Thomson Reuters Retiree Medical Plan

Summary Plan Description

Thomson Reuters

January 2024

KEY CONTACT INFORMATION

If you have specific questions regarding benefits eligibility or your rights and obligations with respect to plan benefits, information is available online or by contacting the Thomson Reuters HR Services Center (HRSC):

Your Benefit Resources (YBR) – this site is also accessible through Workday via the "Benefits Quicklinks" app

http://digital.alight.com/thomsonreuters – for prior Thomson Reuters employees and dependents

Important Phone Numbers:

HRSC Toll Free Number:	1-866-443-MyHR (6947)
International Number:	1-718-354-1369

Representatives (excludes weekends & holidays): 7:30am to 5:30pm CT

This summary plan description (SPD) describes the benefits provided to you under the Thomson Reuters Retiree Medical Plan ("the Plan"). The SPD together with the benefit booklet(s) and insurance contract, constitute the official plan document. The SPD is not, nor is it intended to be, a contract between Thomson Reuters and any employee, former employee or contractor, or a guarantee of employment. Every effort has been made to ensure the accuracy of this information. In the unlikely event that there is a discrepancy between the SPD and the benefit booklet or insurance contract, as applicable, the benefit booklet or insurance contract will control. As you review this SPD, be advised that it is only a summary. It is impossible for this SPD to cover every detail or circumstance that may apply to you. If you have specific questions regarding benefits eligibility or your rights and obligations with respect to plan benefits, please contact the Thomson Reuters HR Services Center.

Thomson Reuters, as plan administrator, reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time.

There may be situations where the plan(s) provides different benefits to different employee groups. Only those benefits applicable to you based on your employee group apply.

This SPD may be available to you through **Your Benefits Resources**. You may have access and the ability to view and print pages of this SPD from this site. You also have the right to request and receive, free of charge, a printed copy of the electronically delivered documents, including all of the documents referenced in this document from the Thomson Reuters HR Services Center. If there are any discrepancies between the information on the Your Benefits Resources Website and your printed copy, the Website version will normally control.

Provisions described in this SPD are effective as of January 1, 2024, and it supersedes all prior summaries. To understand benefits available for claims arising before this date, you should consult prior documents.

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Retiree Medical Plan Overview

Thomson Reuters Retiree Medical Plan (the “Plan”) is designed to protect you financially in case of illness or injury.

Enrolling for Coverage

You must enroll in the Retiree Medical Plan within 31 days of retiring or losing your Active Medical Plan coverage through severance (if applicable), by calling the Thomson Reuters HR Services Center.

If you are eligible for the Thomson Reuters Group Pension Plan, you must start your pension benefits within 31 days of retiring, or no later than the end of your Active Medical plan coverage through severance (if applicable), to be eligible to enroll in the retiree medical plan.

Coverage Options

The Plan has two benefit coverage options, the “Pre 65 Retiree Medical Plan” and the “Post 65 Retiree Medical Plan.”

The Pre 65 Retiree Medical Plan provides retiree medical coverage for covered members ineligible for Medicare. The Pre 65 Retiree Medical Plan is self-insured, which means benefit claims are paid by Thomson Reuters out of its general assets. The cost of coverage under Pre 65 Retiree Medical Plan is paid in part by Thomson Reuters, out of its general assets, and in part by covered members. For additional information about the Pre 65 Retiree Medical Plan please review the benefit booklet.

The Post 65 Retiree Medical Plan provides retiree medical coverage for covered members eligible for Medicare. The Post 65 Retiree Medical Plan is fully insured, which means benefit claims are paid by the insurance company. The pharmacy component of the Post 65 plan is self-insured. The insurance premiums for coverage under the Post 65 Retiree Medical Plan are paid in part by Thomson Reuters, out of its general assets, and in part by covered members. For additional information about the Post 65 Retiree Medical Plan please review the insurance contract.

If You Have Other Coverage Available

You may be eligible for coverage under more than one medical plan – for example, your spouse may cover you under their employer’s plan. Normally, if you are eligible to enroll in the Retiree Medical Plan, but you choose to waive coverage, you lose eligibility for coverage and **cannot** enroll in the future.

However, if you waive coverage because you will remain covered under a Thomson Reuters medical plan as your spouse/domestic partner’s dependent or through

COBRA, you can enroll yourself and your covered spouse/domestic partner in the plan when such other medical coverage ends.

In addition, if you receive severance payments upon termination of employment from Thomson Reuters, your pension may start, but since the active Thomson Reuters medical plan is still offered you can waive your retiree medical coverage until your severance period is exhausted.

You **must** start retiree medical coverage on the 1st day of the month following the loss of coverage under the Thomson Reuters active medical plan, as an employee, covered dependent, through severance, or through COBRA. There **cannot** be a gap in between your Thomson Reuters active medical coverage and retiree medical coverage.

Having coverage under more than one medical plan doesn't necessarily mean you get more benefits. Most plans coordinate benefits. For example, your total benefit is limited to what you would receive under the plan with the highest coverage level.

Be sure to review all of your benefit plan options carefully before making enrollment choices.

Paying for Coverage

You and Thomson Reuters share the cost of your retiree medical coverage. Your share of the cost (that is, your premium) is indicated on your annual Confirmation of Coverage notice.

For Pre 65 coverage, because the medical and prescription drug components of the plan are self-insured (in other words, benefits are payable from Thomson Reuters general assets), the premium represents a percentage of Thomson Reuters projection of the actual cost of coverage.

For Post 65 coverage, because the medical component plan is fully insured (in other words benefits are paid by the insurance company), the medical premium is set by the insurance company. The prescription drug component of the plan is self-insured, so the prescription drug premium represents a percentage of Thomson Reuters projection of the actual cost of coverage.

If you didn't receive a Confirmation of Coverage notice upon satisfying the eligibility requirements applicable to you (refer to Who is Eligible for Retiree Coverage), contact the Thomson Reuters HR Services Center.

You pay your monthly premiums through one of the following methods:

- **Pension Deduction.** If you participate in a Thomson Reuters pension plan, payment may be made by monthly after-tax deductions from your pension check. If your pension check isn't large enough to cover the entire premium amount, you'll be

billed for the entire amount and no deductions will be taken from your pension check.

- **ACH Payment.** You can have the amount you owe debited automatically on the 1st of each month from your checking, savings, or investment account.
- **Payment by Check.** You will receive a bill around the 15th of each month for your coverage for the next month. Payment is due on the 1st of each month. A 30-day grace period applies. For example, you'll receive a bill for your June coverage around May 15. Payment is due June 1 but is accepted if postmarked by June 30.

Coverage Eligibility

Who is Eligible for Retiree Coverage

You're eligible for retiree medical coverage if you (i) meet the age and service requirements designated by your employer at the time you apply for coverage, (ii) you begin your pension benefit within 31 days from the date you retire or your severance ends (if you participate in a Thomson Reuters sponsored pension plan), and (iii) you are covered under a Thomson Reuters medical plan at the time you apply for coverage. The following are eligibility provisions that apply under the plan.

Important! To be eligible for Thomson Reuters Post 65 retiree medical plan coverage, if applicable based on the criteria outlined below, **you must**:

- Be actively enrolled in Medicare Part A and Part B
- Not be covered under any other medical plan, with the exception of Medicare and Thomson Reuters Prescription Drug coverage

Retiree medical coverage is only available if you are age 55 or older when you commence your coverage.

West Publishing Retire Eligibility Criteria

- At work on 03-31-1997
- 20 or more years of service
- Less than 65 years old at retirement
- At least age 55 at retirement

Coverage will terminate at age 65.

Thomson Healthcare - Retiree Eligibility Criteria

- At work on 12-31-1992
- 10 or more years of **full-time** service on 12-31-1992
- At least age 45 years old on 12-31-1992

OR

- At work on 12-31-1992
- 10 or more years of **full-time** service after age 45

CBC - Retiree Eligibility Criteria

- At work on 05-31-1991
- At least age 60 years old at retirement
- 10 or more years of service at retirement

Coverage will terminate at age 65.

