Baxter International Inc.

Retiree Benefits

Summary Plan Description

January 2023

For Non-English Speaking Retirees

This booklet contains a summary in English of your rights and benefits under Baxter's retiree benefit plans. If you have any questions regarding the information in this booklet, please call HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free) for assistance.

Para Jubilados Que No Hablan Inglés

Este folleto contiene un resumen en inglés de los derechos y prestaciones que a usted le corresponden bajo los planes de beneficios que Baxter ofrece a sus empleados jubilados. Si tiene dudas en relación con la información contenida en este folleto, llame sin costo alguno a HRCentral Support a (1-844-249-8803), para obtener asistencia.

IMPORTANT INFORMATION ABOUT THIS SUMMARY BOOKLET

This summary is intended to describe the main features of the Baxter International Inc. Welfare Plan for Retirees and Disabled Individuals and the Baxter International Inc. and Subsidiaries Welfare Benefit Plan for Active Employees Plan as they apply to benefits provided to eligible retirees and their dependents (collectively referred to in this booklet as the "Plans"). The complete terms and conditions of the Plans are described in the plan documents, as they may be amended from time to time. The plan documents are the official governing document for the Plans. Plan benefits are paid only if provided for in the official plan documents. If there are any discrepancies between this summary and the official plan documents, the official plan documents will govern.

The terms "you" and "your" as used in this summary refer to a Baxter retiree who otherwise meets all the eligibility and participation requirements under the Plan (and, with respect to certain rights and obligations under the Plan, the retiree's covered dependents). Receipt of this booklet does not guarantee that the recipient is a participant under the Plan or otherwise eligible for benefits under the Plan.

Nothing in this booklet says or implies that participation in the Plans is a guarantee that Plan benefits levels or costs will remain unchanged in future years. Baxter International Inc. has the right—and sole discretion—to suspend, amend, or terminate the Plan and benefits provided under the Plan at any time in any manner—to the extent permitted by law. The Plan Administrator, or its designee, has sole discretionary authority to interpret and construe the provisions of the Plans, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plans. Benefits under the Plans will be paid only if the Plan Administrator or its designee decides, in its discretion, that the applicant is entitled to them.

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Introduction

While you were working at Baxter[*], the company offered you a variety of benefit plans. The benefits offered included welfare plans—such as a medical plan and dental plan, disability plans, life insurance plans, and retirement plans.

Baxter continues to offer certain health and welfare benefits to you during your retirement years, including the Baxter Retiree Medical Plan and the Baxter Retiree Life Insurance Plan if you were hired by Baxter before January 1, 2016, had 65 or more credits as of December31, 2016 and meet the Plan's eligibility requirements. Baxter Retiree Medical Plan coverage ends for retirees and their dependents who have reached the age of 65. However, post-65 retirees and dependents will be able to acquire their own Medicare supplemental health insurance through the individual insurance market, using the Via Benefits insurance exchange if they wish. If an eligible post-65 retiree or dependent purchases health insurance coverage through Via Benefits, he or she may also be eligible to have a portion of the insurance premiums, and certain other medical expenses, reimbursed on a tax-free basis through the Health Reimbursement Account Plan (the "HRA") described in the Health Reimbursement Account Plan Summary Plan Description. Here's a summary of what happens when you retire, if you satisfy eligibility requirements described in this summary:

- *Medical* coverage for you and your eligible dependents can continue under the Baxter Retiree Medical Plan until age 65. You may have several options from which to choose, including certain HMOs that offer coverage to Baxter retirees.

- Generally, you receive $5,000 of *life insurance coverage* under the Baxter Retiree Life Insurance Plan at no cost when you retire.

- Upon retirement, you may continue your active Basic, Employee and Dependent Supplemental Life coverage under the portability provision (subject to plan maximums) or convert your coverage to an individual policy within 31 days of your termination date. Baxter's life insurance carrier provides you with information about converting these coverages.

- Any coverage you have under the *Basic or Supplemental Personal Accident Insurance Plan* ends at the end of the month in which you retire. You may continue this coverage under the conversion provision by applying within 31 days of your termination date. Baxter's personal accident insurance carrier provides you with information about converting these coverages.

As used in this booklet, "Baxter" refers to Baxter International Inc. and all of its subsidiaries and affiliates that have adopted the Plans. This booklet is a summary of the retiree benefits provided under the Baxter Retiree Medical Plan and the Baxter Retiree Life Insurance Plan. It describes

[*] Beginning January 1, 2023, employees or former employees of Hill-Rom Company, Inc or former employees of Welch Allyn, Inc. may be eligible to participate in the Baxter Retiree Medical Plan or the Welch Allyn Retiree Life Insurance Plan. See the *Who is Eligible* section for details.

your benefits in effect on January 1, 2023. If you have any questions about any of the information in this booklet, call HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free).

The Baxter Benefit Resources

HRCentral

HRCentral at YourBenefits.Baxter.com, is our easy to use, 24/7 benefits resource with personalized information for all your benefits needs. You may utilize this site any time to view current coverages, make changes due to a qualifying life event (such as marriage or birth of a child), locate a doctor or hospital in your plan's network and more.

For questions and assistance, you can reach a representative at HRCentral Support (1-844-249-8581 English Toll-Free, or 1-844-249-8803 Spanish Toll-Free Monday through Friday, from 8:00 a.m. to 5:00 p.m. CST). If a representative is unable to answer your questions, they will direct you to additional resources for information.

You may reach a variety of resources, including the Plan's medical claims administration for your particular Retiree Medical Plan option. If a representative is unable to answer your questions, they will direct you to additional resources for information. If you select an HMO, you will need to call the HMO directly.

You can call HRCentral Support 24 hours a day. However, the customer service departments for each of the plan carriers generally operate during normal business hours. Plan claims administrators, insurance carriers and HMOs may have limited information available through an automated voice response system during evenings and on weekends.

Here's a quick summary of HRCentral Support's services

- During the ***retirement*** process, HRCentral Support:

  — provides enrollment and plan information for you to enroll in the retiree benefit plans;

  — answers questions about the enrollment process at the time of retirement;

  — records your eligible dependents;

  — records your benefit elections for the retiree benefit plans; and

  — sends your enrollment information to the appropriate claims administrator or HMO for your Retiree Medical Plan option for processing.

- During ***annual enrollment***, HRCentral Support:

  — provides you with enrollment and plan information;

— answers questions about the enrollment process and annual enrollment communications;

— records the annual benefit elections you make; and

— sends your enrollment information to the appropriate claims administrator or HMO for your Retiree Medical Plan option for processing.

- ***Throughout the plan year***, HRCentral Support:

— answers questions about Baxter's benefit programs;

— records any new elections you may make as a new retiree as well as any changes you may make during the plan year as the result of a qualified change in status;

— sends your coverage elections upon retirement-or any change information you may have during retirement-to the appropriate claims administrator and/or HMO or insurance carrier for processing;

— collects any premium payments you may have for retiree benefits; and

— assists in processing certain claims if you die.

Although HRCentral Support representatives are trained in and knowledgeable about the Baxter plans, they are not authorized to waive any of the plan requirements or alter any provision of the plan, and their interpretations, if contrary to the terms of plan documents, are not binding.

HRCentral Support is provided to participants as a convenience to enable you to more efficiently monitor and manage your coverage. It is YOUR responsibility to ensure that all instructions that you give using HRCentral Support are actually carried out. If you use HRCentral Support to direct a change in your coverage options, you should always receive a written confirmation that the change has been implemented. There may be periods during which HRCentral Support are not available due to technical difficulties, system overloads, or routine maintenance and updating. ***Under no circumstances will Baxter, the Administrative Committee, or any officer or employee of Baxter have any responsibility or liability whatsoever for the failure of any instructions given through HRCentral Support (or any similar facility, including any web site, maintained by any claims administrator or carrier) to be implemented for any reason.***

The Baxter Retiree Medical Plan

Retiree Medical Plan Introduction

The Baxter Retiree Medical Plan is designed to help you financially when you or your covered family members need medical care. At the same time, Baxter encourages you to be an informed consumer of health care services, and the variety of coverage options available enables you to choose the type of coverage that best suits your needs.

