care or treatment is appropriate for you or your dependents.

The medical, dental and vision Benefit Programs use provider networks. Therefore, a provider listing will be furnished to you, without charge. Therefore, a provider listing will be furnished to you, without charge—visit the Claims Administrator's website for details. For information regarding the provider network(s) for a particular Benefit Program, refer to the applicable Certificate or SPD Booklet and/or contact the Insurer or other Claims Administrator, or the Plan Administrator, whose contact information appears in the "**Administrative Information**" section.

More Information about the Benefit Programs

Details about each of the Benefit Programs, such as eligibility conditions, coverage details and schedules, claims and appeals procedures, etc., can be found in the Certificates, and SPD Booklets, and additional information is available in the annual enrollment materials. These materials and other important information about the Plan may be found on rivianbenefits.com. Participants and

beneficiaries also may request paper copies of these materials from the Plan Administrator, whose contact information appears in the "Administrative Information" section.

If you have any questions about a Certificate, SPD Booklet or the Benefit Program in which you are enrolled, you should contact the applicable Insurer or other Claims Administrator, or the Plan Administrator, whose contact information appears in the "**Administrative Information**" section and/or in the applicable Certificate or SPD Booklet.

Amendment or termination of the Plan

The Company reserves the right to amend or terminate the Plan or any Benefit Program available under the Plan at any time. Refer to the "**Administrative Information**" section for more information.

Who Is Eligible

You

Please refer to the applicable Certificate or SPD Booklet for specific eligibility requirements, enrollment requirements (including deadlines) and entry dates that apply for each Benefit Program under the Plan. Generally, coverage is extended to full-time employees working or expected to work more than 30 hours per week, part-time employees regularly scheduled to work 20 or more hours per week, and an otherwise eligible employee on short-term disability, in accordance with the terms of applicable Program Document.

Your eligible dependents

Eligible dependents are described in detail in the applicable Certificates and SPD Booklets. Generally, eligible dependents includes:

- Your spouse (including a same-sex spouse who is considered your spouse for federal tax purposes pursuant to applicable Internal Revenue Service guidance).

- Your domestic partner if your domestic partnership meets the requirements determined by the Company and you provided any required documentation to the Plan Administrator.

- Your (or your spouse's/domestic partner's) dependent children until they turn age 26. Your eligible children include your natural children, legally adopted children or children who are placed with you for adoption, stepchild, foster child, and children who reside in your household under your legal guardianship.

- Your unmarried incapacitated dependent children (refer to the applicable Certificate or SPD Booklet for details).

- Your dependents eligible under the applicable Certificates and SPD Booklets or required by law.

- In addition, a court order could require you as a parent to provide for your child's group health plan coverage. If this is the case and the court order is determined by the Plan Administrator to satisfy all applicable legal requirements (and is therefore a *qualified medical child support order*, or "QMCSO"), the Company will offer coverage to the extent required by law and under the Plan. To obtain a copy of the Plan's QMCSO procedures, free of charge, contact the Plan Administrator whose contact information appears in the "**Administrative Information**" section.

If you, your spouse, or your children are Company employees, then neither you, your spouse, or your children can be covered as both employees and dependents under the Plan.

You may be required to provide proof of your dependent's eligibility from time to time and your dependent will not be considered eligible for coverage unless and until satisfactory proof of such eligibility is submitted to the Plan Administrator or the Insurer. The Plan Administrator reserves

the right (in its sole discretion) to establish rules regarding the time, form, and manner in which such proof must be submitted. Failure to submit the required proof according to those rules may result in ineligibility. If you attempt to intentionally or fraudulently misrepresent your dependent's eligibility, the Company (and the Insurer) reserve the right to retroactively rescind your coverage and to seek to recoup any benefits that you (or your dependents) received to the extent permitted by (and applying the procedural requirements of) applicable law.

Taxation of Domestic Partner Coverage

The cost of a Company subsidy (if any) associated with providing benefits to a domestic partner, where the domestic partner is not your dependent for purposes of Section 152 of the Code, as modified by Code Section 105(b), shall be treated for withholding purposes as taxable compensation to you. You should speak with your tax advisor or legal counsel if you have questions regarding the tax implications of coverage for your domestic partner.

Enrollment and Cost of Coverage

When you are first hired, and each year before the annual enrollment period, you will receive information about enrolling for benefits.

New employee

To elect coverage as a new employee:

- Review the new hire enrollment information you receive carefully. Be sure to note the deadline for making your enrollment elections.
- Decide which Benefit Program(s) (and Benefit Program option(s)) you want and whom you want to cover under the elective Benefit Programs of the Plan.
- Timely complete the Plan's enrollment form (and any other forms required by the Insurer(s)).

If you don't complete an election form within 14 days after you are first eligible that failure will constitute an election not to participate in the elective Benefit Programs and an election to receive your full compensation in cash, except that the Plan Administrator reserves the right to select a default enrollment option and deem you have elected coverage in that default option.

Please be aware that some enrollment requests (for example, a request to purchase life insurance coverage over the "guaranteed issue" amount set by the Insurer) may require you to submit "evidence of insurability" (or "EOI"), and such requests will require Insurer approval. Please refer to the Certificate for details. Any approved request will take effect on the date determined by the approving Insurer.

You generally may not change your coverage elections until the next annual enrollment period unless you experience an event described in the "**Changing Your Coverage Elections**" section.

Annual enrollment

You may change your coverage elections once each year during the annual enrollment period. Information about the Benefit Program options available to you will be provided to you during annual enrollment period.

Your failure to make an election during annual enrollment will constitute (i) a re-election of the same Benefit Program benefits and coverage, if any, immediately before the end of the preceding plan year, except for the Health Care Spending Account, Dependent Care Spending Account, Limited Purpose Health Care Spending Account and Health Savings Account, and any default enrollment option as communicated in your annual open enrollment materials; and (ii) an election to not participate in the Health Care Spending Account, Dependent Care Spending Account, Limited Purpose Health Care Spending Account and Health Savings Account for the upcoming plan year.

Mid-year enrollment

If you previously declined coverage because you were covered under another health plan and you then lose that coverage, special enrollment rules may apply. See the "**Special Enrollment Rules**" section below for more information.