RIA, West Webster, West LCP, or West Bancroft Whitney- Retiree Medical Eligibility Criteria

- At work on 05-31-1993
- 10 or more years of service on 05-31-1993

OR

- At work on 05-31-1993
- 10 or more years of service after attaining age 45

TL South Western, TL Wadsworth, or TLPS- Retiree Eligibility Criteria

- At work on 12-31-1992
- 10 or more years of service on 12-31-1992
- At least age 45 on 12-31-1992

OR

- At work on 12-31-1992
- 10 or more years of service after attaining age 45

TL College, DBM, or BarBri - Retiree Eligibility Criteria
Special HBJ Grandfathered Group Only

- At work on 12-31-1991
- 10 or more years of service on 01-01-1992 **OR** are at least age 55 on 01-01-1992
- At least age 65 at retirement

TL College, DBM, BarBri - Group 1

- At work on 12-31-1991
- At least age 55 on 01-01-1992 OR 10 or more years of service on 01-01-1992
- At least age 55 at retirement

TL College, DBM, BarBri - Group 2

- At work on 12-31-1991
- Less than 10 years of service on 01-01-1992
- Less than 55 years old on 01-01-1992
- At least age 55 at retirement
- 10 or more years of service at retirement

Effective July 1, 2005, if you are eligible to participate in the plan but you transfer to an employer that does not participate in the plan, your eligibility to participate in the plan transfers with you – subject to the plan provisions that applied to you prior to your transfer.

Reuters Guild and Non-Guild Retiree Group

- Group 1: Retiree pays 25% of full premium.

- Age 55 as of 12/31/2002 + years of service = 80 points

- Group 2: Retiree pays 50% of full premium.
  - Age 60 as of 2/28/2009 + years of service = 80 points and employee retires from the Company by 2/28/2009.

- Group 3: Retiree pays 100% of full premium.
  - Age 60 + years of service = 80 points and employee retires from the Company by 12/31/2010

To qualify for any of these groups, an employee must have been a full time or part time U.S. home-based employee of Reuters America LLC scheduled to work at least 17.5 hours per week at Reuters or one of its subsidiaries at the time that the various grandfathering groups were established.

Eligibility Rules for Rehired Retirees

If you leave Thomson Reuters and return to work more than one year from the time of termination, you will forfeit your retiree medical benefit eligibility. If you are eligible for West Publishing retirement benefits, this restriction is not applicable.

Eligibility Rules for Survivors of Retirees

Normally, when you die, your surviving dependent will remain enrolled in the plan if **both** of these apply:

- You're enrolled in the plan on the date of your death.

- Your surviving eligible dependent is enrolled in the plan on the date of your death.

If you are a West Publishing, CBC, Thomson Newspaper, Thomson Scientific and Healthcare, or Reuters Guild or Non-Guild retiree, special rules may apply. Refer to *Survivor Eligibility* for additional information.

Coverage You Need to Elect

Retiree Coverage

As a retiree who meets the eligibility requirements (refer to *Who is Eligible for Retiree Coverage*), you're eligible to enroll in the Retiree Medical Plan.

If you don't timely enroll when you first retire (refer to *Enrollment*), you won't have

coverage and you won't be eligible to enroll for coverage in the future, unless:

- You have waived coverage because you will remain covered under a Thomson Reuters medical plan as your spouse/domestic partner's dependent.

- You're covered under a Thomson Reuters medical plan through COBRA or due to being on severance.

In these cases, you can waive your retiree coverage and enroll yourself and your spouse/domestic partner when such other medical coverage ends.

When Coverage Begins

At Retirement

If you timely enroll in the plan, your coverage takes effect retroactive to the first of the month after your last day of coverage under the Thomson Reuters active medical plan.

Remember, if you participate in a Thomson Reuters sponsored pension plan, you must start your pension plan benefits within 31 days of retiring to be eligible to enroll in the retiree medical plan.

Special Rule for 2014. If you terminated employment with Thomson Reuters between July 1, 2014 and December 31, 2014, you do not have to start your benefit under the Thomson Reuters Group Pension Plan to be eligible to enroll in the retiree medical plan if you elected to commence your pension benefits by April 1, 2015.

When Becoming Eligible for Medicare After Retirement

As a reminder, to be eligible for Thomson Reuters Post 65 retiree medical plan coverage**,** you must:

- Be actively enrolled in Medicare Part A and Part B
- Not be covered under any other medical plan, with the exception of Medicare and Thomson Reuters Prescription Drug coverage

For retirees eligible to continue coverage under the Plan upon turning age 65, you will be notified roughly 120 days prior to your 65th birthday to begin the process to obtain the HICN (Health Insurance Claim Number) that will be required to continue coverage upon turning 65. About 90 days before your 65th birthday, you'll receive a reminder notice to obtain your HICN and provide the number to Thomson Reuters HR Services Center within 30 days. Once you provide the HICN, you will automatically be enrolled in the Post 65 Retiree medical plan.

Note: If you do not provide your HICN 45 days before turning 65, there is a chance you may have to pay 100% for your Rx coverage and it may not be reimbursable.

Important, if you are a West Publishing or CBC retiree, the following rules apply:

- Your coverage and/or eligibility for coverage under the Plan ends when you become eligible for Medicare. However, if you are covering an eligible dependent under the Plan who has not yet become eligible for Medicare at the time you become eligible, their coverage can continue until they become eligible for Medicare.
- Your eligible dependent's coverage under the Plan ends when they become eligible for Medicare. However, if you are not yet eligible for Medicare at that time, your coverage will continue until you become eligible for Medicare.

"Split Family" Coverage

There may be situations where you and your dependent are enrolled in different medical coverage based on eligibility for Medicare.

As applicable, if you or your dependent is eligible for Medicare you can choose secondary coverage for that person under the Post 65 Retiree Medical Plan in addition to Medicare coverage. The other person will remain covered by the Pre 65 Retiree Medical Plan. In this case, you will automatically be enrolled in two Retiree Medical options – Pre 65 Retiree Medical Plan coverage for the covered member ineligible for Medicare and Post 65 Retiree Medical Plan coverage for the covered member eligible for Medicare. Each plan includes similar benefits, but the pricing may differ.

Dependents You Can Cover

If You're a Retiree

As an eligible retiree, you can enroll your eligible dependent for coverage in the plan only if they were covered under a Thomson Reuters medical plan at the time of your retirement.

You can enroll your eligible dependent at the time of your retirement or when your dependent's coverage under a Thomson Reuters medical plan ends.

Yrighr:

- Spouse
- Domestic Partner

However, if you are a **West Publishing** retiree, the following provisions may apply to you:

- Your spouse/domestic partner is not eligible for coverage under the Plan if you were never covered under the Plan. If you retire after attaining Medicare eligibility, neither you nor your dependent will not be eligible for retiree medical coverage.

- Your spouse/domestic partner is not eligible for coverage under the Plan if they are eligible for Medicare.
- If you retired before January 1, 2007, your children or your domestic partner's children may be eligible for coverage under the plan. If you retire on or after January 1, 2007, your children or your domestic partner's children are not eligible to participate in this plan.
- If you retired before January 1, 2007, you could have added (prior to January 1, 2007) your newborn child or newly adopted child back to the date of the birth or adoption, provided that Thomson Reuters HR Services Center was notified within 60 days of the event. Failure to timely notify Thomson Reuters HR Services Center could result in a loss of coverage for your dependent.
- If you retired before January 1, 2007, you could have added (prior to January 1, 2007) your newly eligible spouse/domestic partner to coverage back to the date of the event, provided that Thomson Reuters HR Services Center was notified within 60 days of the event. Failure to timely notify Thomson Reuters HR Services Center could result in a loss of coverage for your dependent.

The Child Eligibility Rules and Qualified Medical Child Support Order provisions of the SPD apply only if your children are eligible for coverage as outlined above.

Spouse Eligibility Rules

Definition of Spouse

If you're eligible for coverage, you can normally enroll your spouse for coverage under the plan if your spouse was enrolled in a Thomson Reuters medical plan at the time you retire. Refer to *Dependents You Can Cover* for additional information. If your spouse is also an eligible Thomson Reuters employee, special rules apply.