If you meet the Plan's eligibility requirements, you decide whom to cover when you enroll. Depending on your Medicare eligibility status and your primary residence (your residence on file HRCentral Support), the following Retiree Medical Plan options may be available to you if you are an eligible retiree[†]:

Please note: The Retiree Medical Plan bases the available options as well as the premiums for the options on the home zip code and the age of the Baxter eligible retiree.

- Baxter Traditional Option (BTO);
- Participating Provider Option (PPO);
- Blue Preferred POS (POS);
- Health Savings Account (HSA 1 and 2) Options;
- A Health Maintenance Organization (HMO); or
- No Coverage.

Not all HMOs offer coverage to Baxter retirees. Your enrollment materials include only the HMOs for which you are eligible.

It's important to review the enrollment materials you receive each year. These materials highlight the Retiree Medical Plan options being offered for the upcoming plan year and describe enrollment procedures and plan design changes that have taken place since the last annual enrollment.

The following section of this booklet is a summary of the Baxter Retiree Medical Plan, in effect as of January 1, 2023. If there is a conflict in the terms of this summary and the official plan documents, the plan documents will control. If you have any questions about any of the information in this section, call HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free).

A summary of your rights and benefits under the HMO option is contained in separate written materials available from the HMOs. To identify the HMOs available to you, please consult your most recent enrollment materials or HRCentral Support (1-844-249-8581 English Toll-Free or 1-

[†] Eligible Hillrom retirees and eligible Welch Allyn retires should refer to the section **A Snapshot of the Options and How the Retiree Medical Plan Pays Benefits** later in this booklet for a list of the medical plan options available to you.

844-249-8803 Spanish Toll-Free). For information about HMO coverage, contact HRCentral Support or the HMO directly.

Who Is Eligible

You and your family members may be eligible for Baxter Retiree Medical Plan coverage. If you were hired by Baxter on or after January 1, 2016, you are not eligible to participate in the Baxter Retiree Medical Plan.

You
You may elect coverage under the Baxter Retiree Medical Plan for you and your eligible dependents under age 65, provided:

- you meet the definition of an "eligible retiree" or "eligible Hillrom retiree" as described below;
- you are under age 65; and
- Baxter continues to offer retiree medical coverage.

How the Plans define "eligible retiree"
You are a "retiree" eligible to participate in the Baxter Retiree Medical Plan and the Baxter Retiree Life Insurance Plan if you meet any of the following requirements.

- You were hired by Baxter before January 1, 2016, and had at least 65 credits as of December 31, 2016. Employees with less than 65 credits on December 31, 2016, will not be eligible to participate in the Baxter Retiree Medical Plan or the Baxter Retiree Life Insurance Plan.
- You left Baxter **on or after October 1, 1997,** and you had at least 65 credits under the Baxter Retiree Medical Plan at the time your employment terminated.
- You left Baxter **before October 1, 1997, but on or after January 1, 1990,** and you had at least 65 or more points[*] under the Baxter International Inc. and Subsidiaries Pension Plan or the Baxter International Inc. and Subsidiaries Pension Plan II at the time your employment terminated. Points under the Pension Plan or Pension Plan II include your age points, benefit service points and other points, as determined by the Baxter Retiree Medical Plan.
- You left Baxter **before January 1, 1990**, and you were at least 55 years old and had at least 10 years of service under the Baxter International Inc. and Subsidiaries Pension Plan at the time your employment terminated.

[*] Effective October 1, 1997, "points" are referred to as "credits."

- You retired under the American Hospital Supply Corporation Retiree Medical Plan, and you elected coverage under the Baxter Retiree Medical Plan.

For purposes of determining whether you have 65 credits under the Baxter Retiree Medical Plan, *in general*, your credits equal your age plus your years of service with a participating Baxter business unit *minus* one (to account for the one-year eligibility waiting period). This formula does not apply to everyone. For example, special credit rules may apply if you terminated employment with Baxter but were later rehired. To get an accurate statement of your Retiree Medical Plan credits, you must call HRCentral Support for an individualized statement. You may also login to YourBenefits.Baxter.com to view your Baxter Retiree Medical Plan credits.

You complete one year of eligibility service if you are working for a participating employer on the first anniversary of your hire date. Only regular employees scheduled to work at least 20 hours per week are eligible to earn eligibility service and credits for a year of service. You are eligible to begin earning service credits only after you complete one year of eligibility service. You receive your age credit as of your birth date each year, whether or not you are working for a participating employer, after you complete one year of eligibility service. For example, a 65-year-old employee who terminates after 10 months of employment has no credits under the Retiree Medical Plan because that individual has not satisfied the one-year eligibility period. Employees with less than 65 credits as of December 31, 2016, will not earn additional credits and will not be eligible to participate in the Baxter Retiree Medical Plan or the Baxter Retiree Life Insurance Plan.

If you transfer to the U.S. prior to January 1, 2016, once you are on the U.S. payroll and working for an employer who is participating in the Baxter Retiree Medical Plan, service while you are not on the U.S. payroll but working for a Baxter employer, will count toward credits. However, service while you are on the U.S. payroll and working for an employer who does not participate in the Baxter Retiree Medical Plan, does not count. If you transfer to the U.S. on or after January 1, 2016, or have fewer than 65 credits as of December 31, 2016, you are not eligible to participate in the Baxter Retiree Medical Plan or the Baxter Retiree Life Insurance Plan.

For purposes of determining whether you earn a year of service, you are credited with a year of service as of each December 1, provided you are working for a participating employer as of that date. To illustrate this point, please see the following examples:

An employee who is currently 45 years of age and was hired on June 1, 1995, has a total of 65 credits on December 1, 2015. However, an employee who is currently 45 years of age and was hired on December 15, 1995, has 64 total credits as of December 1, 2015.

If you left Baxter prior to January 1, 2016, and are then rehired on or after January 1, 2016, you will not be credited with service following your rehire date.

If you had fewer than 65 credits as of December 31, 2016, you are not eligible to participate in the Baxter Retiree Medical Plan or the Baxter Retiree Life Insurance Plan.

Remember, as long as you are a retiree younger than age 65, are not covered under another employer's plan as an active employee or a dependent of an active employee and are not entitled to Medicare due to a Social Security disability, your coverage under the Baxter Retiree Medical

Plan, if you qualify, will be your primary health insurance coverage. If you are entitled to Medicare due to a Social Security disability, Medicare is your primary insurer and the Baxter Retiree Medical Plan offers you secondary coverage. Likewise, if your spouse or domestic partner is Medicare-eligible (due to a Social Security disability), the Baxter Retiree Medical Plan offers secondary coverage and Medicare is the primary insurer. For more information regarding coordination of benefits, see the "Coordination of Benefits" section later in this booklet.

How the Plans define "eligible Hillrom retiree"
Beginning January 1, 2023, you are a "Hillrom retiree" eligible to participate in the Baxter Retiree Medical Plan if you meet any of the following requirements. Hillrom retirees are not eligible to participate in the Baxter Retiree Life Insurance Plan.

- You are an employee or former employee of Hill-Rom Company, Inc. or one of its participating subsidiaries who was not covered by a collective bargaining agreement, and met the following eligibility requirements:

    a) An Employee who retired prior to July 1, 2009, will be a Hillrom retiree if, at the time of his or her termination, the Employee was at least age 55 and had at least five years of service, as determined by the Administrator based on applicable records.

    b) An Employee who retires on or after July 1, 2009, will be a Hillrom retiree if he or she (i) was hired by the applicable Employer prior to October 1, 2008, (ii) was at least age 40 on or before July 1, 2009, and (iii) at the time of his or her termination, was at least age 55 and had at least five years of service, as determined by the Administrator based on applicable records.