Cost of coverage and cost sharing—*Elective Benefit Programs*

The Company pays a portion of your elective coverages. You pay your portion of the cost through payroll deductions. Your costs for elective coverage are based on the Plan option and coverage level you select. Your contributions are generally deducted from your pay on a pre-tax basis. Information regarding the applicable benefits, pricing, and whether the benefit premiums are payable on a pre-tax or after-tax basis will be available during the annual enrollment period.

The elective Benefit Program options also may contain certain cost sharing features, such as deductibles and co-payments. These are the responsibility of the Plan participant or dependent, and are described in detail in the Certificates and SPD Booklets.

Cost of coverage and cost sharing—*Non-Elective Benefit Programs*

The Company pays the cost of your non-elective insurance coverages.

Special rule for rehires

If you terminate employment during the Plan Year and are rehired within 30 days during the same Plan Year, the elective coverages that you paid for on a pre-tax basis before your employment terminated generally will automatically be reinstated on your rehire, if you otherwise are eligible for such coverages. If you have experienced a qualifying life event during that period, you may be able to change your coverage election(s) with timely notice of such event as described in "**Changing Your Coverage Elections**" below.

Changing Your Coverage Elections

The circumstances under which you may change your Benefit Program coverage elections during the year are described below. If none of these circumstances apply, you may not change your coverage elections during the year. In order to make a mid-year change to your coverage elections, you must meet the requirements of the Plan and of the applicable Benefit Program, as described in the Certificate for that Benefit Program.

Changing your coverage

Under certain circumstances, you may enroll in coverage, add or remove dependents, or change coverage that is paid for on a pre-tax basis during the year. For example, you may make a prospective change to your coverage (and/or the coverage of your dependents, if applicable), if:

- You experience a "change in status" (as described below) that affects your or your dependents' eligibility for a Benefit Program;
- You qualify for a special enrollment during the year (as described below);
- The Plan Administrator or Insurer receives a QMCSO or other court order, judgment or decree requiring you to enroll a dependent child;
- You, your spouse, or your dependent becomes entitled to or loses Medicare or Medicaid coverage;
- You, your spouse, or your dependent experiences a significant, unexpected and unforeseen increase (or decrease) in the cost of coverage;
- You, your spouse, or your dependent child experience a significant reduction in coverage or a total loss of coverage;
- The Plan adds a benefit package option or significantly improves coverage under an existing option;
- You experience a reduction in hours from more than 30 hours per week, on average, to less than 30 hours per week, on average, followed by enrollment in Health Insurance Marketplace coverage or other qualifying coverage no later than the start of the second full month following the reduction;*
- You or your dependents qualify for annual or special enrollment in Health Insurance Marketplace coverage, with Marketplace coverage to begin no later than the day following the termination of your coverage under this Plan; and*
- Any other event recognized for purpose of changing Plan elections under applicable law and regulation, in the sole discretion of the Plan Administrator.

*These events only permit election changes to your medical coverage election.

Coverage election changes must be consistent with the event and generally must be made within 30 days of the event, or within such other timeframe provided in the applicable Certificate or Benefit Booklet. The Plan Administrator will determine, in its sole discretion, if an event has occurred that permits a change under these rules.

Special rule applicable to Health Savings Account (HSA) contributions

The limitation on election changes and the election change events described in this section do not apply to your pre-tax contributions to your Health Savings Account—you may (at least monthly) prospectively change your contributions to your HSA at any time during the Plan Year, subject to the IRS contribution limits for the year (which apply to your contributions and any Employer contributions, combined).

Change in status

You may change certain coverage elections under the Plan during the year if you experience a change in status. Depending on the event that you experience, you may change your coverage elections. You also may change your pre-tax salary reduction amount, and you may be able to add or remove dependents from coverage. Changes in status include:

- You get married, divorced, or legally separated or you have your marriage annulled;
- Your spouse or dependent dies;
- Your dependent becomes eligible for coverage or ineligible for coverage (e.g., he or she reaches the eligibility age limit);
- You or your spouse has a baby, you adopt or you have a child placed with you for adoption;
- You, your spouse, or your dependents experience a change in employment status that leads to a loss of or gain in eligibility for coverage; or
- Your home residence changes and your previous coverage is no longer available or new coverage options become available.

Regardless of what type of change in status you have, any coverage election change you make under the Plan must be because of and consistent with the change in status. The Plan Administrator will determine (in its sole discretion) whether a particular event constitutes a change in status. The change must also be permitted by the Insurer, if applicable. If you experience a change in status or any other event described in this section, you must notify the Plan Administrator within 30 days after the event, or within such other timeframe provided in the applicable Certificate or Benefit Booklet, to change your Benefit Program coverage election. In addition, you may be required to provide proof of your change in status or the other event. If you do not, you cannot change your coverage until the next annual enrollment period, unless you once again experience a change in status.

Effective date of coverage change

Except as otherwise provided in the applicable Certificate (and except for a change in status based on birth, marriage, adoption, or placement for adoption), your coverage change will generally be effective as soon as administratively practicable after the date you timely file a completed election form with the Plan Administrator or Insurer. For birth, marriage, adoption, or placement for adoption, your change will be effective as of the date of birth, marriage, adoption, or placement for adoption provided you enroll your child within 30 days of the event date, or within such other timeframe specified in the applicable Certificate or Benefit Booklet. Notwithstanding the foregoing, if the employee is permitted to elect coverage retroactive to his or her date of marriage, at the Plan Administrator's sole discretion, the employee will pay his or her share of the cost of such retroactive coverage with after-tax dollars or the Company will pay the employee's share of the cost of such retroactive coverage.

Special enrollment rules

If you decline enrollment in the Plan for yourself or your dependents because of other health coverage and you later lose that other coverage or the employer providing other coverage stops making contributions, you may be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends, or within such other timeframe provided in the applicable Certificate.

Your loss of other health coverage qualifies for special enrollment treatment only if you satisfy both of the following conditions:

- You (or your dependents) were covered under another group health plan or health insurance coverage when coverage under the Plan was originally offered to you; and

- You (or your dependents) lost your other coverage either because you exhausted your rights under COBRA continuation coverage or you were no longer eligible under that plan.

If you gain a dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependent(s), provided that you request enrollment within 30 days after the event, or within such other timeframe provided in the applicable Certificate.