Your spouse is the person to whom you're legally married to under the laws of the state or country in which you were married.

A legal spouse includes a common-law spouse in states that recognize common-law marriages.

Common-Law Spouse

Only certain states currently recognize common-law marriages. Each state has different requirements for common-law marriages. You are responsible for checking with your state to find out if your relationship meets the requirements.

Some of the more common requirements are:

- Living together for a specified period

- Having joint bank accounts
- Filing joint tax returns
- Introducing each other in public as your "husband" or "wife"

If you live in a state that doesn't recognize common-law marriages, you can still enroll your common-law spouse if you previously lived in a state that recognizes such marriages, and you met that state's requirements while living there.

By adding a common-law spouse as a dependent, you certify that your relationship meets your state's requirements for common-law marriages.

Keep in mind that once you've entered into a valid common-law marriage, it can be ended only by death or formal, legal divorce.

Domestic Partner Eligibility Rules

Definition of Eligible Domestic Partner

If you're eligible for plan coverage, you may normally enroll your partner in the plan if your partner is enrolled under a Thomson Reuters medical plan at the time of your retirement. Refer to Dependents You Can Cover for additional information.

Your partner qualifies as your "domestic partner" if either:

- Your domestic partnership has been registered with a governmental entity pursuant to state or local law authorizing such registration; or
- You and your partner satisfy the following criteria:
    - Are at least 18 years old.
    - Are not legally married to anyone else and are not the legal domestic partner of anyone else, nor have been for the preceding 6 months.
    - Intend to remain each other's sole domestic partner indefinitely.
    - Reside together in the same principal residence for at least 6 months, are responsible to each other for the direction and management of your household and intend to reside together indefinitely.
    - Are emotionally committed to each other and share joint responsibilities for your common welfare and financial obligations.
    - Are not related by blood closer than would prohibit marriage in the state you live in.
    - Are mentally competent to enter into contracts.

- You have not been married to each other and divorced at any time within the past 12 months.

If your domestic partner is also an eligible Thomson Reuters employee or retiree, special rules apply.

Enrolling Your Dependent for Coverage

You should enroll your spouse or domestic partner for coverage within 31 days of the date they become eligible for coverage by calling the Thomson Reuters HR Services Center. Failure to timely enroll your eligible dependent could result in a loss of coverage for such dependent.

Child Eligibility Rules

Children are not eligible for coverage under the Plan.

If you were covering a child under the Thomson Reuters Pre 65 or Post 65 Retiree Medical Plan **before April 1, 2005**, the coverage for that child continues until they no longer satisfy the eligibility provisions. If you are a West Publishing retiree, special rules may apply – refer to the *Dependents You Can Cover* section for additional information.

An eligible disabled child can be covered for as long as you are eligible for coverage.

Retirees Within the Same Family

Health Plan Coverage

If your dependent is an employee and/or retiree who is eligible for coverage, special rules apply.

You have two options for covering yourself and your dependent:

- You may both enroll for active employee or retiree coverage.
- One of you may enroll for employee or retiree coverage and cover the other as a dependent.

Individuals can't be covered both as an employee and a dependent.

Enrollment

Initial Enrollment for Retiree Coverage

You can enroll in coverage up to 45 days before you retire or within 31 days after you retire. You must call the Thomson Reuters HR Services Center to enroll. Normally, if you don't timely enroll when you first become eligible, you won't have coverage and you won't be eligible to enroll in the plan in the future. However, if you have waived coverage because you will remain covered under a Thomson Reuters medical plan as your spouse/domestic partner's dependent, through COBRA, or as part of a severance agreement, you can enroll yourself and your spouse/domestic partner in the plan when such other medical coverage ends.

When you enroll, and as applicable, you need to determine whether to cover your eligible dependent. You will then be assigned a coverage category.

Normally, plan coverage stays in effect until you and/or your dependent cease to satisfy the eligibility requirements applicable to you or you choose to drop coverage. Refer to *When Eligibility Ends* and *Changing Your Coverage* for additional information.

Remember, you and your eligible dependent must be enrolled in a Thomson Reuters medical plan at retirement and must commence your pension benefits within 31 days of your retirement (if applicable) to be eligible for coverage under the Plan (see an exception under the Special Rule for 2014 described in *When Coverage Begins)*.

Coverage Categories

For Retirees

When you enroll in retiree medical coverage, you need to provide information about the dependents you want to cover. They can include your spouse/domestic partner and, in limited circumstances (*see Child Eligibility Rules*), your eligible children.

Normally, if either you or your eligible dependent is eligible for Medicare, but the other is not yet eligible for Medicare, special "split family" rules may apply. In these scenarios, you must elect two medical plans – one for the person eligible for Medicare (Post 65 Retiree Medical Plan), and one for the person who isn't (Pre 65 Retiree Medical Plan). Refer to *When Becoming Eligible for Medicare After Retirement* for additional information.

Assigned Default Coverage

At Initial Retirement

If you're newly eligible for retiree coverage but don't enroll by the deadline, outlined above, you're assigned "no coverage" under the plan and you normally lose your right to enroll for coverage in the future. However, if you're a West Publishing retiree special rules may apply. Refer to *Enrollment* for additional information.

Changing Your Coverage

Rules for Changing Retiree Coverage

You can drop retiree medical coverage for yourself and/or your dependents by calling Thomson Reuters HR Services Center. Normally, your election to drop coverage becomes effective prospectively (that is, as soon as practicable after you call Thomson Reuters HR Services Center). In limited circumstances, (for example, death of a covered dependent), you may be able to drop coverage retroactively; however, retroactive changes cannot exceed 60 days.

If you drop coverage, you and/or your dependents lose eligibility and **cannot** enroll again at a later date.

Remember, you can only enroll your eligible dependent in the plan if coverage under a Thomson Reuters medical plan was in place for them at the time of your retirement. Therefore, if you marry or enter into a domestic partnership after your retirement, your spouse/domestic partner won't be eligible for coverage. However, if you are a West Publishing retiree, special rules may apply. Refer to *Dependents you Can Cover* for additional rules that apply.

When Eligibility Ends

Your Eligibility

Your eligibility for coverage may end when:

- You no longer meet the eligibility requirements.
- You belong to a group that becomes ineligible.
- You die.
- The plans are discontinued or amended.
- You become eligible for Medicare, if you're a West Publishing or CBC retiree.
- You engage in fraud or make an intentional misrepresentation to the Plan.

- You enroll in another Part D Prescription Drug Plan or medical plan, if age 65 or over. Coverage will be terminated for you and your dependent, if applicable.

Your Spouse's/Domestic Partner's Eligibility

If applicable, your spouse's/domestic partner's eligibility for coverage may end when:

- Your eligibility ends.*
- You and your spouse divorce or become legally separated.
- You end a domestic partnership.
- Your spouse/domestic partner dies.
- You drop coverage for your spouse/domestic partner.
- You engage in fraud or make an intentional misrepresentation to the Plan.
- Your spouse/partner enrolls in another Part D Prescription Drug Plan or medical plan, if age 65 or over. Coverage will not be terminated for the former retiree of Thomson Reuters.

***Note:** Your spouse's/domestic partner's eligibility for coverage may end when Medicare eligibility is attained, applicable to the spouse/domestic partner of a West Publishing or CBC retiree.

Your Child's Eligibility

If applicable, your child's eligibility for coverage may end when:

- Your eligibility ends.
- Your child enters the military.
- Your child loses disabled dependent status.
- Your child dies.
- You choose to drop coverage for your child.

Your Survivors' Eligibility

Your enrolled surviving dependent’s eligibility normally ends at time of death. However:

- If you are a West Publishing or CBC retiree, coverage may end when your survivor becomes eligible for Medicare.
- If you are a Thomson Newspaper retiree, your survivor's coverage ends one year

after the date of your death.