For purposes of determining service, years of service as of December 31, 2022, shall be based on the applicable records of Hillrom on such date. On and after January 1, 2023, you will receive credit one year of service for a Hillrom Retiree on each one-year service anniversary that he or she continues in employment with the applicable Employer,

How the Plans define "eligible Welch Allyn retiree"
Beginning January 1, 2023, you are a "Welch Allyn retiree" eligible to participate in the Baxter Retiree Medical Plan if you meet the following requirements. Welch Allyn retirees are not eligible to participate in the Baxter Retiree Life Insurance Plan.

- You are a former employee of Welch Allyn, Inc. who met the requirements of and was participating in the applicable retiree medical plan sponsored by Welch Allyn, Inc. (the "Welch Allyn Retiree Medical Plan") on December 31, 2022.

Beginning on January 1, 2023, you are a "Welch Allyn retire" eligible to participate in the Welch Allyn Retiree Life Insurance Plan if you meet the following requirements:

- You were previously employed by Welch Allyn, Inc. and participated in retiree life insurance plan(s) or policies maintained by Welch Allyn, Inc. (collectively, the "Welch Allyn Retiree Life Insurance Plan") as of December 31, 2022.

Your eligible dependents
You may elect coverage under the Retiree Medical Plan for yourself and your eligible dependents who are under age 65; which include:

- Your spouse unless your spouse is covered as a Baxter retiree or employee. Your spouse is the individual to whom you are legally married under applicable state law. An individual is considered to be your spouse only if he or she would be recognized as your spouse under federal tax law. Eligible Hillrom retirees may cover a spouse only if such individual was at least age 55 on the date your employment terminated.

> If you, your spouse or domestic partner, or your children are Baxter employees or Baxter retirees, then neither you, your spouse or domestic partner, nor your children can be covered as both employees/retirees and dependents under the Baxter plans.

- Your domestic partner, unless your domestic partner is covered as a Baxter retiree or employee. Your domestic partner is someone of the same or opposite sex with whom you have a committed relationship of mutual caring and support. Eligible Hillrom retirees may cover a domestic partner only if such individual was at least age 55 on the date your employment terminated. The partnership must meet the following requirements as of the date coverage is scheduled to begin:
  - Neither partner is legally married or legally separated, nor a member of another domestic partnership,
  - The partners have shared a non-platonic, committed and continuous relationship for at least six (6) months,
  - Both partners are at least 18 years of age and capable of consenting to the domestic partnership,
  - Both partners reside in the same household and intend to do so indefinitely,
  - The partners share financial assets and obligations, and
  - Neither partner is related by blood in a way that would prevent them from being married to each other.

If you and your partner are in a state-recognized civil union, you will be treated as domestic partners under the terms of the Retiree Medical Plan.

You must certify that your partner qualifies as a domestic partner by completing the process established by the Plan Administrator. In addition, you will be required to submit proof of shared financial assets and obligations. To do so, you will be required to submit two of the following (but no more than one from any category):

1. Evidence of joint purchase or ownership of a home
2. Notarized copy of lease naming both domestic partners
3. Evidence of joint savings or checking account

4. Title and registration of joint ownership of an automobile
5. Evidence of joint use of and liability for credit cards
6. Evidence of durable power of attorney for the domestic partner
7. Other documentary evidence which depicts significant joint financial interdependency between the employee and domestic partner.

- If you are an eligible retiree, your unmarried dependent children, provided they primarily depend on you for support and maintenance. Eligible Hillrom retirees and eligible Welch Allyn retirees are not permitted to cover dependent children under the Retiree Medical Plan. Your unmarried dependent children are eligible for coverage—as long as they remain unmarried and dependent on you for support—until the end of the plan year in which they turn age 19 (or age 23* if they are full-time students in an accredited high school, college, or university, they are not eligible for coverage through another employer's plan, and they are participating in the Retiree Medical Plan on the day coverage would otherwise end). HRCentral Support or the claims administrator for your Retiree Medical Plan option may require you to provide proof of your dependent's eligibility.

Your eligible children include your natural children, legally adopted children or children who are placed with you for adoption, and children who reside in your household while under your legal guardianship or the legal guardianship of your spouse or domestic partner. Your eligible children also include the natural children and legally adopted children of your spouse or domestic partner and the children placed with your spouse or domestic partner for adoption.

> Be sure to call HRCentral Support within 60 calendar days of the date of the court order or the date of placement to enroll your adopted child in the Retiree Medical Plan.

A newborn child is eligible for coverage at birth, as long as you enroll the child by calling HRCentral Support within 60 calendar days of birth. If you do not enroll your newborn within 60 calendar days (begins on the date of birth and includes weekends), you will not be able to enroll your child until the next annual enrollment period. In the case of an adopted child or a child who is placed with you or your spouse or domestic partner for adoption, or legal guardianship, coverage takes effect as of the date of placement for adoption (provided you or your spouse or domestic partner has assumed and retained a legal obligation for total or partial support of such child as of such date) or the effective date of the guardianship, as applicable. Otherwise, coverage takes effect on the date you assume such obligation. Other rules may apply to certain HMOs. Contact HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free) for more information.

* Due to state law requirements, some HMOs may cover older dependent children or additional categories of dependents. For example, some HMOs may cover eligible dependent children who are full-time students up to age 30. Contact your HMO for questions about dependent eligibility.

- Your unmarried incapacitated children (see the following sub-section for details).

You will be required to provide proof of your dependent's eligibility and your dependent will not be considered eligible for coverage unless and until satisfactory proof of such eligibility is submitted to either Baxter or an eligibility verification vendor designated by Baxter and reviewed on behalf of the Plan Administrator. 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 will result in loss of coverage for your unverified dependent.**

When you re-enroll your eligible dependents for coverage during annual enrollment, you certify that each person meets the definition of an eligible dependent spouse, domestic partner, or child under the Baxter Retiree Medical Plan. Enrolling or re-enrolling individuals who do not qualify for dependent coverage under the Baxter Retiree Medical Plan is considered fraudulent and may result in retroactive cancellation of coverage. If you are unsure about whether a family member meets the definition of an eligible dependent under the Baxter Retiree Medical Plan, contact HRCentral Support.

Incapacitated dependent children
If you are an eligible retiree and you or your spouse or domestic partner have an unmarried incapacitated child who is covered under the Baxter Retiree Medical Plan and becomes ineligible for coverage because of age, you may continue coverage for the child, provided:

- the child continues to meet the definition of an "eligible dependent" (other than the limiting age);
- you continue to be eligible to elect dependent coverage for the child under the Retiree Medical Plan;
- the child is under age 65; and
- the child remains unmarried and incapable of self-support.

Eligible Hillrom retirees and eligible Welch Allyn retirees are not permitted to cover an incapacitated dependent child under the Retiree Medical Plan.

To continue coverage for an incapacitated child, you must submit proof of the child's incapacity to your Retiree Medical Plan option's claims administrator within 31 days of the date the child would have otherwise lost coverage. Coverage continues as long as the medical claims administrator approves the submitted proof. You may have to provide proof of your child's continued incapacity at least once every 12 months. If you do not timely respond to the claim administrator's request for proof of incapacity, your child's coverage will be terminated. Coverage is not available for adult children who became disabled after reaching age 19 (or age 23 if covered as a full-time student).

Survivor coverage
If you are eligible for coverage under the Baxter Retiree Medical Plan at the time of your death, coverage under the Retiree Medical Plan continues for your eligible dependents. However, if

your surviving spouse remarries, the Retiree Medical Plan does not consider the new husband or wife as an eligible dependent. Similarly, if your surviving domestic partner commences a new domestic partnership, the Retiree Medical Plan does not consider the new domestic partner as an eligible dependent.

If you are an American Hospital Supply Company retiree eligible for medical coverage under the American Benefit Choice Program, your surviving eligible dependents who are under age 65 may elect coverage only under the Baxter Retiree Medical Plan at the time of your death. Surviving eligible dependents who are 65 or older may elect coverage under the American Benefit Choice Program.