If you and/or your dependents are eligible for health coverage under the Plan but do not elect such coverage during a regular enrollment period, and either:

- Your and/or your dependent's Medicaid or State Children's Health Insurance Program ("CHIP") coverage is terminated due to a loss of eligibility; or

- You and/or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP,

then you may enroll yourself and/or your dependents in health care coverage under the Plan, provided you request enrollment within 60 days after the occurrence of either of these events.

Circumstances Which May Affect Benefits

Your and your dependents' eligibility for Plan benefits will terminate upon the occurrence of any of the events described under "**When coverage ends**," section below, or described in the applicable Certificate or SPD Booklet.

Other circumstances may result in the termination, reduction, loss, offset, or denial of benefits including, but not limited to, exclusions for certain medical procedures, limitations on coverage for new drugs, and rights of recovery of benefits paid by a particular Benefit Program (for example, the Benefit Program's rights of reimbursement and/or subrogation). Benefits under a particular Benefit Program may also be subject to coordination of benefits if you have coverage under another plan.

Refer to the applicable Certificate or SPD Booklet for specific information regarding the circumstances which may affect your benefits under the particular Benefit Program.

Preexisting conditions

Some of the Benefit Programs include limitations on preexisting limitations. Notwithstanding the foregoing, no "group health plan" (as that term is defined under the Affordable Care Act) will impose a pre-existing condition exclusion. *Refer to the applicable Certificate or SPD Booklet for information about that Benefit Program's preexisting condition rules and how they apply to your coverage.*

When coverage ends

Your coverage generally ends when:

- your employment with Company ends;
- you no longer meet the eligibility rules of the Plan or a Benefit Program;
- the Plan or Benefit Program terminates;
- you stop making any required contributions;
- you commit fraud against the Plan;
- you fail to repay overpayments, amounts subject to reimbursement under any Benefit Program, or mistaken payments from a Benefit Program within 90 days after the Plan Administrator requests repayment or according to a repayment schedule approved by the Plan Administrator; or
- you go on strike or are locked out to the extent not prohibited by the applicable collective bargaining agreement.

Except where otherwise provided in the applicable Certificate or SPD Booklet, coverage that terminates due to one of the events listed above will remain in effect through the end of the month

in which the applicable terminating event occurs, including termination of employment. Because coverage remains in effect for the full month in which employment ends, you are responsible for the applicable employee share of premiums for that entire month. Premiums under the Plan are assessed on a monthly basis and will not be prorated unless otherwise provided in the applicable Certificate or SPD.

Notwithstanding the foregoing, for purposes of the medical Benefit Program, dependent coverage will continue through the last day of the month in which the dependent turns 26.

Medical, dental and vision benefit programs terminate after 26-weeks of continuous leave in accordance if the Plan Administrator's procedures.

Your dependent's coverage ends on the date your coverage ends, or on the last day of the month in which your dependent no longer meets the Plan's definition of an eligible dependent.

Refer to the applicable Certificate or SPD Booklet for information about when coverage under a particular Benefit Program ends. (The Certificates and SPD Booklets also contain information about converting to an individual policy when your coverage under the group program ends, if applicable.)

Rights Under Federal Law

Your rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a normal vaginal delivery; or
- 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 (or 96) hours.

The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. *For more information and coverage details, refer to the applicable medical Certificate or SPD Booklet.*

Your rights under the Women's Health and Cancer Rights Act of 1998

The Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, and the complications resulting from a mastectomy (including lymphedema). These benefits include reconstruction and surgery to achieve breast symmetry, and prostheses. *For more information and coverage details, refer to the applicable Medical Program Certificate or SPD Booklet.*

Military leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your health coverage for up to 24 months as long as you give the Company advance notice (with certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from the Employer, does not exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (including both the Company and your contributions) necessary to cover a similarly-situated employee who does not go on military leave.

If you are on military leave for less than 18 months and you do not return to work at the end of your leave or you do not elect to continue coverage during your leave, you may be entitled to purchase COBRA continuation coverage for the remaining months, up to a total of 18 months from the commencement of the military leave. Refer to page 28 for information about COBRA continuation coverage.

HIPAA Privacy

As a participant in any of the group health plan coverages under the Plan, your "protected health information" is subject to safeguard under the privacy provisions of the Health Insurance Portability and Accountability Act ("HIPAA"). As a Benefit Program participant, you will receive or have received a "privacy notice" that describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a copy of this notice, you should contact your Insurer or the Plan Administrator.

Children's Health Insurance Program (CHIP) Notice

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") but are unable to afford the premiums, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but who also have access to health insurance through their employer. If you or your children are NOT eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, or if you think you might be eligible for Medicaid or CHIP, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS-NOW** (**543-7669**), or go to **www.insurekidsnow.gov** to find out if premium assistance is available. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Refer to the notice provided to you each year for information about premium assistance programs in various states (the current notice is also available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/chipra/model-notice.pdf).

Mental Health Parity and Addiction Equity Act

The Plan, to the extent its Benefit Programs provide mental health or substance use disorder ("MH/SUD") benefits, may not, under federal law, impose less favorable benefit limitations on those MH/SUD benefits than on medical/surgical benefits, as required under the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). For more information and coverage details, refer to the applicable Medical Program Certificate or SPD Booklet.

Continuation of Coverage During FMLA Leave

For any Company approved leave of absence, paid or unpaid, you may continue the same benefits that you were receiving immediately before the start of your leave, if permitted under the applicable insurance policies and appropriate payment arrangements are made for unpaid leaves. If your leave qualifies under the Family and Medical Leave Act of 1993, as amended ("FMLA"), you will be entitled to receive the same medical, vision and dental Benefit Program benefits that you were receiving immediately before the start of your FMLA leave. The Company also intends to allow you to continue to receive all other Plan benefits during your FMLA leave, to the extent

possible. For a leave of absence that does not qualify for the FMLA, you may continue to participate in the Benefit Programs you elected, if permitted in the applicable Certificate or SPD Booklet, provided you make the appropriate Benefit Contributions.

- If you do not wish to receive some or all of the coverage during your leave that you were receiving just prior to your leave, you must inform the Company before the start of your leave. Benefits under the Plan will terminate at the end of the month when you start your leave of absence.

- If you wish to continue your participation in the Plan, and you are currently required to contribute a certain amount for your coverage, you must make arrangements with the Company to pay for the coverage you wish to maintain during the course of your leave. If your leave is a paid leave, you may continue making contributions during your leave. If your leave is unpaid, you can pay your benefit contributions before you go on leave, during your leave by sending a check to the Company or when you return to work.

- Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not make the required payments in a timely fashion.

- If the Company advances money by making contributions for you during your leave, in whole or in part, it can recoup the amounts advanced to you upon the end of your leave, whether or not you return to employment following your leave. If you return to employment following your leave, the Company may recoup those amounts through payroll deductions. If you do not return from a leave of absence, you are responsible for reimbursing the Company for the entire cost to the Company (i.e., the Company's contribution) for providing any benefits under this Plan during your leave, unless the leave was an FMLA qualified leave of absence, and you do not return due to the continuation of a serious health condition or circumstances beyond your control.

- When you return from your FMLA leave, you are not required to satisfy the waiting period under the Benefit Programs.

If you are on an approved disability leave from the Company, you may continue the same benefits that you were receiving immediately before the start of your leave if permitted by the applicable Certificate or SPD Booklet. Your Benefit Contributions will be automatically deducted from your paycheck.

For additional information about FMLA leaves, contact:

Rivian's Benefits Team
https://www.rivianbenefits.com/us/leaves-of-absence/

Preventing surprise medical bills

To the extent required by the Consolidated Appropriations Act, 2021 (the "Consolidated Appropriations Act" or "CAA"), including, without limitation, the No Surprises Act (at Division BB, Title I of the CAA) and Transparency provisions (at Division BB, Title II of the CAA), each applicable Benefit Program (e.g., the Medical Program) will cover (i) out-of-network "emergency

services," (ii) out-of-network non-emergency services performed by out-of-network providers at certain in-network facilities, and (iii) out-of-network air ambulance services (if the Benefit Program covers in-network air ambulance services) at the levels required by, and subject to all applicable requirements of, the Consolidated Appropriations Act (e.g., via Sections 716 and 717 of ERISA and/or Sections 9816 and 9817 of the Code) and the rules of the Plan. For more information and coverage details, refer to the applicable Medical Program Certificate or SPD Booklet.

Continuity of care upon the expiration of provider network contract

To the extent required by the Consolidated Appropriations Act, each applicable Benefit Program (e.g., the Medical Program) will provide continued transitional care to a "continuing care patient" within the meaning of, and subject to the requirements of, the Consolidated Appropriations Act (e.g., via Section 718 of ERISA and/or Section 9818 of the Code, as applicable) and the rules of the Plan. For more information and coverage details, refer to the applicable Medical Program Certificate or SPD Booklet.

Compliance with all other applicable federal laws

The Plan is intended to be interpreted and administered in accordance with all other applicable federal laws and requirements, including, without limitation, the requirements under the Patient Protection and Affordable Care Act, as amended ("Affordable Care Act"), MHPAEA, and the Consolidated Appropriations Act.

Filing a Claim for Benefits Under the Plan

Even though it does not happen often, occasionally disagreements about benefit eligibility or amounts arise. In most cases, they are resolved quickly. However, if you are unable to resolve the disagreement, formal appeals processes are in place to help you (or your authorized representative acting on your behalf) file a claim and appeal a denied claim.

In this section you will find the timeframes for responding to initial claims, as well as the appeals process. The timeframes for responding to claims depend on the type of claim (eligibility claim or claim for benefits, described below).

In no event can you (or any other person) challenge a decision in court until the applicable claims procedures have been complied with and exhausted. The decision of the Plan Administrator or the Claims Administrator, as applicable, on the final level of mandatory appeal will be final and binding on you, your dependents and any other interested party.

To the extent that the Plan Administrator properly delegates its claims authority to a Claims Administrator, the Claims Administrator may apply alternative timeframes than those set forth below, as described in the applicable Certificate or SPD Booklet. To the extent that an Insurer (or other Claims Administrator) administers claims under a Benefit Program, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company. Insurers will determine claims related to eligibility only to the extent eligibility depends on an insurance requirement, such as evidence of insurability.

The Claims Administrators for the various benefits provided by the Plan are listed in the "**Administrative Information**" section. The Claims Administrators do not guarantee the payment of benefits under the Plan.

Authorized representatives

As the claimant, you are entitled to designate someone to act on your behalf as your "authorized representative" to file a claim for you and/or to pursue an appeal for you whenever your claim for Plan eligibility or benefits has been denied. However, the Plan or a Claims Administrator may recognize an "authorized representative" only if you follow the Plan's (or the Claims Administrator's) required process for designating such a representative. No person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives the requisite form signed by the claimant (or other acceptable documentation; e.g., a power of attorney), except that for Urgent Care Claims (as defined below), the Plan will, even in the absence of the requisite documentation, recognize a health care professional with knowledge of the claimant's medical condition (e.g., the treating physician) as the claimant's authorized representative unless the claimant provides specific written direction otherwise.

Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise.

Where appropriate, references in these claims procedures to "you" or the "claimant" include your (the claimant's) authorized representative.

An agreement to pay another person or entity (e.g., a health care professional) directly for purposes of Plan benefit payment does not constitute appointment of an authorized representative under these claims procedures (refer to the "**No assignment of rights or benefits**" section).

Procedures Regarding Eligibility

These procedures apply to claims for eligibility for coverage or enrollment in the Plan, to the extent those determinations have not been delegated to a Claims Administrator.

Filing a Claim

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 at the following address:

Rivian, LLC Benefits Committee
13250 N. Haggerty Rd.
Plymouth, MI 48170
734-855-4350

Initial Claim Decision

When an eligibility or enrollment claim is received, the Plan Administrator must notify you of its benefit 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 will send you a written notice of an adverse benefit 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 benefit determination on appeal.

Appealing an Eligibility or Enrollment Claim Denial

If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (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 will furnish you with a written decision providing the final determination of the appeal. The Plan Administrator's decision 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 will notify you in writing of the extension within 60 days of receiving your appeal. The Plan Administrator's decision 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.