- If you are a Thomson Scientific and Healthcare retiree, your survivor will receive retiree medical coverage for the remainder of their lifetime.
- If you are a Reuters Non-Guild or Guild retiree, your spouse is offered coverage for life.
- Your survivor enrolls in another Part D Prescription Drug Plan or medical plan, if age 65 or over.

When Coverage Ends

Timing for Retiree Coverage

Retiree medical coverage ends on the **last day of the month** in which you or your dependent lose eligibility for coverage or fail to make a premium payment. If your coverage ends for failure to pay premiums, it will end retroactive to the date coverage was paid through.

Timing for Survivor Coverage

Your survivor's medical coverage ends on the **last day of the month** in which they lose eligibility for coverage or fail to make a premium payment. If coverage ends for failure to pay premiums it will end retroactive to the date coverage was paid through.

Coverage Your Survivors Can Continue

Your survivor's eligibility normally ends after they die, subject to your survivor's continued payment of premiums; however:

- If you are a West Publishing or CBC retiree, coverage ends when your survivor becomes eligible for Medicare. Your survivor may then be able to continue coverage under COBRA.
- If you are a Thomson Newspaper retiree, your survivor's coverage ends one year after the date of your death. Your survivor may then be able to continue coverage under COBRA.
- If you are a Thomson Scientific and Health retiree, your survivor will receive retiree medical coverage for the remainder of their lifetime.
- If you are a Reuters Non-Guild or Guild retiree, your spouse is offered coverage for life.

Information You or Your Dependent May Receive

When coverage ends, you and/or your dependent may receive:

- Certificate of Group Health Coverage, to show how long you and/or your dependent were covered under the medical plan.
- As applicable, a COBRA Enrollment Notice with information about continuing your health care coverage.

COBRA

Continuing Coverage as a Retiree

A federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that you and your dependents be able to continue health care coverage under specified circumstances. Special rules apply when you or your dependents lose coverage under a Thomson Reuters health plan due to a COBRA qualifying event. Additional continuation coverage may be available under state law; to the extent such requirements are not preempted by ERISA.

When you retire, you may (i) elect to continue participation in the Medical Plan applicable to **active employees** through COBRA, and/or (ii) upon satisfying the eligibility requirements applicable to you, enroll in the retiree medical plan. You may also be eligible to enroll in the dental and/or vision Plans applicable to **active employees** if you were enrolled in those plans prior to retirement.

Notification of a Qualifying Event

The COBRA administrator will be notified within 30 days of when a qualifying event occurs for one of the following reasons:

- You retire.
- You die.
- You become entitled to Medicare, which you are obligated to advise.
- Employer's bankruptcy.

You or your covered dependents must call Thomson Reuters HR Services Center within 60 days of the date a qualifying event occurs for one of the following reasons:

- You get divorced, become legally separated, or your domestic partnership terminates.
- Your child is no longer eligible for coverage.
- You die while covered under COBRA.

Note: You must give notification of a second qualifying event by phone. Thomson Reuters HR Services Center **cannot** accept written notification.

COBRA Enrollment Notice

When you or your covered dependents lose coverage due to a COBRA qualifying event, a COBRA Enrollment Notice is sent to your permanent mailing address within 14 days after the COBRA administrator is notified of the qualifying event.

The notice includes information on available coverage and cost. It also includes instructions on how to elect COBRA coverage.

Electing COBRA Coverage

Each qualified beneficiary has the right to choose coverage independently.

You or your covered dependent(s) must call Thomson Reuters HR Services Center to make your COBRA elections within 60 days of the date you lose coverage on account of the qualifying event or the date the COBRA Enrollment Notice is sent, whichever is later.

If the Thomson Reuters HR Services Center determines that you or your eligible dependent is not eligible for COBRA continuation coverage, it will notify you as to the reason why within 14 days of receiving notice of the qualifying event.

COBRA coverage will take effect when your first monthly premium payment is received. COBRA coverage is retroactive to the date your active coverage ends.

Generally, if you or your covered dependents don't elect COBRA coverage within the 60-day election period, you lose the opportunity to continue coverage under COBRA.

Paying for COBRA Coverage

If you or your covered dependents elect COBRA coverage, you or they are required to pay monthly premiums for that coverage.

Typically, Thomson Reuters HR Services Center must receive the first premium payment within 45 days of the date COBRA coverage is elected. Otherwise, your coverage won't take effect, and any health plan claims that you've submitted will be denied.

Your first monthly premium payment is likely to be higher than subsequent payments because it's for more than one month of coverage, retroactive to the date you lost coverage.

After that, payments are due on the 1st of each month. A 30-day grace period applies. For example, the June payment is due June 1 but will be accepted if it's postmarked by June 30.

You or your dependents are responsible for paying the full cost of the elected coverage (the total of what you and Thomson Reuters were paying for your coverage), plus a 2% administration fee, as allowed by law.

Note: If you're covered under USERRA continuation coverage, you continue to pay 102% of the COBRA premium for the duration of that coverage. Your cost doesn't increase after 18 months.

Costs vary, depending on the coverage elected and the number of dependents covered. When you or your dependents become eligible for COBRA, you'll be notified about the monthly premium amount. The cost for coverage may change at the beginning of a new plan year.

Changing Your COBRA Coverage

As COBRA coverage participants, you and other qualified beneficiaries have the same rights and restrictions as other plan participants to change your coverage during the year and at annual enrollment. You may need to demonstrate a qualified change in status to change your coverage during the year.

When COBRA Coverage Ends

Your COBRA coverage continues through the end of the 18-, 29-, or 36-month period you're entitled to, based on the qualifying event.

Note: If you're also eligible for continuation coverage under USERRA and your qualifying event was active military leave, your coverage continues for a minimum of the length of your active service or 24 months, whichever is less.

However, the plan can end your COBRA coverage earlier if:

- You or your covered dependents fail to make the first premium payment within 45 days of its due date.
- You or your covered dependents fail to make one of the ongoing premium payments within 30 days of its due date.
- The person receiving COBRA benefits becomes covered under another group plan (not maintained by Thomson Reuters) that has no preexisting condition exclusion or limitation affecting him/her.
- The person receiving COBRA benefits becomes entitled to Medicare.
- You or your covered dependents engage in fraud or make an intentional misrepresentation to the Plan.

- Thomson Reuters ends the plan.

Note: If you are entitled to Medicare or other group coverage **before** you elect COBRA, you are still eligible for COBRA. If you elect COBRA and subsequently become entitled to Medicare, COBRA can be terminated unless there is an applicable preexisting condition clause.

You may choose to end COBRA at any time.

COBRA coverage will **not** continue for more than 36 months, even if multiple qualifying events occur.

If your coverage is terminated early, you will be notified, as soon as administratively possible, of the reason for the early termination, the date of the termination, and your right, if any, to elect alternative coverage.

Note: If you're eligible for trade-adjustment assistance (TAA), you may be eligible for a tax credit or an advance payment for your COBRA premiums. You may also qualify for a second opportunity to elect COBRA coverage if you didn't elect coverage during the regular election period. However, you must elect coverage within 60 days of the first day of the month in which it's determined that you qualify as a TAA recipient. In addition, you must elect coverage within 6 months after you lost the coverage qualifying you as a TAA recipient. Call the Health Coverage Tax Credit Customer Contact Center at 1-866-628-4282 for more information.

Note: If you're receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC), you may be eligible for a tax credit or advance payment for your COBRA premiums. Call the Health Coverage Tax Credit Customer Contact Center at 1-866-628-4282 for more information.

Annual Enrollment for COBRA Participants

If, upon retirement, you (i) elect to continue participation in the medical, dental, and/or vision plans applicable to active employees under COBRA, or (ii) enroll in the Retiree medical plan and also elect to continue dental and/or vision coverage under the plans applicable to active employees through COBRA (refer to COBRA for additional information), annual enrollment applies to the COBRA offered plans.

Qualified beneficiaries participate in annual enrollment the same way as active employees. Annual enrollment is held each year in the fall. You'll be notified when it's time to enroll. You can complete your COBRA enrollment by contacting the Thomson Reuters HR Services Center or on the Your Benefits Resources website.