Medical child support orders
If you become divorced, certain court orders could require that you provide health care coverage for your child(ren), even if you do not have custody. A qualified medical child support order (QMCSO) is an order issued by a state court or through an administrative process under state law that requires you, as a parent, to provide for your child's medical coverage. If Baxter receives a medical child support court order that satisfies all of the applicable legal requirements (is "qualified"), Baxter will enroll your child (and you, if you are not already enrolled) in Baxter Medical Plan coverage to the extent provided by law and consistent with the Plan's procedures and the terms of the QMCSO. To obtain a copy of Baxter's QMCSO procedures, free of charge, contact HRCentral Support (1-844-249-8581 English Toll-Free, or 1-844-249-8803 Spanish Toll-Free).

Electing Coverage and Cost of Coverage

If you are an eligible retiree, upon retirement, you can elect coverage under the Baxter Retiree Medical Plan or you can defer your election and enroll for coverage under the Retiree Medical Plan at a later date. If you defer, you continue to accumulate credits for each year of your age (subject to certain restrictions beginning January 1, 2003), which the Retiree Medical Plan uses to determine the amount you pay for coverage.

If you are an eligible Hillrom retiree, upon retirement, you can elect coverage under the Baxter Retiree Medical Plan within 60 days of your termination date. If your position is eliminated, your 60-day enrollment period will begin immediately following the date any COBRA cost share period ends, provided you timely enroll in COBRA and pay the required premiums.

Effective with enrollment for the 2003-2004 plan year, enrolled retirees or dependents who waive (decline) Baxter Retiree Medical coverage will not be able to rejoin the Retiree Medical Plan again at a later date. Those who have never elected Baxter Retiree Medical coverage – or those who had previously elected coverage but revoked coverage prior to April 1, 2003, and continuously waive it – may still join the Retiree Medical Plan. However, if they later waive coverage, they will no longer be eligible to enroll.

When you leave the company
Within two to three weeks following your retirement date, you will receive enrollment information at your home. The enrollment materials contain important information about retiree benefits. If you are an American Benefit Choice retiree and want details about electing retiree medical coverage, see *American Benefit Choice retirees* later in this section.

If you elect retiree medical coverage immediately upon retirement
To elect coverage under the Baxter Retiree Medical Plan immediately upon retirement:

- Access HRCentral or YourBenefits.Baxter.com to review your Retiree Medical Plan options and select your coverage.
- Decide whom you want to cover under the Retiree Medical Plan. You must indicate the eligible family members under the age of 65 (including yourself) that you want to cover.
- The Retiree Medical Plan option you select remains in effect until the end of the plan year unless you have a qualified change in status. See *Qualified change in status* later in this section.
- Coverage under the Baxter Retiree Medical Plan for you and your eligible dependents begins on the first day of the month following your retirement date, unless you elect a later date for coverage to begin while enrolling online.
- The Retiree Medical Plan options available to you are based on your zip code. However, you may be willing to drive outside your zip code area to access providers associated with an option that is not available to you. If this is the case, you may be able to "opt-in" to the other option. Contact HRCentral Support to initiate the opt-in appeal process.
- After making your elections and submitting them online, print a copy of the online confirmation statement for your records.
- If you enroll in an HMO[‡] option, you may be required to select a Primary Care Physician (PCP). If so, you will receive a PCP selection form with your confirmation statement. You should select a PCP for each of your covered family members and return the form as directed. If the Retiree Medical Plan option you select requires a PCP selection and you do not complete and return the selection form, you and your dependents will be assigned a PCP based on your zip code. For additional information about PCPs, see *Primary Care Physicians (PCPs)* in the "A Snapshot of the Options and How the Plan Pays Benefits" section of this booklet.

If you are an eligible retiree and you do not enroll immediately upon retirement, the Retiree Medical Plan assumes that you want to defer retiree medical coverage as described below. Remember, once you elect one of the Retiree Medical Plan options, you stop accumulating age credits. The Retiree Medical Plan uses your accumulated credits at the time your retiree medical

[‡] Not all HMOs require a PCP selection.

coverage initially begins to determine the amount you pay for coverage. (See *Cost of retiree medical coverage* later in this section.)

If you defer retiree medical coverage
If you are an eligible retiree and you defer coverage upon retirement, you may elect coverage under the Baxter Retiree Medical Plan for you and your eligible dependents at any time. All you have to do is contact HRCentral Support when you want to enroll. HRCentral Support will send you the appropriate enrollment materials, which will explain the Retiree Medical Plan options available at the time you want to enroll. Be sure to read these materials carefully.

Once you complete your online enrollment, coverage under the Baxter Retiree Medical Plan takes effect on the first day of the month after you complete your online enrollment form. During online enrollment you can elect a later date (generally up to six (6) months after the date you make your enrollment election) if you do not want coverage to begin the first day of the month after you submit your elections.[§]

If you defer your retiree medical coverage, you continue to accumulate age credits toward your cost-share amount. You earn one additional age credit each year, on your birthday, until you make a retiree medical coverage election. You stop accumulating age credits on the day your coverage initially takes effect.

However, employees hired on or after January 1, 2003, including employees acquired in a corporate transaction, and employees who terminated employment on or before December 31, 2002, with less than 65 credits and are rehired on or after January 1, 2003, but before December 31, 2016, will only be allowed to "age into" the next cost share level. For example, if you were hired on or after January 1, 2003, and you were eligible for the 75 – 79 credit cost share level at retirement you could only continue to accumulate age credits until you reached 80 – 84 credit cost share level.

American Benefit Choice retirees
Upon retirement, you're eligible to elect coverage under the American Benefit Choice Program, provided you were:

- already retired under the American Retiree Medical Plan on November 25, 1985;
- an active American Hospital Supply Company employee age 55 or older with at least ten years of service on November 25, 1985; or
- an American Hospital Supply Company employee age 65 or older on November 25, 1985, regardless of your years of service.

[§] This event date must be the first day of the month on or after today's date. If you are looking to begin Retiree Medical Coverage during the current calendar year, then you may select a start date on the first of the month within the current plan year. If you are looking to start your coverage during the next calendar year, then please note, in general, you may select a start date for the next plan year beginning in November.

Annual enrollment
You may change your coverage elections once each year during the annual enrollment period. Information about the benefit options available to you will be available online at YourBenefits.Baxter.com or by calling HRCentral Support. To help you with your annual enrollment decisions, you receive an annual enrollment guide at your home. The information describes the enrollment procedures and changes in the Retiree Medical Plan options available for the upcoming plan year. If you have deferred your retiree medical coverage, you may request this information from HRCentral Support during the annual enrollment period.

Any change you make during annual enrollment takes effect on January 1—the start of the new plan year.

During the annual enrollment period, you enroll by logging in to YourBenefits.Baxter.com. HRCentral Support can also assist you by phone. However, if your current Baxter Retiree Medical Plan option is available for the upcoming plan year and you want to keep this coverage at the same coverage level, you do not have to do anything to enroll. Your current Retiree Medical Plan option automatically remains in effect for the next plan year at the option's new retiree contribution amount.

However, you must login to YourBenefits.Baxter.com or call HRCentral Support if:

- you want to select a new Retiree Medical Plan option for which you are eligible;
- you want to change your current coverage level;
- you elected to "opt-in" to coverage during the previous plan year and need to "opt-in" to coverage again for the upcoming plan year if the option is not listed as available to you based on your home zip code;
- you want to drop your current Retiree Medical Plan option election; or
- your current Retiree Medical Plan option is not available for the upcoming plan year and you want to continue coverage under a different option.

Important opt-in information
The Retiree Medical Plan options available to you are based on your zip code. However, you may be willing to drive outside your zip code area to access providers associated with an option that is not, according to your enrollment materials, available to you. If this is the case, you may be able to "opt-in" to the other option. Contact the HRCentral Support to determine your eligibility and initiate the opt-in appeal process.

To elect coverage during the annual enrollment period:

- Log on to YourBenefits.Baxter.com or contact HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free) within the time period specified in your enrollment materials.
- The Retiree Medical Plan option you select remains in effect until the end of the plan year unless you have a qualified change in status.