Procedures Regarding Adverse Benefit Determinations

How Claims for Benefits Are Processed

How a claim for benefits is processed depends on the type of claim it is. There are several categories of claims:

- Concurrent Care Claim -- A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. When possible, this type of claim should be filed at least 24 hours before the expiration of the course of treatment for which an extension is being sought.
- Pre-Service Claim -- A Pre-Service Claim is a claim for a benefit with respect to which the terms of Health Coverage require approval of the benefit in advance of obtaining medical care.
- Post-Service Claim -- A Post-Service Claim is a claim for a benefit that is not a Pre-Service Claim. Most claims are Post-Service Claims.
- Urgent Care Claim -- An Urgent Care Claim is any Pre-Service Claim for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize the life or health of you or your Dependent or subject you or your Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject

of the claim. This type of claim generally includes those situations commonly treated as emergencies.

Submitting a Benefit Claim

You must report claims to the address appearing in "**Administrative Information**" section promptly but no later than one year after the date of the service. If you do not provide this information to us within one year of the date of service, benefits for that health service will be denied or reduced, at the Claim Administrator's discretion. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits, you may be required to provide all of the following information:

- Employee's name and address.
- The patient's name, age and relationship to the employee.
- The member number stated on your ID card.
- An itemized bill from your provider that includes the following:
    - Patient diagnosis;
    - Date(s) of service;
    - Procedure code(s) and descriptions of service(s) rendered;
    - Charge for each service rendered;
    - Provider of service name, address and Tax Identification Number;
    - The date the injury or sickness began; and
    - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you re-enrolled for other coverage you must include the name of the other carrier(s).

Submit your claims to the address "**Administrative Information**" section.

Benefit Determinations

The Claims Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider (assuming the Plan Administrator, in its sole discretion, chooses to recognize the assignment).
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

Pre-Service Urgent Care

Urgent Care Claims are those for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize: (i) the life or health of you or your dependent; (ii) the ability of your or your dependent to regain maximum function; or (iii) subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

This type of claim generally includes those situations commonly treated as emergencies. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or

- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will set forth the specific reason or reasons for the denial, refer to specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted (if applicable) an explanation of why such information is necessary. This letter will also describe the process for filing a formal appeal and the time limits for filing an appeal, including your right to bring a civil action following an adverse determination upon appeal. If the denial is based on medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the

timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post service or pre-service timeframes, whichever applies.

Pre-Service Claims

Pre-service claims are those claims that require certification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day timeframe, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted and an explanation of why such information is necessary, and describe the process and time limits for filing a formal appeal including your rights to bring a civil action following an adverse determination upon appeal. If the denial is based on the medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day timeframe and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted and an explanation of why such information is necessary, and describe the process and time limits for filing a formal appeal including your right to bring a civil action

following an adverse determination upon appeal. If the denial is based on the medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Appeals

If your question or concern is about a benefit determination you may informally contact the appropriate Claims Administrator before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in "**Submitting a Claim**" section, you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact customer service and later wish to request a formal appeal in writing, you should contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address of the claims administrator.

If you are appealing an Urgent Care Claim denial, please refer to the "**Urgent Claim Appeals that Require Immediate Action**" section below and contact customer service immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your request may be required to include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of

charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

You will be provided notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from the receipt of a request for appeal of a denied claim.

- For appeals of post-service claims, you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.

- For procedures associated with urgent claims, see "**Urgent Claim Appeals that Require Immediate Action**" below.

Notice of Decision on Appeal

If your appeal is denied, you will receive a notice explaining the following: the reason for the denial, specific references to the part of the Plan on which the denial is based, a statement that you are entitled by law to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim, a statement regarding any voluntary appeal procedures offered by the Plan and your right to bring a civil action after an adverse determination on appeal, information about the internal rule, guideline or protocol that was relied on, if applicable, information on the scientific or clinical judgment for the determination if the adverse decision is based on medical necessity or experimental treatment, and a description of the external review process, including how to initiate an external review and the time limits that apply.

Please note that the Claims Administrators' decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

External Review Process

In certain instances, you may be entitled to an external review by an independent reviewer under the Medical Program, including an expedited external review. In accordance with (and to the extent required by) ERISA, external review is only available with respect to adverse benefit determinations involving:

- medical judgment (except claims that only involve interpretation of a contract or law without any use of medical judgment);

- consideration of whether the Plan (or the Insurer) is complying with the surprise billing and cost-sharing protections required by the Consolidated Appropriations Act (as set forth in Sections 716 and 717 of ERISA); or

- a rescission of coverage (regardless of whether the rescission has any effect on any particular benefit at that time). For this purpose, a "rescission" (or coverage that has been rescinded) is the cancellation or discontinuance of coverage that has a retroactive effect, but does not include, for example, a retroactive cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions (e.g., for COBRA coverage) or that is initiated by the participant without influence by the Company or any other Employer, the Plan, etc.

Preliminary Review

Within five business days of receipt of your request, the Claims Administrator will complete a preliminary review to determine that:

- You were covered by the Plan at the time the service was requested or provided;

- The adverse claim determination was not related to your failure to meet the plan's eligibility requirements;

- You had exhausted the plan's internal appeals process, if required under law; and

- You had provided all of the necessary information and forms to process an external review.

Within one business day after completing the preliminary review, the Claims Administrator will contact you in writing. If your request was complete but not eligible for an external review, the notice will tell you why and provide you with the contact information for the Employee Benefits Security Administration. If your request is incomplete, the notice will describe what information is needed to perfect your review request. You have 48 hours from receipt of this notice, or up to the original four month external appeal filing deadline, to provide the requested information.

Referral to Independent Review Organization

If your claim qualified, the Claims Administrator will assign your review request to an accredited Independent Review Organization ("IRO") that will conduct the external review. The Claims

Administrator will provide the IRO with the documents and any information considered in previously denying your claim.

The IRO will notify you in writing of your eligibility and acceptance for external review. The notice will inform you of your right to submit additional information for review in writing to the IRO within 10 business days following receipt of the notice.

Within one business day of receiving any additional information from you, the IRO will forward that information to the Claims Administrator. The Claims Administrator may then reconsider its benefits denial. If the Claims Administrator decides to reverse its previous denial, the external review will be terminated, and you will receive a written notice of the Claims Administrator's decision within one business day.

The IRO will review your claim without regard to any previous decision or conclusions reached during the internal claims and appeals processes. You will receive written notice of the IRO's decision within 45 days after the IRO received your review request.

If the IRO reverses the Plan's adverse benefit decision, your claim will be immediately paid or coverage must be immediately provided (whichever applies to your claim).