COBRA Qualifying Events

Definition of a Qualifying Event

For Retirees

When You Lose Coverage

You or your dependents have a qualifying event if you lose group health coverage for one of these reasons:

- You retire.
- You become entitled to Medicare.
- Employer's bankruptcy.

When Your Dependents Lose Coverage

Your covered dependents can also have a qualifying event if:

- You get divorced, become legally separated, or terminate your domestic partnership.
- Your child is no longer eligible for coverage.
- Your covered dependent becomes entitled to Medicare.
- You die.

Continuation Period

The length of time you or your covered dependents can continue coverage under COBRA depends on the qualifying event (as indicated below). However, continuation coverage under the Health Care Flexible Spending Account normally continues through the end of the current year only.

Qualifying Event Qualified	Length of Beneficiaries	Coverage
You retire.	You, your spouse, your domestic partner, and/or your child(ren) or child(ren) of your domestic partner	18 months
You or your dependent is determined to be disabled (as defined by the Social Security Act) on or before the COBRA- qualifying event or within the first 60 days of COBRA coverage.*	You, your spouse, your domestic partner, and/or your child(ren) or child(ren) of your domestic partner	29 months
You divorce, become legally	Your ex-spouse, your former	36 months

Qualifying Event Qualified	Length of Beneficiaries	Coverage
separated from your spouse, or terminate your domestic partnership.	domestic partner and/or your child(ren) or child(ren) of your domestic partner	
Your child(ren) lose(s) eligibility.	Your child(ren) or child(ren) of your domestic partner	36 months
You reach age 65 or become eligible for Medicare	Your spouse, your domestic partner and/or your child(ren) and/or child(ren) of your domestic partner	36 months**
You Die	Your spouse, your domestic partner, and/or your children or children of your domestic partner	36 months
Significant reduction in coverage within one year before or after the employer's filing for bankruptcy under Title 11 of the United States Code	You and your spouse	Until death, in the case of the covered surviving spouse, 36 months after the death of the covered former employees.

* If you, your covered spouse, or covered dependents are determined to be disabled (as defined by the Social Security Act) during the first 60 days of your COBRA coverage, up to a total of 29 months of COBRA coverage may be available to your family at a higher premium. To be eligible, the disabled individual must be:

1. Determined to be disabled prior to begin date of COBRA, or
2. Determined to be disabled within 60 days of COBRA begin date, and
   - Disability award letter must come within the initial 18-month COBRA period, and
   - Thomson Reuters HR Services Center must be notified within 60 days of you receiving the award letter, and
   - Individual must be deemed disabled through the 18-month COBRA period.

Note: You must give notification of the disability extension by phone. Thomson Reuters HR Services Center **cannot** accept written notification.

** If you become eligible for Medicare within the 18-month period before the qualifying event of termination or reduction of hours, your qualified dependents are eligible for COBRA coverage. COBRA coverage ends 36 months from when you became eligible for Medicare.

Note: If you are entitled to Medicare or other group coverage **before** you elect COBRA, you are still eligible for COBRA. If you elect COBRA and subsequently become entitled to Medicare, COBRA can be terminated unless there is an applicable preexisting condition clause.

Second Qualifying Event

If your dependents are covered under COBRA because you leave Thomson Reuters or your work hours are reduced and a second qualifying event occurs during their initial 18 or 29 months of COBRA coverage, they can elect up to a total of 36 months of COBRA coverage.

To qualify for an extension of coverage, you or your dependents must notify Thomson Reuters HR Services Center within 60 days of the second qualifying event.

Note: You must give notification of a second qualifying event by phone. Thomson Reuters HR Services Center **cannot** accept written notification.

Note: If you're eligible for trade-adjustment assistance (TAA), you may be eligible for a tax credit or an advance payment for your COBRA premiums. You may also qualify for a second opportunity to elect COBRA coverage if you didn't elect coverage during the regular election period. However, you must elect coverage within 60 days of the first day of the month in which it's determined that you qualify as a TAA recipient. In addition, you must elect coverage within 6 months after you lost the coverage qualifying you as a TAA recipient. Call the Health Coverage Tax Credit Customer Contact Center at 1-866-628-4282 for more information.

Qualified COBRA Beneficiaries

Definition of Qualified Beneficiary

For Retirees

A qualified beneficiary is an individual who is, **on the day before** a qualifying event, covered under (enrolled in) a Thomson Reuters group health plan.

A qualified beneficiary can be:

- The covered employee or covered retiree.
- The covered spouse/domestic partner of a covered employee or covered retiree.
- The covered dependent child of a covered employee or covered retiree.
- A newborn or newly adopted child or a child placed for adoption who is added to a former employee's COBRA coverage within 30 days of birth, adoption, or placement for adoption.

Each qualified beneficiary can make COBRA elections independent of any other qualified beneficiary's elections.

Nonqualified Beneficiaries

A qualified beneficiary can also add certain nonqualified beneficiaries to his or her COBRA coverage, either during annual enrollment or if there is a qualified change in status.

Nonqualified beneficiaries are family members who otherwise would have been eligible for coverage under Thomson Reuters plans, but weren't covered on the day before the qualifying event.

A nonqualified beneficiary may be:

- A new spouse/domestic partner.
- A newly added dependent (other than a newborn or newly adopted child).
- A spouse/domestic partner or dependent added during annual enrollment or a qualified change in status.

Nonqualified beneficiaries receive the same coverage that the qualified beneficiary chooses. They don't have independent coverage election rights under COBRA.

Coverage During Military Duty

Who is Eligible

If you miss work because of duty in the uniformed services, such as the U.S. Armed Forces, you can continue medical coverage for yourself and your dependents under the Uniform Services Employment and Reemployment Rights Act (USERRA).

For more information, contact the Thomson Reuters HR Services Center.

Certificate of Group Health Coverage

When your Thomson Reuters health coverage ends, a federal law known as HIPAA (the Health Insurance Portability and Accountability Act) requires Thomson Reuters to provide you with a Certificate of Group Health Coverage (sometimes called “Proof of Continuous Coverage"). The certificate shows the length of time that you were "continuously covered" under a Thomson Reuters health plan.

The certificate is intended to reduce or eliminate the waiting period that another plan may have regarding the payment of claims relating to preexisting conditions.

For example, if you enroll in another employer's health plan before having a break in coverage of 63 days, your continuous coverage under Thomson Reuters Health and

Welfare Plan would reduce or eliminate the new plan's preexisting condition waiting period.

You should keep the certificate for your records.

Retiree Medical Plan Overview

Please refer to the benefit booklet (for the Pre 65 Retiree Medical Plan) or insurance contract (for the Post 65 Retiree Medical Plan) for detailed information about your plan benefits. The benefit booklet or insurance contract, as applicable, together with this SPD, is the official plan document for the Plan, and describes expenses that are covered under the plan, plan maximums, limitations and exclusions, your copays and deductibles, Thomson Reuters' right of subrogation and recovery of overpayments, and other important information you should know. Therefore, please take the time to read the benefit booklet or insurance contract, as applicable, carefully. In the event of a discrepancy between this SPD and the benefit booklet or insurance contract, the benefit booklet or insurance contract, as applicable, will control.

Coverage Under the Women's Health and Cancer Rights Act

Thomson Reuters medical plans provide benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications from a mastectomy (including lymph edema). For details about the mastectomy-related services available under your health plan, refer to the applicable benefit booklet.

Coverage Under the Newborns' and Mothers' Health Protection Act

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

Mental Health and Substance Abuse Treatment

As a retiree, you're automatically enrolled for mental health and substance abuse treatment coverage if you enroll in the Retiree Medical Plan. Refer to the benefit booklet for more information regarding coverage and benefits.

Prescription Drug Coverage

Eligibility for Coverage

For Retirees

You're automatically enrolled for prescription drug coverage if you enroll in the Retiree Medical Plan. The prescription drug carrier is CVS Caremark.

Your prescription drug coverage is included as part of your medical plan option and provides coverage for medically necessary drugs and medicines prescribed by your or your covered dependent's doctor on an outpatient basis. Contact your prescription drug insurer directly to obtain a list of covered drugs, as some drugs and medicines aren’t covered by your plan.