- Review your current elections, your list of eligible dependents and make any necessary changes and/or corrections. Review your confirmation statement after submitting your changes and print your online confirmation statement. If you do not make necessary changes during annual enrollment, you will not be able to make a change until the next annual enrollment period unless you have a qualified change in status.

- When you initially enroll in an HMO* option, you may be required to select a Primary Care Physician (PCP) during your online enrollment. You should select a PCP for each of your covered family members. If the Retiree Medical Plan option you select requires a PCP selection and you do not do so during your online enrollment, you and your dependents will be assigned a PCP based on your zip code. Contact your Retiree Medical Plan HMO option's Member Services department if you want to change your PCP.

If you do not make changes online or call HRCentral Support within the annual enrollment period, your coverages (if available) carry forward for the next plan year. If your current Retiree Medical Plan option is no longer available and you do select a new option, you default to the Participating Provider Option (PPO) or the Blue Preferred POS (POS) for Wisconsin residents, if it is available. Otherwise you will default to the Baxter Traditional Option (BTO), at your current coverage level and you must wait until the next annual enrollment to change your coverage (unless you have a qualified change in status, as explained next).

Qualified change in status

Once you make your elections under the Baxter Retiree Medical Plan, *you may not add or drop dependents or change your medical coverage until the beginning of the next plan year, unless you have a qualified change in status.* To change your coverage or to add or drop an eligible dependent, contact HRCentral Support *within 31 calendar days* (60 days for adoption; legal guardianship or birth of a child) of the date you experience the qualified change in status. The 31 (or 60) calendar days includes weekends and begins on the day on which the change occurs. If you do not make your change within the 31-day period (60 days for adoption, legal guardianship or birth of a child), you must wait until the next annual enrollment or until you have an additional qualified change in status event that is consistent with the desired change.

> **Initiating changes**
> To initiate any changes in coverage due to a qualified change in status, contact HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free). Be sure to call within 31 calendar days of the qualified change in status.

Any change you make must be consistent with your change in status. For example, if you marry and add a new dependent, you may choose to increase coverage. Or, if you become divorced and drop a dependent, you may decrease coverage. You may change your Baxter Retiree Medical Plan coverage option and coverage level (that is, the number of dependents you cover) as long as you have a qualified change in status. You may only make a change if your change in status causes you or your dependents to gain or lose eligibility under a health plan.

The following is a list of events that are considered to be a qualified change in status:

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* Not all HMOs require a PCP selection.

- birth, adoption, placement for adoption, legal guardianship or marriage of a dependent child
- death of a spouse, domestic partner or dependent child
- start or end of your, your spouse's, domestic partner's or dependent's employment
- change in your, your spouse's, domestic partner's or dependent's employment status
- loss of eligible dependent status of your dependent (other than a change in student status)
- your dependent child over the age of 19 enrolls as a full-time student at (or withdraws or graduates from) an accredited high school, college, or university; provided, however, that no more than one such change in student status during a plan year will be considered a qualified change in status event
- marriage, divorce or annulment of marriage[**]
- commencement or termination of a domestic partnership
- you, your spouse, your domestic partner or your dependent initially declines coverage under the Retiree Medical Plan because you are covered under another plan, and you become ineligible for coverage under that plan or the employer providing that coverage stops making contributions to that plan
- you are required to provide dependent medical coverage as the result of a valid court decree which meets the requirements of a qualified medical child support order (QMCSO)

Your coverage change will be effective on the date of the qualifying event.

Changes you make in connection with your dependent over the age of 19 enrolling at an accredited high school, college or university will become effective on the date you submit the required proof of your dependent's eligibility due to his or her student status and elect to add coverage for your dependent, or as soon as administratively possible thereafter.

Your Baxter Retiree Medical Plan ID card

Your Baxter Retiree Medical Plan ID card is separate from your Caremark Prescription Drug Program card (which applies to the PPO, POS, HSA (1 and 2) and BTO). (See the "Prescription Drug Program" section to determine if you are eligible for this program.) You receive an ID card directly from the carrier for your Retiree Medical Plan option. You can use your ID card to verify coverage under the Retiree Medical Plan.

[**] If you marry your domestic partner, you must contact HRCentral Support to change your domestic partner's status to spouse.

Cost of retiree medical coverage
If you are an eligible retiree, your cost of retiree medical coverage depends on when you retire[††].

If you retired on or after January 1, 1990
You pay a percentage of the total premium cost for coverage under the Baxter Retiree Medical Plan. The Retiree Medical Plan bases your percentage of cost on the number of credits[**] you accumulate as of the date your coverage under the Retiree Medical Plan initially begins. (For details on how the Plans calculate credits, see *How the Plans define "eligible retiree"* in the "Who Is Eligible" section of this booklet.) There are five cost share levels: 65 – 69 credits; 70-74 credits; 75 – 79 credits; 80-84 credits; 85 or more credits. The higher credit levels require a lower retiree cost share. You pay 100% of the cost at the 65-69 credit level. Effective January 1, 2017, Baxter has capped the dollar amount of subsidy from the Plan at the amount provided in 2016 at each cost share level.

The Retiree Medical Plan calculates credits by adding together your age (as of the date your retiree medical coverage initially begins) and your years of creditable service (as of the date you leave the company). This means that even though you do not continue to earn creditable service once you leave the company, you continue to earn one additional credit for each year of age until retiree medical coverage initially begins. However, employees hired between January 1, 2003, and December 31, 2015, including employees acquired in a corporate transaction, or employees who terminated employment prior to December 31, 2002, with less than 65 credits and are rehired between January 1, 2003, and December 31, 2016, will only be allowed to "age into" the next cost share level.

If you previously elected retiree medical coverage, and you return to work for Baxter prior to 1/1/2016 and become covered under the Baxter Medical Plan, the Baxter Retiree Medical Plan will take into account the new credits you earn during your most recent employment when determining your cost-share level at the time you subsequently retire and elect retiree medical coverage to begin. If you are rehired on or after January 1, 2016, you will not be credited with additional service following your rehire date.

Baxter reserves the right to amend or change the Retiree Medical Plan at any time, including increasing premium costs, adding or eliminating coverage options and/or changing the cost share percentages.

For employees with 65 or more credits on December 31, 2002, future increases in the Retiree Medical Plan subsidized portion of the total premium costs were subject to a comparable dollar level of subsidy for the options. Effective January 1, 2017, Baxter capped the dollar amount of subsidy from the Retiree Medical Plan at the amount provided in 2016.

[††] If you are an eligible Hillrom retiree, your costs are based on the terms of the Hill-Rom Retiree Medical Plan in effect on December 31, 2022. If you are an eligible Welch Allyn retiree, your costs are based on the terms of the Welch Allyn Retiree Medical Plan in effect on December 31, 2022.

[**] Prior to October 1, 1997, these are referred to as points.

In general, for employees with less than 65 credits on December 31, 2002, future increases in the Retiree Medical Plan subsidized portion of the total premium costs (if any)were capped at the lower of: (1) Medical Consumer Price Index, or (2) 5%. Effective January 1, 2017, Baxter capped the dollar amount of subsidy from the Retiree Medical Plan at the amount provided in 2016.

In general, for employees hired by Baxter between January 1, 2003 and December 31, 2015, including employees hired as part of an acquisition or purchase, and employees who terminated prior to December 31, 2002, with less than 65 credits on their date of termination and who are rehired between January 1, 2003 and December 31, 2016, the Retiree Medical Plan-subsidized portion of the applicable total premium cost was reduced, and any future increases in the Retiree Medical Plan-subsidized portion of the total premium costs (if any) were capped at the lower of: (1) Medical Consumer Price Index, or (2) 5%. Effective January 1, 2017, Baxter capped the dollar amount of subsidy from the Retiree Medical Plan at the amount provided in 2016.

By logging on to YourBenefits.Baxter.com you can view your Baxter Retiree Medical Plan Credits and current contribution rates for each Retiree Medical Plan option, which may change each plan year.