The written decision of the IRO will include the following:

- A general description of the reason for the external review request, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount (if applicable), notice regarding the availability of the diagnosis code and its corresponding meaning and/or the treatment code and its corresponding meaning, and the reason for the previous denial);

- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Claim Administrator and you;

- A statement that judicial review may be available to you; and

- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

For urgent care claims and appeals, there is an expedited external appeal process. In such a case, the Claims Administrator will immediately determine if the claim is eligible for an external review

and provide all documents and information to the IRO electronically or by phone or fax to expedite the process. The IRO will make a decision on your claim within 72 hours of receiving it.

The decision of the IRO is binding upon all parties, however you still have the right to bring an action under section 502(a) of ERISA.

Exhaustion of Administrative Remedies

In no event can you (or any other person) challenge a decision in court until this claims procedure has been complied with and exhausted. If you have complied with and exhausted the appropriate claims procedures and intend to exercise your right to bring civil action under ERISA Section 502(a), you must bring the civil action under ERISA Section 502(a) within one year after your initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Benefit Program.

Your Legal Right to Continue Coverage Under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. Although not required by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Plan will extend continuation coverage that is similar to COBRA to domestic partners in accordance with the terms of this section. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

For purposes of any Benefit Program administered by an Insurer, you may have additional continuation rights under state law. Refer to the Certificate or contact the Insurer at the address listed at the end of this Plan for more information. You may also have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You and your spouse divorce or legally separate; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Special rules applicable to Health Care Spending Accounts

COBRA continuation coverage under a Health Care Spending Account will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health Care Spending Account COBRA coverage that will be charged for the remainder of the Plan Year. COBRA coverage will consist of the Health Care Spending Account coverage in force at the time of the qualifying event (i.e., the elected annual contribution reduced by reimbursable claims submitted up to the time of the qualifying event), and through the end of the current Plan Year (the extensions of COBRA continuation coverage described below generally do not apply to Health Care Spending Accounts).

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan

Administrator within 60 days after the qualifying event occurs. *You must provide this notice in writing to the Plan at the contact address under "**Plan contact information**" below.*

How is COBRA coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. *You must provide this notice in writing to the Plan at the contact address under "**Plan contact information**" below.*

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the

spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. *You must provide this notice in writing to the Plan at the contact address under "**Plan contact information**" below.*

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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

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

Please note, former employees who are Medicare-eligible at the time COBRA continuation coverage is elected have coverage under the Plan as their secondary coverage to Medicare.

The Plan presumes that you will enroll in Medicare Parts A and B once you separate employment. This means the Plan will not pay expenses for which Medicare would be primarily responsible under federal law, regardless of whether you have actually enrolled in Medicare. If you do not enroll in Medicare and are enrolled in COBRA continuation coverage, you will only have secondary coverage under the Plan for COBRA continuation coverage and will be left without any primary coverage.

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

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

Termination of continuation coverage

Other events will cause COBRA continuation coverage to end sooner. Coverage will end short of the maximum period on the earliest of the following:

- The Company no longer provides group health plan coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- You or your dependents become entitled to Medicare;
- With respect to the disability extension, the Social Security Administration no longer considers you or your dependent to be disabled; or
- You become covered under another group health plan (provided preexisting condition exclusions or limitations under the group healthcare plan do not apply).

How much does COBRA coverage cost?

Generally, qualified beneficiaries may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated participant or beneficiary who is not receiving continuation coverage. You will have 45 days from the date of electing continuation coverage to start paying for that coverage. The first payment must include the cost of coverage for the entire period from the date coverage was lost because of the qualifying event at least through the date of payment. Each other payment is due by the first day of the month for which continuation coverage is provided. A 30-day grace period will apply for making each month's payment.

A qualified beneficiary who is disabled may be required to pay up to 150% of the cost of his or her COBRA continuation coverage during the disability extension.

If you have questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator, whose contact information appears below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your plan informed of address changes

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

COBRA Administrator contact information

infinisource
PO Box 889

Coldwater, MI 49036
800-594-6957
https://secure.myisolvedbenefits.com/qbclient/login.aspx

Administrative Information

The Plan is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). This section provides important legal and administrative information you may need such as:

- how to contact the Plan Administrator;
- information about the Insurers that insure and administer the Benefit Programs of the Plan and how to contact them; and
- your rights under ERISA.

If you have any questions about any of the information contained in this SPD, contact the Plan Administrator.

Plan identification

This Plan is named the Rivian, LLC Welfare Benefit Plan. The Plan number is 501.

Plan Sponsor

The Plan is sponsored by Rivian, LLC ("Company"). The Company's address is:

Rivian, LLC
14600 Myford Rd.
Irvine, CA 92606
888-748-4261

The employer identification number (EIN) assigned to the Plan sponsor by the Internal Revenue Service is 84-4942307.

Plan Administrator

The Plan Administrator is the Rivian, LLC Employee Benefit Plan Committee, other entity or individual designated by the Board of Directors of the Company to supervise the administration of the Plan. The Plan Administrator is your primary source of information about the Plan. The Plan Administrator's business address and telephone number are:

Rivian, LLC Benefits Committee
13250 N. Haggerty Rd.
Plymouth, MI 48170
734-855-4350

The Plan Administrator (or its designee) has sole discretionary authority to interpret and construe the provisions of the Plan, to grant or deny benefits, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under this Plan will be paid only if the Plan Administrator (or its designee) decides in its sole discretion that the applicant is entitled to them. Decisions of the Plan Administrator (or its designee) shall be final and binding.

Plan year

The Plan year is January 1 to December 31.

Plan type, funding, and administration

The Plan is an ERISA welfare benefit plan. The Benefit Programs of the Plan may be fully-insured by the Insurers pursuant to group insurance contracts entered into between Company and the Insurers or self-funded by the Company. For fully-insured benefits, premiums are paid to the Insurers from Company's general assets. The Insurers are responsible for paying benefit claims incurred while the applicable group insurance contracts are in effect. For self-fund benefits, the Company is responsible for paying benefit claims for its general assets.