For specific information regarding your Prescription Drug benefits, please review your Prescription Drug Benefit Booklet located on Your Benefits Resources (YBR) website or call the Thomson Reuters HR Services Center to obtain a copy of your current benefit booklet.

Note: For those who are enrolled in EGWP (prescription drug plan) upon turning 65, you will need to look at the SilverScript Benefit Booklet on YBR.

Creditable Coverage (Medicare Part D)

If you or a covered dependent is eligible for Medicare or will soon become eligible, you're also eligible for Medicare Prescription Drug Coverage (Part D).

You don't need to enroll in the Medicare Part D if your Thomson Reuters Prescription Drug Program coverage is creditable, which means that your coverage is as good as Medicare Part D standard coverage.

Thomson Reuters has determined that the CVS Caremark Prescription Drug component of the Post 65 Retiree Medical Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage, and thus is creditable.

For more information about your Prescription Drug Program coverage, refer to the Creditable Prescription Drug Coverage Notice you receive in the mail. You can also

request a copy of the Creditable Prescription Drug Coverage Notice by calling the Thomson Reuters HR Services Center. General information about Creditable Prescription Drug Coverage is available in the “Creditable Prescription Drug Coverage” section of this document.

Note: If you are enrolled in the EGWP retiree prescription drug program, the information provided below is not applicable to you.

How the Program Works

If You Enroll in Medicare Part D

The Prescription Drug Program doesn't coordinate benefits with Medicare Part D.

Important! If you're eligible for Medicare, you cannot participate in both Medicare Part D and the Thomson Reuters Post 65 Retiree Medical Plan prescription drug program at the same time. If you enroll in Medicare Part D, your Thomson Reuters Post 65 Retiree Medical Plan and its prescription drug coverage will end and you will not be allowed to re-enroll.

Three-Tier Prescription Drug Coverage

For Retirees

The 3-tier copayment approach to prescription drug coverage is used by the Retiree Medical Plan.

With the 3-tier approach, your copayment for prescription drug coverage will vary based on 3 different drug categories. The smallest copayment will continue to apply for generic drugs, but copayments for brand-name drugs will vary between formulary brand-name drugs and nonformulary brand-name drugs.

Generic drugs and drugs that are on plans' formularies are of equal quality to and are no less medically effective than brand-name drugs that are not on the formulary. As always, it is up to you and your doctor to decide which prescription drugs are best for you. You are never required to use generic drugs or drugs that are on any plan's formulary drug list.

It is also important to note that the drugs included in each of the tiers are updated from time to time. Check with the plan carrier for detailed information regarding any formulary in place.

How Formularies Work

A formulary is a list of drugs, both brand-name and generic, that are covered by a managed pharmacy program and chosen based on quality and cost.

Formularies often change for a variety of reasons, including approval of new drugs by the Food and Drug Administration (FDA), expiration of patents, and validation of clinical tests. Drugs on the list are classified according to treatment category, such as antidepressants or antibacterials.

Prescription drug coverage varies between the medical plan options. Refer to the applicable benefit booklet and/or contact the plan directly for specific prescription drug coverage information.

Creditable Prescription Drug Coverage

Note: This document contains general information on Thomson Reuters prescription drug coverage. For detailed information about your individual coverage, refer to the Creditable Prescription Drug Coverage Notice you received in the mail or contact the Thomson Reuters HR Services Center.

Important Information From Thomson Reuters About Your Prescription Drug Coverage and Medicare

Please read this information carefully and keep it where you can find it. This information is about your Thomson Reuters prescription drug coverage and prescription drug coverage available under Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

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

- Starting January 1, 2006, Medicare prescription drug coverage is available to everyone with Medicare.
- Thomson Reuters has determined that the prescription coverage option(s) listed in the Creditable Coverage section, on average for all plan participants, are expected to pay out as much as the standard Medicare prescription drug coverage will pay.
- Thomson Reuters has determined that the prescription drug coverage option(s) listed in the Non-Creditable Coverage section, on average for all plan participants, is NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. This is important, because for most people, enrolling in Medicare prescription drug coverage before 05/15/2006 means you will get more assistance with drug costs.

You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. Read this information carefully as it explains your options.

Starting January 1, 2006, prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Creditable Coverage

Thomson Reuters has determined that the CVS Caremark Prescription Drug component of the Post 65 Retiree Medical Plan option is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you do decide to enroll in a Medicare prescription drug plan, be aware that this will affect your Thomson Reuters coverage.

Important! Your Thomson Reuters coverage pays for other medical expenses in addition to prescription drugs. If you (the Thomson Reuters retiree) enroll in a Medicare prescription drug plan, **the Thomson Reuters medical and prescription drug coverage <u>will end</u>** for you and your covered dependents. If a Medicare eligible dependent of a Thomson Reuters retiree independently enrolls in a Medicare prescription drug plan and you (the retiree) do not, Thomson Reuters medical and prescription drug coverage will end for the dependent and your coverage will remain in effect. Once coverage ends under the Thomson Reuters plan, it can't be reinstated.

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

You should also know that if you drop or lose your current coverage with Thomson Reuters and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information

If you need additional information, contact the Thomson Reuters HR Services Center (see "*Key Contact Information*").

Please address any written correspondence to:

Thomson Reuters HR Services Center
DEPT 06957
PO Box 1490
Lincolnshire IL 60069-1490

Note: You may receive a Creditable Prescription Drug Coverage Notice before the next period you can enroll in Medicare prescription drug coverage, or if your Thomson Reuters prescription drug coverage changes. You also may request a copy at any time. ***It's important you keep the notice***. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

For More Information About Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

Filing Medical Plan Claims

Retiree Medical Plan

If applicable, you need to file a claim for all medical expenses with the Plan within twelve months after the date you receive services and incur the charges.

For purposes of determining claims under the Pre 65 Retiree Medical Plan, both the medical and prescription drug components, Thomson Reuters has contracted with a third party administrator to be the named fiduciary for claims administration. The third party administrator has the full power to make factual determinations, and interpret and apply the terms of the Pre 65 Retiree Medical Plan. See the benefit booklet for more information about the claims process for self-insured benefits.

For purposes of determining claims under the Post 65 Retiree Medical Plan medical component, the insurance company is the named fiduciary, with the full power to make factual determinations, and interpret and apply the terms of the Post 65 Retiree Medical Plan. See the insurance contract for more information about the claims process for fully insured benefits. For purposes of determining claims under the Post 65 Retiree Medical Plan prescription drug component, Thomson Reuters has contracted with a third party administrator to be the named fiduciary for claims administration. The third party administrator has the full power to make factual determinations, and interpret and apply the terms of the Pre 65 Retiree Medical Plan. See the benefit booklet for more information about the claims process for self-insured benefits.

To the extent not covered in a benefit booklet or insurance contract, as applicable, the claims procedures outlined in the *Claims Review Process* on page 37 apply.

How to Appeal Denied Claims

Once you turn in your medical claim, the claim administrator will review the claim and make a decision. Claims may be denied in some situations. You have the right to appeal denied claims by following the claims review process in accordance with the procedures that apply to your plan. Refer to the applicable benefit booklet or insurance contract for claims and appeals procedures. ***Failure to follow the applicable claims procedures can result in a loss of or delay of plan benefits***.

Right of Recovery

If any claim or benefit is overpaid, the plan reserves the right to recover the overpayment or to reduce future payments. The person receiving the benefit must produce any instruments or papers necessary to ensure this right of recovery.

Subrogation

If you recover any charges for covered expenses from a third party, the benefit amount that the medical plan pays is reduced by the amount you recover. If the plan pays benefits before you recover any charges, you need to reimburse the plan.

Coordination of Benefits

Definition of Coordination of Benefits

Some people are covered under multiple health plans. For instance, if you're married and your spouse/domestic partner works for a different company, each of you can choose to cover the other under your respective companies' plans.

Most medical and dental plans have coordination of benefits rules to ensure that, when multiple plans are involved, the insurance companies don't overpay or duplicate payments for covered medical or dental services.