If you retired before January 1, 1990
Your cost share level is based on the 80 – 84 credit level for those who retired after January 1, 1990. Effective January 1, 2017, Baxter capped the dollar amount of subsidy from the Retiree Medical Plan at the amount provided in 2016.

If you retired during a "window period" or under the Special Retirement Program (SRP)
If you retired during the "window period"—between January 1, 1990, and December 31, 1990—or you retired under the Special Retirement Program (SRP) at any time, you pay a percentage of the total premium cost for retiree medical coverage. The Retiree Medical Plan based your percentage of cost on the number of credits you had on the date your coverage initially began under the Baxter Retiree Medical Plan (for details on how the Retiree Medical Plan calculates credits, see *How the Plan defines "eligible retiree,"* in the "Who Is Eligible" section of this booklet). There are two cost share levels based on your accumulated credits at the time you first elected retiree medical coverage: 65-84 credits; 85 or more credits. The higher credit levels require a lower retiree cost share. Effective January 1, 2017, Baxter capped the dollar amount of subsidy from the Retiree Medical Plan at the amount provided in 2016.

By logging on to YourBenefits.Baxter.com you can view the current contribution rates for each Retiree Medical Plan option, which may change each plan year.

Cost of retiree medical coverage for a surviving spouse or domestic partner

If you elect coverage under the Baxter Retiree Medical Plan and die, your surviving spouse or domestic partner continues to pay for retiree medical coverage at the same share level.

If you elect coverage under the American Benefit Choice Program and die, the share level applicable to your surviving spouse or domestic partner depends on the following:

- If your spouse or domestic partner is younger than age 65, he or she continues to pay 40% (and Baxter pays 60%) of the total premium cost for retiree medical coverage.

- If your spouse or domestic partner is age 65 or older, Baxter continues to pay 100% of the total premium cost for retiree medical coverage. Coverage is available to your spouse or domestic partner at no cost.

As previously noted, Baxter reserves the right to amend or change the Retiree Medical Plan at any time, including increasing premium costs, adding or eliminating coverage options and/or changing the cost share percentages.

A Snapshot of the Options and How the Retiree Medical Plan Pays Benefits

This section provides an overview of the features and benefits of the Retiree Medical Plan options.

A snapshot of the Retiree Medical Plan options for eligible retirees
Some of the Retiree Medical Plan options are "self-insured." This means that the Retiree Medical Plan pays benefits from Baxter general assets, and that Baxter has an Administrative Service Contract with each option's claims administrator to access network providers and process claims. The self-insured Retiree Medical Plan options include:

- Baxter Traditional Option (BTO);

- Participating Provider Option (PPO);

- Blue Preferred POS (POS);

- Health Savings Account (HSA (1 and 2)) Options; and

The Retiree Medical Plan offers Health Maintenance Organizations (HMOs) to retirees who live in certain areas. Keep in mind, however, that not all available HMOs offer retirees coverage.

HMOs are "insured" products. This means they are subject to state insurance laws and may pay benefits for certain services that the other Retiree Medical Plan options do not cover. In addition, coverage is subject to the terms and conditions of the agreement between Baxter and each HMO, as well as each HMO's established procedures. As a result, this booklet does not describe HMO coverage in detail. Contact the HMO directly for detailed information about the HMO's benefits, covered services, claims procedures, and required copayments or coinsurance.

Generally, all of the Retiree Medical Plan options cover the same types of medical services. However, the deductibles, copayments, coinsurance amounts, annual out-of-pocket maximums, and the *way* the Retiree Medical Plan covers the services may differ. The chart on the following page is a snapshot of all of the self-insured Retiree Medical Plan options. Many of the terms highlighted in the chart are defined in detail on the following pages.

> As long as you or your covered dependent is eligible for Medicare (regardless of age), the Retiree Medical Plan coordinates with both Medicare Parts A and B coverage, regardless of whether you or your covered dependent elects Medicare coverage. If you are (or a covered dependent is) eligible for Medicare, but fail to enroll, your Retiree Medical Plan benefits will be reduced by an estimate of the amount that Medicare would have paid.

The Retiree Medical Plan options—and the costs associated with each—may change in future plan years. In all cases, the options and costs are subject to Baxter's decision to continue to offer retiree medical coverage.

A snapshot of the Retiree Medical Plan options for eligible Hillrom retirees

The Retiree Medical Plan options available to you are "self-insured." This means that the Retiree Medical Plan pays benefits from Baxter general assets, and that Baxter has an Administrative Service Contract with each option's claims administrator to access network providers and process claims. The self-insured Retiree Medical Plan options include:

- Health Savings Account (HSA (1 and 2)) Options

Generally, all of the Retiree Medical Plan options cover the same types of medical services. However, the deductibles, copayments, coinsurance amounts, annual out-of-pocket maximums, and the *way* the Retiree Medical Plan covers the services may differ. The chart on the following page is a snapshot of all of the self-insured Retiree Medical Plan options. Many of the terms highlighted in the chart are defined in detail on the following pages.

The Retiree Medical Plan options—and the costs associated with each—may change in future plan years. In all cases, the options and costs are subject to Baxter's decision to continue to offer retiree medical coverage.

> As long as you or your covered dependent is eligible for Medicare (regardless of age), the Retiree Medical Plan coordinates with both Medicare Parts A and B coverage, regardless of whether you or your covered dependent elects Medicare coverage. If you are (or a covered dependent is) eligible for Medicare, but fail to enroll, your Retiree Medical Plan benefits will be reduced by an estimate of the amount that Medicare would have paid.

A snapshot of the Retiree Medical Plan options for eligible Welch Allyn retirees
The Retiree Medical Plan offers the following plans to eligible Welch Allyn retirees. Eligibility for each plan is based the requirements in the applicable retiree medical plan sponsored by Welch Allyn, Inc. (the "Welch Allyn Retiree Medical Plan") on December 31, 2022.

- Welch Allyn Medical Plan 100
- Welch Allyn Medical Plan 80

The options listed above are "insured" products. This means they are subject to state insurance laws and may pay benefits for certain services that the other Retiree Medical Plan options do not cover. In addition, coverage is subject to the terms and conditions of the agreement between Baxter and each plan option, as well as each option's established procedures. As a result, this booklet does not describe coverage in detail. Contact the plan administrator directly for detailed information about your benefits, covered services, claims procedures, and required copayments or coinsurance.

The Retiree Medical Plan options—and the costs associated with each—may change in future plan years. In all cases, the options and costs are subject to Baxter's decision to continue to offer retiree medical coverage.

> As long as you or your covered dependent is eligible for Medicare (regardless of age), the Retiree Medical Plan coordinates with both Medicare Parts A and B coverage, regardless of whether you or your covered dependent elects Medicare coverage. If you are (or a covered dependent is) eligible for Medicare, but fail to enroll, your Retiree Medical Plan benefits will be reduced by an estimate of the amount that Medicare would have paid.

Comparisons of the Retiree Medical Plan Options					
Plan Feature	**Baxter Traditional Option (BTO)**	**Health Maintenance Organizations (HMOs)** *Available at some locations*	**Participating Provider Option (PPO) and Blue Preferred POS (POS)**	**Health Savings Account (HSA 1) Option**	**Health Savings Account (HSA 2) Option**
			Services Provided by a Network Provider*	**Services Provided by a Network Provider***	**Services Provided by a Network Provider***
Plan Year deductible • Individual • Family	$500 $1,000	$0 $0	$500 $1,000	$2,000 $4,000	$5,000 $10,000
Copayments •Primary Care Physician Office Visit •Specialist Office visit	N/A	Varies depending on which HMO you select	$25 copay $40 copay	80% (after deductible)	80% (after deductible)
Coinsurance	80% (after deductible)	Varies depending on which HMO you select	80% after deductible (copayments may apply)	80% after deductible	80% after deductible
Plan Year out-of-pocket maximum • Individual • Family	(includes deductible) $2,900 $5,800	Most HMOs do not have a stated coinsurance maximum since they usually pay 100% of covered expenses beyond applicable copayments	(includes deductible and copayments) $2,900 $5,800	(includes deductible) $4,000 $8,000	(includes deductible) 6,000 $12,000
Prescription drugs	CVS Caremark's Prescription Drug Program	Varies depending on which HMO you select	CVS Caremark Prescription Drug Program	CVS Caremark Prescription Drug Program	CVS Caremark Prescription Drug Program
No Coverage Option	You may waive all medical coverage. Doing so means you will not have any medical coverage under the Baxter Retiree Medical Plan.				