Insured benefit programs

The following Insurers insure and administer the applicable Benefit Programs under the Plan:

BENEFIT PROGRAM	CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE
MEDICAL	Kaiser Permanente 3100 Thornton Avenue 4th Floor #4120 Burbank, CA 91504 https://healthy.kaiserpermanente.org/ 800-464-4000	The Company pays part of the cost for coverage. You pay the rest through your pre-tax benefit contributions.
LONG TERM DISABILITY PROGRAM	Unum Group 1 Fountain Square Chattanooga, TN 37402 www.unum.com 866-679-3054	The Company pays for the cost of basic coverage.
LIFE INSURANCE PROGRAM	Securian Financial Group Inc. 400 Robert Street North St. Paul, MN 55101 www.securian.com 833-810-8260	The Company pays for the cost of basic coverage. You pay for dependent life insurance through your post-tax benefit contributions.
ACCIDENTAL DEATH AND DISMEMBERMENT PROGRAM	Securian Financial Group Inc. 400 Robert Street North St. Paul, MN 55101 www.securian.com 833-810-8260	The Company pays for the cost of basic coverage. You pay for dependent AD&D insurance through your post-tax benefit contributions
CRITICAL ILLNESS & GROUP ACCIDENT	Unum Group 1 Fountain Square Chattanooga, TN 37402 www.unum.com 866-679-3054	You pay for the cost of coverage with after-tax benefit contributions.

Third-party administrators

The following organizations administer the applicable Benefit Programs under the Plan:

BENEFIT PROGRAM	THIRD-PARTY ADMINISTRATOR/CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE
MEDICAL	Anthem P.O. Box 54149 Los Angeles, CA 90054 www.anthem.com 833-824-2275	The Company pays part of the cost for coverage. You pay the rest through your pre-tax benefit contributions.
DENTAL PROGRAM	Delta Dental of California PO Box 997330 Sacramento, CA 95899-7330 https://www1.deltadentalins.com/ 1-800-765-6003	The Company pays part of the cost for coverage. You pay the rest through your pre-tax benefit contributions.
VISION PROGRAM	EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 https://member.eyemedvisioncare.com/member/en 844-225-3107 Vision Service Plan (VSP) Attn: Claims Services PO Box 385018 Birmingham, AL 35238-5018. https://www.vsp.com/ 800-877-7195	The Company pays part of the cost for coverage. You pay the rest through your pre-tax benefit contributions.
EMPLOYEE ASSISTANCE PROGRAM	Anthem P.O. Box 54149 Los Angeles, CA 90054 www.anthem.com 833-824-2275	The Company pays for the cost of coverage.

BENEFIT PROGRAM	THIRD-PARTY ADMINISTRATOR/CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE
HEALTH SAVINGS ACCOUNT*	HealthEquity P.O. Box 14374 Lexington, KY 40512 www.healthequity.com 866-346-5800	You decide how much, if any, you want to contribute on a pre-tax basis to your HSA. The Company may also contribute to your HSA. Please note, the HSA is not a Company-sponsored benefit.
DEPENDENT CARE SPENDING ACCOUNT*	HealthEquity P.O. Box 14374 Lexington, KY 40512 www.healthequity.com 866-346-5800	You pay the coverage through your pre-tax benefit contributions.
HEALTH CARE SPENDING ACCOUNT	HealthEquity P.O. Box 14374 Lexington, KY 40512 www.healthequity.com 866-346-5800	You pay the coverage through your pre-tax benefit contributions.
HEALTH REIMBURSEMENT ACCOUNT	Anthem P.O. Box 54149 Los Angeles, CA 90054 www.anthem.com 833-824-2275	The Company pays for the cost of coverage.
SHORT TERM DISABILITY PROGRAM	Sedgwick Claims Management Services, Inc. 8125 Sedgwick Way Memphis, TN 381251 Fountain Square Chattanooga, TN 37402 www.sedgwickunum.com 866-679-3054	The Company pays for the cost of coverage.
SEVERANCE	Rivian, LLC Benefits Committee c/o Rivian, LLC 14600 Myford Road Irvine, California 92606	The Company pays for the cost of coverage.

Agent for service of legal process

The agent for service of legal process on the Plan is:

Rivian, LLC Benefits Committee
13250 N. Haggerty Rd.
Plymouth, MI 48170
734-855-4350

Amendment or termination of the Plan

The Company reserves the right to amend or terminate the Plan or any Benefit Program at any time. Any such amendment or termination may be made by proper action of the Board of Directors or their designee. Alternatively, in certain instances, the Plan Administrator may amend the Plan through the issuance of revised SPD Booklets, enrollment materials, brochures, or Certificates.

No employment rights

The Plan shall not confer employment rights upon any person. No person shall be entitled by virtue of the Plan to become or to remain in the employ of the Company and nothing in the Plan shall restrict the right of the Company to terminate the employment of any eligible employee or other person at any time.

Subrogation

General Principle

When you or your eligible dependent receives benefits under the Plan which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your eligible dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your eligible dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your eligible dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, even if you or your eligible dependent has not been paid or fully reimbursed for all damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your eligible dependent to assert a claim to any of the benefits to which you or your eligible dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from Company.

If the Plan should become aware that you or your eligible dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your eligible dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your eligible dependents.

Participant Duties and Actions

By participating in the Plan you and your eligible dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your eligible dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your eligible dependent has any reason to believe that you or your eligible dependent may be entitled to recovery from any third party, you or your eligible dependent must notify the Plan. At that time, you and your eligible dependent (and your or your eligible dependent's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your eligible dependent to any payment, amount or recovery from a third party.

If you or your eligible dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your eligible dependents until the agreement is signed. Alternatively, if you or your eligible dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your eligible dependent, your or your eligible dependent's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

You and your eligible dependent consent and agree that you or your eligible dependent shall not assign your or your eligible dependent's rights to settlement or recovery against a third person or party to any other party, including your eligible dependent's attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Company.

Coordination of medical benefits

The Plan has a coordination of benefits feature with respect to medical benefits. This prevents duplication of benefits if you or an eligible dependent is covered by more than one medical plan. When a claim is made, the "primary" plan pays benefits first, without regard to the other plan. When the Plan is secondary, the Plan calculates what it would have paid if it were primary and reduces benefits by what the other plan has paid.

The Plan will not supplement the other plan to bring reimbursement up to 100%, but will coordinate with the other plan to bring your reimbursement up to the Plan's benefit level. Generally, the plan covering a person as an employee is the "primary" plan while the plan covering the same person as a dependent is the "secondary" plan.