When Coordination Is Needed

Coordination of benefits is needed when you and/or your dependents have coverage under:

- More than one company-provided health plan.
- A university-sponsored student plan and a company plan.
- An individually purchased plan and a company plan.
- Medicare and a company plan.*

* An individual may become eligible for Medicare based on age, disability or End Stage Renal Disease. It is your responsibility to know if and when you or a dependent become Medicare eligible and the steps, if any, required to enroll for Medicare benefits. ***Your eligibility for Medicare benefits may impact your eligibility for plan benefits***. If you have any questions regarding Medicare eligibility and the impact on your plan benefits, refer to the applicable benefit booklet or insurance contract, or call the Thomson Reuters HR Service Center at 1-866-443-MyHR (6947). Detailed information regarding Medicare can be found at www.medicare.gov. See also the “Medicare Overview” section of this SPD.

How Coordination Rules Work

If a health care expense is covered by two (2) plans, one plan is the "primary" plan and has first responsibility for the expense. When the primary plan has paid its normal benefits, the other, or "secondary," plan may make an additional payment based on its provisions.

When The Company Plans Are Primary

When Thomson Reuters plan is primary, it pays full benefits according to its rules. After you've received an explanation of benefits (EOB) from the plan, you can submit any remaining expenses to the secondary plan for consideration.

When The Company Plans Are Secondary

When Thomson Reuters plan pays benefits as the secondary plan, the primary plan pays its benefits first. Then, the claims administrator determines whether any additional benefit is payable. The claims administrator compares the primary plan's benefit with the amount Thomson Reuters plan would have paid as your only source of coverage. Thomson Reuters plan makes up the difference, if any, between the amount you've already received and the amount Thomson Reuters plan would have paid had it been primary. Thomson Reuters plan will not pay a benefit if the primary plan paid the amount Thomson Reuters plan would have paid had it been the primary plan.

This type of coordination of benefits provision is often referred to as non-duplication.

If the Expense Is for You

Thomson Reuters plan is the primary plan for you (the company employee) and pays benefits without regard to other coverage.

If the Expense Is for a Dependent

If a covered dependent is an employee of another company and is covered by that company's plan, the other employer's plan will be primary.

If a child is covered under both parents' plans, the primary plan will be that of the parent who has the earlier birthday during the calendar year.

If a child is covered under both plans of parents who are divorced or separated and not remarried, the plan of the parent with custody of the child is primary. An exception is if the court has decreed that financial responsibility for medical and dental care expenses belongs with the other parent.

If the parent with custody has remarried and a stepparent's plan also covers the child, the plan of the parent with custody pays first and then the plan of the stepparent pays. The plan of the parent without custody pays last.

If the Other Plan Has No Coordination Rules

If the other plan has no provision regarding coordination of benefits, that plan is primary.

When None of the Rules Apply

If none of the rules above determine the primary plan, the primary plan will be the one that has covered the person for the longest period of time.

If You're Eligible for Medicare as a Retiree

Prescription Drug Coverage

If you're eligible for Medicare and you enroll in the Retiree Medical Plan, your prescription drug coverage is included in your plan. The Retiree Medical Plan coverage doesn't coordinate with Medicare Part D prescription drug coverage.

Imputed Income

Imputed Income for Retiree's Domestic Partner Coverage

When you enroll your domestic partner or your partner's child(ren) in one of Thomson Reuters medical plans, the IRS considers Thomson Reuters contribution toward the additional coverage as your imputed income.

If you have imputed income, it will show up on an IRS Form 1099.

Disclaimer

Thomson Reuters is not providing you with tax advice or attempting to evaluate your particular situation. You are urged to consult your own tax advisor(s) concerning the federal and state income tax and employment tax ramification from your enrolling your domestic partner or your partner's child(ren) in one of the company sponsored medical plans.

Medicare Overview

For detailed information about Medicare, contact Medicare or visit the Medicare Website at www.medicare.gov. To the extent there is an inconsistency between the information provided in this SPD and the Medicare Website, the Medicare Website provisions shall supersede these.

Medicare provides medical benefits if you meet any of these criteria:

- You're age 65 or older and eligible for Social Security or railroad retirement benefits.
- You're entitled to Social Security disability benefits after being totally disabled

for 24 months.

- You have End-Stage Renal Disease requiring dialysis and/or kidney transplant.

  Important note: If you have End Stage Renal Disease, Medicare is the secondary payer to this plan for a specified coordination period. Following the coordination period, Medicare becomes the primary payer and this plan becomes the secondary payer. ***You must enroll in Medicare (e.g., Parts A & B) before the end of the coordination period to prevent a gap in coverage***. Refer to the applicable Benefit Booklet for further information.

If your earnings history makes you ineligible for Social Security benefits, you can "buy in" to Medicare when you reach age 65. You can apply by contacting the Social Security Administration.

There are 3 primary components to Medicare benefits:

- **Part A**—Hospital insurance benefits
  - Typically provided at no cost as you, deductions were taken via payroll taxes while you were working
- **Part B**—Supplemental insurance benefits.
  - Monthly premiums apply in most cases
- **Part D**—Prescription drug benefits.
  - Monthly premiums apply in most cases

Note that Medicare Part C, also called Medicare Advantage, is an alternative to Medicare Part A and Part B, and is available through private insurers.

Visit www.medicare.gov for more information on eligibility, enrollment, premium costs, and plan coverage.

Benefit Plans Sponsor and Administrator

The plan sponsor and plan administrator is Thomson Reuters Holdings Inc.

You may direct any questions about your rights under the plans to the plan sponsor at any time by writing to this address:

Thomson Reuters Holdings Inc.
Attn: Thomson Reuters Health & Welfare Plan Administrator
610 Opperman Drive
Eagan, MN 55123
1-651-687-7000

Beginning **April 1, 2024**, the plan sponsor address will be:
2900 Ames Crossing Road, Eagan, MN 55121

Plan Administration

The plan administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including component benefit programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including component benefit programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits.

Any construction of the terms of any plan document and any determination of fact adopted by the plan administrator shall be final and legally binding on all parties. Any interpretation, determination, or other action of the plan administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the plan administrator shall be based only on such evidence presented to or considered by the plan administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the plan administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

The plan administrator may delegate its powers and authorities under the Plan to one or more persons or entities.

Plan Operations

Because benefits under the Plan are provided both through an insurance contract and on a self-insured basis, the Plan is administered by Thomson Reuters (in its capacity as plan administrator), a third-party administrator (for the Pre 65 Retiree Medical Plan) and the insurance company (for the Post 65 Retiree Medical Plan).

Except as noted below for the Pre 65 and Post 65 Retiree Medical plan, Thomson Reuters HR Services Center, has been delegated full and final authority and discretion to:

- Make all final determinations or allow changes under the plans, including eligibility for benefits.
- Interpret and construe all the terms and provisions of the plans.

The Thomson Reuters HR Services Center also authorizes or performs the day-to-day

operations of the Plan, such as authorizing benefit payments, resolving questions, maintaining records, filing reports, and distributing information to Plan participants and beneficiaries.

Officers and employees of Thomson Reuters at various work locations are not authorized to represent or speak on behalf of the plan, the plan administrator, or any delegate or claims fiduciary.

Claims under the Pre 65 Retiree Medical Plan are administered by a third-party administrator contracted by Thomson Reuters. The third part administrator, as the named fiduciary for claims administration under the Pre 65 Retiree Medical Plan, has complete discretion in deciding claims and appeals and such determinations are binding on all parties.

Role of the Insurance Company

The Post 65 Retiree Medical Plan is fully insured. Benefits under the Post 65 Retiree Medical Plan are provided under a group insurance contract entered into between Thomson Reuters and the insurance company. Claims for benefits under the Post 65 Retiree Medical Plan are submitted to the insurance company. The insurance company, not the Thomson Reuters, is responsible for determining and paying claims.

The insurance company is responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Post 65 Retiree Medical Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals with respect to benefits under the Post 65 Retiree Medical Plan.