* See the detailed schedule of benefits for information on services not provided by a network provider.
Percentages (%) shown in this table represent the percentage of eligible charges the Retiree Medical Plan will pay. The eligible charge may be less than the actual billed charges. You are responsible for any expenses in excess of the eligible charge, in addition to any copayment, deductible and coinsurance amounts. PPO POS and HSA (1 and 2) network providers agree to accept negotiated fees and not bill for charges in excess of those fees.

Temporary COVID-19 Provisions

This section describes temporary Plan coverage provisions in response to the COVID-19 outbreak.

Coverage of COVID-19 Tests

The HSA (1 and 2), BTO, PPO, and POS Baxter Medical Plan options will pay 100% for certain COVID-19 tests, as described below:

Coverage	Description	Temporary Coverage Period
COVID-19 diagnostic testing ordered by treating health care provider	The Plan will cover approved COVID-19 diagnostic testing, plus certain other tests and services performed during a health care provider visit to determine an individual's need for COVID-19 diagnostic testing, with no deductible, coinsurance, or other cost-sharing requirements. Coverage will be provided for testing services provided by a network provider or out-of-network provider. Coverage includes at-home COVID-19 tests when the test is ordered by an attending health care provider who has determined that the test is medically appropriate for the individual based on current accepted standards of medical practice.	From March 18, 2020, through the end of the expiration of the U.S. Department of Health & Human Services Secretary's COVID-19 public health emergency declaration

For information about the U.S. Department of Health & Human Services Secretary's COVID-19 public health emergency declaration, contact Baxter HRCentral Support at 1-844-249-8581 for English, or 1-844-249-8803 for Spanish, Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time.

Temporary Extension of Certain Benefit Deadlines

Effective March 1, 2020, certain important deadlines are temporarily extended due to the COVID-19 outbreak. This temporary relief effectively pauses certain benefits-related time limits that would normally run during the "**COVID Emergency Period**," which began on March 1, 2020, and will end **60 days after the expiration of the COVID-19 national emergency declaration**. Impacted deadlines are temporarily paused for the "**Extension Period**," which is determined on an individual-by-individual basis, measured from the date of the triggering event. For the deadlines described below, the Extension Period began on March 1, 2020, and will end as of the *earlier* of (i) the end of the **COVID Emergency Period** (*i.e.*, 60 days after the expiration of the COVID-19 national emergency declaration), or (ii) **one calendar year** from the date of the triggering event. For information about the COVID-19 national emergency declaration, contact Baxter HRCentral Support at 1-844-249-8581 for English, or 1-844-249-8803 for Spanish, Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time.

- *Extra time to enroll in medical insurance coverage for "special enrollment" events* – The Extension Period is disregarded in applying the 31- or 60-day deadline to request to enroll yourself or your eligible family member(s) in Baxter Medical Plan coverage because of a special enrollment event (*i.e.*, birth, adoption, placement for adoption, marriage, loss of coverage under another group health plan, loss of coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or new eligibility for premium assistance under CHIP or Medicaid), as described in the section entitled "Special enrollment rules".

- *Extra time to give notice of a qualifying event, second qualifying event, or disability determination* – Notice deadlines described in the section entitled "Your Legal Right to Continue Coverage Under COBRA" are temporarily extended due to the COVID-19 outbreak. The Extension Period is disregarded in calculating the 60-day period to notify HRCentral Support of your divorce or termination of domestic partnership, or of a dependent child's loss of eligibility for coverage. In addition, if you and/or your family members are covered under COBRA due to the termination of your employment or reduction of your hours of employment with Baxter, the Extension Period is disregarded in calculating the 60-day period to notify HRCentral Support of (i) the Social Security Administration's determination of a covered family member's disability (the notice must still be provided before the end of the initial 18-month COBRA period), or (ii) a second qualifying event that would have caused your dependent to lose coverage under the plan if your employment termination or reduction in hours had not occurred.

- *Extra time to enroll in COBRA* – The Extension Period is disregarded in calculating the 60-day period to enroll in COBRA continuation coverage, as described in the section entitled "Your Legal Right to Continue Coverage Under COBRA".

- *Extra time to make your COBRA payment without losing your coverage* – The Extension Period is disregarded in calculating the deadlines to pay your COBRA continuation coverage premiums as described in the section entitled "Your Legal Right to Continue Coverage Under COBRA". Your COBRA coverage will be pended (put on hold) until you've paid your first premium. However, as long as you timely make your COBRA premium payments by the end of the extended deadline, your coverage will be reinstated back to the date you lost coverage. In addition, you will have 30 days after the end of the Extension Period to make any subsequent monthly COBRA premium payments that become due during the COVID Emergency Period. You will still be responsible for all premiums for the entire period you and your dependents have COBRA coverage.

- *Extra time to submit claims, appeals, and requests for external review* – The Extension Period is disregarded in calculating the deadlines for claimants to submit claims for benefits, to request appeals of denied benefit claims, or to request external review of denied medical claims as described in the section entitled "Filing a Health Care Claim".

How the Retiree Medical Plan pays benefits

You and Baxter share the cost of covered medical expenses each plan year. Depending on the Retiree Medical Plan option you select, and whether a PCP provides or coordinates your care, different deductibles, copayments, coinsurance and out-of-pocket maximums apply (as shown in the chart above).

Deductible
The deductible is the amount of money you must pay each plan year for covered medical care before the Retiree Medical Plan begins to pay benefits. Covered medical expenses for several different illnesses or injuries may be added together to meet the deductible. Under the BTO, PPO, and POS options, you are subject to both individual and family deductibles. Under the HSA (1 and 2), you are subject to the individual deductible if you are enrolled in individual (retiree-only) coverage; if you cover dependents the family deductible must be met before the Retiree Medical Plan begins to pay benefits.

Individual Deductible
BTO, PPO and POS: The individual deductible applies to each covered person. Once you meet the individual deductible (even if you have family coverage), the Retiree Medical Plan begins paying benefits.

HSA (1 and 2): The individual deductible applies if you have retiree only coverage (*i.e.*, you don't cover dependents). Once you meet the individual deductible, the Retiree Medical Plan begins paying benefits.

Refer to the chart in the "A Snapshot of the HSA (1 and 2), BTO, PPO and POS" section for the individual deductible amounts under the HSA (1 and 2), BTO, PPO and POS options.

Family Deductible
BTO, PPO and POS: Two or more covered family members can be combined to meet the family deductible. The Retiree Medical Plan requires only one individual deductible if two or more members are injured in the same accident and incur covered medical expenses.

HSA (1): If you cover dependents, you and your covered dependents must meet the family deductible amount. The family deductible may be met by any combination of covered family members, but no benefits (other than for preventive care) will be payable for any individual covered person until the entire family deductible has been met.

HSA (2): If you cover dependents, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible before the plan pays benefits (other than for preventive care).

Refer to the chart in the "A Snapshot of the HSA (1 and 2) BTO, PPO and POS" section for the family deductible amounts under the HSA (1 and 2), BTO, PPO and POS options.

Copayment
The Retiree Medical Plan may require a copayment before paying benefits. A copayment is a fixed fee and generally applies to certain services, such as office visits or hospitalization. Once

you meet the copayment amount for office visits, the Retiree Medical Plan generally pays 100% of the remaining eligible charges.

Copayments also apply to prescription drugs. See the "Prescription Drug Program" section of this booklet.