Coordination of benefits rules apply whenever you or your eligible dependent is covered by more than one insurance plan. Plans include any other type of coverage for persons in a group—whether the plan is fully-insured or self-funded. No-fault auto insurance that is required by law is also included, even if it is not provided on a group basis. The level of benefits required by law will be considered when benefits are coordinated.

Coordination with other Plans

The Plan describes the coordination of benefits rules in greater detail. Generally, primary and secondary plans are determined as follows:

- The plan covering a person as an employee is the primary plan, and the plan covering the same person as a dependent is the secondary plan.

- For dependent children, the plan of the parent whose birthday occurs earlier in the calendar year is primary (regardless of the year of birth). If both parents have the same birthday, the plan that has covered a parent for the longer period is primary. If the other plan follows a gender rule (i.e., male's plan pays first) instead of the birthday rule to determine order of benefits, the other plan's provision will apply.

  In the case of separated or divorced parents, primary and secondary plans are determined as follows:

  - If a court decree awards joint custody but does not specify which parent is responsible for healthcare expenses, the rules above apply.
  - If a court decree has given financial responsibility for medical care for eligible dependent children to one parent, the plan of this parent is primary.
  - If there is not a court decree establishing financial responsibility for medical care for eligible dependent children,
    - the plan that covers the parent with custody pays first;
    - if the parent with custody has remarried, the plan of the custodial parent pays first, then the plan of the stepparent and last, the plan of the parent without custody.

- In the case of a stepchild or the child of a domestic partner the plan of the parent will be primary.

If none of these rules apply, the plan that has covered the individual for the longest period of time is primary.

Coordination with Medicare

The Plan will pay secondary to Medicare if and to the extent permitted by law, including as summarized below. You may also find more information in the **Medicare & You** handbook, available at: https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf.

Active employees

If you are a participant who is an active employee and you or an enrolled spouse or other dependent becomes eligible for Medicare due to age or disability, the Plan, because coverage is based on your "current employment status" under Medicare rules, generally will be the primary source of coverage (with Medicare secondary), unless you elect otherwise by dropping Plan coverage for yourself and/or such individual(s). If you choose to be covered under both plans (this Plan and Medicare), your Plan coverage generally will be primary and Medicare secondary, unless you or an enrolled dependent has Medicare coverage because of end-stage renal disease (ESRD) and the individual has been enrolled in Medicare for more than 30 months (the point at which Medicare becomes primary for that individual, regardless of your current employment status).

Employees on long term disability and former employees

If you are receiving long term disability benefits from the Company or if your employment is terminated for any reason, the government no longer considers you to be in current employment status, and, so, if you become Medicare-eligible, Medicare generally becomes primary (and the Plan secondary) for you and any of your Medicare-eligible dependents still enrolled in the Plan (e.g., pursuant to COBRA, subject to COBRA rules). In these cases, you and your enrolled dependent(s) who are Medicare-eligible should consider enrolling in Medicare because the Medical Program may assume enrollment in Medicare (both Parts A and B) and pay claims as though you had coverage under both parts of Medicare. In this case, if you or your dependent(s) are eligible for, but not enrolled, in Medicare (both Parts A and B), your out-of-pocket costs could be substantial.

Please refer to your Medical Program's Certificate or SPD Booklet for more information

No assignment of rights or benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void, unless otherwise agreed to, in the sole discretion of the Plan Administrator. The assignment of rights or benefits, as well as the assignment of the right to file a lawsuit, are prohibited, except that a participant may assign covered benefits to an appropriate medical service provider solely for the purpose of allowing the provider to submit a claim and allowing the Plan to pay covered benefits directly to the provider. The payment of benefits directly to a provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan. No compensation reduction elections or other contributions under this Plan shall cause the Company to be liable for, or subject to, any manner of debt or liability of any participant. Notwithstanding the foregoing, wage garnishments under applicable state law shall be permitted to reach cash benefits reflecting deductions from the garnishee's cash account under this Plan, unless otherwise prohibited by law.

Recovery of excess payments
You will be required to return to the Company any benefits, or portion thereof, paid under the Plan by a mistake of fact or law. The Plan reserves the right to offset any such amount(s) against other present or future benefits payable under the Plan, to the full extent permitted by law.

Representations contrary to the Plan
No employee, director or officer of the Company has the authority to alter, vary or modify the terms of the Plan except by means of a duly authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan are binding upon the Plan, the Plan Administrator or the Company.

Rebates and subsidies
If any rebates or subsidies are generated by the operation of the Plan, the amount of any such rebate or subsidy will be the property of the Company to use as it shall determine, and for any purpose.

Responsibility for tax implication of benefits
You will be responsible for the tax implications of any determination of imputed income with respect to any benefits you elect for eligible dependents who are not entitled to tax-free benefits under current federal law.

Applicable law
The Plan will be governed and construed in accordance with the laws of the State of California to the extent not preempted by the laws of the United States.

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 or by electronic mail (email)
You expressly consent to receive emails, phone calls, faxes, text messages, and ringless voicemails made by or on behalf of the Company or its vendors, affiliates, agents or partners regarding any benefit programs offered by the Company. For electronic mail, this includes the use of any personal email address you have provided to the Company or its affiliates. For telephonic outreach, this includes the use of 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 the Company or its affiliates, regardless of whether it is on a state or national Do-Not-Call registry. You also consent to receive emails, phone calls, faxes, text messages, and ringless voicemails from the Company for any communications sent for commercial, sales, telemarketing or advertising purposes. You understand that your email provider, or cellular, landline or facsimile

line carrier may charge you for such emails, calls, faxes, text messages or ringless voicemails and you agree to accept full responsibility for any such charges.

Your ERISA Rights

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

Receive information about your plan and benefits

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and the most recent annual report (Form 5500 series) (if applicable) and an updated summary plan description. The Plan Administrator may make a reasonable charge for these copies.

- Receive a written summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue group health plan coverage

- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent actions by Plan fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, and 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.

Enforcing your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of the 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 your ERISA rights. For instance:

- If you request a copy of plan documents or the latest annual report (if applicable) 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 (indexed for inflation) a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits which is denied or ignored—in whole or in part after going through the appeals procedure—you may file suit in a state or federal court.

- If you disagree with the Plan's decision (or lack thereof) concerning the qualified status of a medical child support order, you may file suit in federal court.

- If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.