As the named fiduciary for benefit determinations for the Post 65 Retiree Medical Plan, the insurance company, to the fullest extent permitted by law, has the discretionary authority to interpret the Post 65 Retiree Medical Plan in order to make benefit determinations. The insurance company also have the authority to require eligible individuals to furnish it with such information as it determines necessary for the proper administration of the Post 65 Retiree Medical Plan.

Plan Identification

When dealing with or referring to the plan in benefit appeals or other correspondence, you'll receive help more quickly if you identify the plan fully and accurately. To identify the plan, use the Employer Identification Number (EIN) and the Plan Number (PN).

The EIN for Thomson Reuters Holdings Inc. is 06-1497995. The plan names, plan numbers, and plan types are shown below.

Plan Name	Plan Number	Plan Type
Thomson Reuters Retiree Medical Plan	511	Welfare plan providing group medical and prescription drug benefits to retirees.

Plan Year

Records for each plan are maintained on a calendar-year basis, starting each January 1 and ending each December 31.

Service of Legal Process

Legal process on the plans may be served on:

Thomson Reuters Holdings Inc.
Attn: Health and Welfare Plan Administrator
610 Opperman Drive, Eagan, MN 55123

Service of legal process also may be made upon the Thomson Reuters HR Services Center.

Beginning **April 1, 2024**, the address will be:
2900 Ames Crossing Road, Eagan, MN 55121

Claims Administrators and Insurance Companies

The following are the claims administrators:

Pre 65 Retiree Medical Plan

Aetna Retiree Medical Plan Group #721108
1-877-512-0370
www.aetna.com

Post 65 Retiree Medical Plan

Aetna Medicare Plan (PPO) Group #CY23606
1-800-307-4830
ThomsonReuters.AetnaMedicare.com

Pre 65 Retiree Prescription Drug Plan

CVS Caremark Prescription Drug Plan Group # TRIRX
1-888-865-6587
www.caremark.com

Post 65 Retiree Prescription Drug Plan

SilverScript (EGWP) Prescription Drug Plan
1-866-363-8198
www.caremark.com

Claim Review Process

The plans follow a claim review process whenever you (or your authorized representative) submit a claim for benefits. The process is designed to ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of those involved in making the decisions. There are two types of claims:

- Enrollment or election change claims
- Benefit claims

The process for filing a claim will differ, depending on the type of claim. ***Failure to follow the applicable claims procedures can result in a loss of or delay of plan benefits***.

To the extent not covered in the benefit booklet (for the Pre 65 Retiree Medical Plan) or the insurance contract (for the Post 65 Retiree Medical Plan), the claims procedures outlined below apply.

Enrollment or Election Change Claim

An enrollment or election change claim is a claim to participate in a plan (or plan option) or change an election to participate during the year. For example, it may be a claim to start, add, or stop participation in a plan for you, your spouse/domestic partner, or eligible dependent.

Thomson Reuters HR Services Center administers claims for enrollment and election changes. Enrollment and election change claims must be filed in writing on a Claim Initiation Form and accompanied by any supporting documentation. Copies of the claim form are available by contacting Thomson Reuters HR Services Center (see "Key Contact Information"). The completed Claim Initiation Form should be sent, along

with supporting documentation to:

Claims and Appeals Management
P.O. Box 1407
Lincolnshire, IL 60069-1407

If Your Claim is Denied

If your claim is denied, you'll be given written or electronic notice within 30 days after your claim is reviewed by the claims administrator. This period may be extended by an additional 15 days for matters beyond the control of the plan, provided you're notified within the initial 30-day period. Similarly, if your claim is incomplete, you will receive a notice that specifically describes the required information and states that you will have 45 days to provide the required information. The notice will effectively suspend the time for a decision on your claim until such information is provided.

If your claim is denied, you'll be given written or electronic notice that will include:

- The specific reasons for denial.
- Specific reference to the plan provisions on which the denial is based.
- A description of any additional material or information needed and an explanation of why it's necessary.
- A description of the plan's claim review procedures and application time limits, including your right to submit written comments and have them considered, your right to review (upon request at no charge) relevant documents and other information and your right to file suit under ERISA section 502(a) (where applicable) with respect to an adverse determination after final review of your claim, subject to any plan imposed limitation period

Request for Review

After receiving notice, you, your beneficiary, or your legal representative may ask for a full and fair review (an appeal) of the decision by writing to the Thomson Reuters Health and Welfare Benefits Committee. You must make this request within 180 days of the date you receive notice of a denied claim. During the 180-day period, you or your authorized representative will be given reasonable access to all documents and information related to the claim, and you may request copies free of charge. You can also submit written comments, documents, records, and other information relating to the claim to the Thomson Reuters HR Services Center. If you don't appeal on a timely basis, you will lose your right to appeal and the right to file suit in court.

Final Decision

The Health and Welfare Benefits Committee will the review the claim again and make a final decision within 60 days of receipt of your request for review based on all comments, documents, records, and other information you've submitted. This period

may be extended by an additional 60 days for matter beyond the control of the plan, provided you're notified within the initial 60-day period.

If your claim is denied on review, you'll receive written or electronic notification that explains:

- The specific reasons for the denial.
- The specific plan provisions on which the denial is based. If an internal rule, guideline, or protocol was relied upon to determine the claim, you'll either receive a copy of the actual rule, guideline, or protocol, or a statement that the rule, guideline, or protocol was used and that you can request a copy free of charge.
- A description of any additional material or information needed and an explanation of why it's necessary.
- A statement of the claimant's rights to bring action under ERISA section 502(a) with respect to an adverse determination after the final review of your claim.

Benefit Claim

A benefit claim includes any claim that isn't a claim with respect to enrollment and election changes, such as a request for medical plan benefits or services.

Benefit claims must be filed directly with the claims administrator for the plan in question. See the applicable benefits booklet or contact the claims administrator for information on how to file your claim for benefits. If you are a service provider filing a claim on behalf of a participant or yourself, please contact the claims administrator, as different procedures may apply.

Please refer to the plans benefit booklet or insurance contract, as applicable, for claim and appeals procedures that apply to benefit claims.

Situations Impacting Your Benefits

Here are a few situations that may affect your benefits from the plans:

- You file claims on an untimely basis.
- You or a covered dependent fail to timely enroll in Medicare.
- No benefits are paid for services or supplies received before coverage begins or after coverage ends.
- You, your provider, or your beneficiary must file a claim before benefits are paid.
- If you, your provider, or your beneficiary file a claim for benefits but do not complete all the necessary information, benefits could be delayed.

- Benefits may be delayed if you don't keep your most current address on file and Thomson Reuters can't locate you.

Changes to the Plans

While Thomson Reuters expects to continue plans indefinitely, it reserves the right to amend, modify, suspend, or terminate the plans at any time in its sole discretion.

Thomson Reuters also reserves the right to change the amount of required employee contributions for coverages under the plans.

Important: An amendment or termination of the plan(s) may affect not only the coverage of the employees (and their covered dependents) but also of COBRA participants and former employees who retired, died, or otherwise terminated employment and their covered dependents.

A plan change may transfer plan assets and debt to another plan or split the plan into 2 or more parts. If Thomson Reuters changes or ends a plan, it may decide to set up a different plan.

Benefit Payments If a Plan Ends

If a plan ends, coverage for all affected participants normally ends on the date of plan termination.

Your Legal Rights Under the Plans

As a participant in the Health and Welfare Plans, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which are listed below.

Receive Information About Your Plan and Benefits

As a plan participant, you're entitled to:

- Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

As a plan participant, you may be entitled to continue health care coverage for yourself, your spouse, or your dependents if there's a loss of coverage under a 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 responsible for the operation of the employee benefit plans. The people who operate your plans, 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that's denied or ignored, in whole or in part, you may file suit in a state or federal court ***within two years after you exhaust the plan's claims and appeals procedures (subject to any shorter plan imposed limitation period specified in the applicable benefit booklet, insurance contract or applicable law)***. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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

The court will decide who should pay court costs and legal fees. If you're 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 your 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 Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.