Coinsurance
The Retiree Medical Plan pays a percentage of your medical costs after you pay the deductible or copayment (if applicable). The amount the Retiree Medical Plan pays is called "coinsurance." Generally, the Retiree Medical Plan pays a percentage of eligible charges and you pay the remaining costs.

Coinsurance also applies to prescription drugs. See the "Prescription Drug Program" section of this booklet.

Out-of-pocket maximum
When your share of eligible charges reaches the out-of-pocket maximum, the Retiree Medical Plan starts paying 100% of most eligible charges for the rest of the plan year.

BTO, PPO and POS: Two or more covered persons can satisfy the family out-of-pocket maximum (where applicable). Exceptions to the 100% benefit are described later in this booklet.

HSA (1): If you cover dependents, two or more out-of-pocket maximum must be met. Coinsurance will apply for covered family members until the full family out-of-pocket maximum has been met.

HSA (2): If you cover dependents, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

There is a separate out-of-pocket maximum which applies to prescription drugs. See the "Prescription Drug Program" section of this booklet.

Maximum benefits
The Retiree Medical Plan options pay an unlimited amount of lifetime benefits for eligible charges for you and each of your covered dependents. Certain services may be subject to annual benefit or visit maximums and are described later in this booklet. HMOs may have different benefit maximums. If you are enrolled in an HMO, refer to your HMO materials for details.

Primary Care Physicians (PCPs)
If you enroll in an HMO, the HMO may require you to choose a PCP for you and your covered family members. A PCP is trained in general medicine and can be a valuable resource to have when you need medical care.

Some doctors belong to Independent Physician Associates (IPAs), which require them to refer only to other members of that IPA. If seeing a particular specialist who is not an IPA member is important to you, be sure to discuss this with your physician.

Medically necessary determination
The Retiree Medical Plan only covers the cost of hospitalization or any health care services and supplies that are determined by the claims administrator to be "medically necessary." In other words, the service, supply or confinement must be necessary for the diagnosis, care or treatment of the illness or injury. You can request a pre-determination of benefits for a health care service

or supply by contacting the claim administrator. Additionally, all hospital admissions must be pre-certified. The claims administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your physician. The claims administrator's determination of medically necessary care is limited to determining whether a proposed admission, continued hospitalization or other health care service is a covered service under the Retiree Medical Plan. For further information on exclusions from coverage, see the section of this booklet entitled "What the Retiree Medical Plan does not cover."

Eligible charge
If you are enrolled in the BTO, PPO, HSA (1 and 2) or POS coverage option, the eligible charge is the amount charged by a provider that is considered by the Retiree Medical Plan in determining the benefits paid by the Retiree Medical Plan.

Providers who are contracted with the claims administrator agree to bill according to a negotiated fee schedule. For a network provider, the billed charge is the eligible charge.

Non-contracted providers can bill independent of a negotiated fee schedule. In other words, when you elect to utilize the services of an out-of-network provider, the Retiree Medical Plan does not pay benefits based upon the amount billed. If you elect to receive covered services from a non-contracted provider, any amounts exceeding the eligible charge can be balance billed to you. Amounts over the eligible charge do not apply to the deductible or out-of-pocket maximum.

Except as described in the "Balance Billing and Other Protections" section below, The eligible charge amount for physicians/other health care professionals and hospital services provided by non-contracted providers is determined by the claims administrator and is based on Medicare reimbursement rates, excluding any Medicare adjustments which are based on information on the claim. If there is no base Medicare reimbursement rate available for a particular service or supply, or if the base Medicare reimbursement rate cannot be determined, then the eligible charge is based on 150% of the non-contracted facility provider's or 100% of the non-contracted professional provider's standard claim charges (unless otherwise required by applicable law or arrangement with the non-contracted provider), but the claims administrator may limit that amount to the lowest contracted rate that the claims administrator has with a network provider for the same or similar services. When utilizing a non-contracted provider, you should request a predetermination of benefits for any service to determine the coverage and the cost.

All references to eligible charges assume that the charges are for covered services determined to be medically necessary.

Balance Billing and Other Surprise Billing Protections
Federal requirements, including, but not limited to, the Consolidated Appropriations Act, 2021, may impact your benefits. Blue Cross will apply federal surprise billing protection requirements in administering benefit claims under the Plan, where applicable.

For some types of out-of-network care, your out-of-pocket expenses are limited under federal surprise billing rules. In these cases, a non-contracted health care provider may not bill you more than the in-network copayment/coinsurance amount. If you receive the types of care listed below, your copayment/coinsurance will be calculated as if you received covered services from a

network provider. Coinsurance amounts will be based on the median contracted rate. Those copayment/coinsurance amounts will apply to any in-network deductible and out-of-pocket maximums.

• • Emergency services from non-contracted providers, as described below;

• • Certain non-emergency care furnished by non-contracted providers during your visit to a network facility, as described below; and

• • Air ambulance services from non-contracted providers.

Emergency services

The Plan will cover emergency services without the need for prior authorization. Emergency services performed by a non-contracted provider are covered at the in-network benefit level, and you cannot be balance billed. These surprise billing protections apply to emergency services provided until your treating non-contracted provider determines that you are medically stable and that you are able to travel a reasonable distance using nonemergency transport. If you continue to receive care from a non-contracted provider once you are stabilized, you are in a condition to receive information from your non-contracted provider and to provide informed consent to receive out-of-network services, and your non-contracted provider has met notice and consent requirements with respect to the services, you may be responsible for any amount in excess of the eligible charge, as described below.

Ancillary out-of-network services provided at a network facility

Federal surprise medical protections also apply if you receive certain ancillary services from a non-contracted provider during your visit to a network facility – for example, emergency medicine, anesthesiology, pathology, radiology and other diagnostic services, neonatology, laboratory services, and other specialty services as may be defined by applicable law.

Other out-of-network services provided at a network facility will be covered at the out-of-network level if the non-contracted provider satisfies notice requirements, and you provide your consent for the out-of-network services.

Notice and consent

There are limited instances when a non-contracted provider performing services at a network facility or post-emergency care stabilization services may send you a bill for up to the amount of that provider’s billed charges. You are only responsible for payment of the out-of-network provider’s billed charges if, in advance of receiving such services, you signed a written notice that informed you of:

• • The provider’s out-of-network status;

• • In the case of services received from a non-contracted provider at a network facility, a list of network providers at the facility who could offer the same services;

• Information about whether prior authorization or other utilization management limitations may be required in advance of services; and

• • A good faith estimate of the provider’s charges.

You should contact Blue Cross if you receive a balance bill for emergency care or for care received while at a network facility

Continuity of Care
If you are under the care of a contracted provider who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that provider's covered services at the in-network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the provider (including receipt of postoperative care from such provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this section shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies you of the provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the section of this booklet entitled "Filing a Health Care Claim".

Coordination of benefits
Benefits from the Baxter Retiree Medical Plan coordinate with other group plans under which you or your dependents are covered. This is called "coordination of benefits" (COB). See the "Coordination of Benefits" section of this booklet for more information on the COB feature.

In addition, if you or one of your covered dependents is eligible for Medicare, benefits coordinate with Medicare as described in the "Coordination of Benefits" section. However, the Retiree Medical Plan will not coordinate with Medicare Part D. You are responsible for notifying HRCentral Support and the claims administrator if you or one of your dependents becomes eligible for Medicare or of any change in Medicare eligibility status.

Your Baxter Retiree Medical Plan Options

This section provides the schedule of benefits for the HSA (1 and 2), BTO, PPO and POS Baxter Retiree Medical Plan options. For each of these options, the Retiree Medical Plan covers services and supplies that are determined by the claims administrator to be "medically necessary." You can request a predetermination of benefits for a health care service or supply by contacting the claims administrator. Additionally, you are responsible for precertifying all hospital admissions, skilled nursing facility services, services received in a coordinated home care program, and private duty nursing services. If you don't precertify, penalties apply. The toll-free Member Services number is printed on your medical ID card.

Baxter Traditional Option (BTO)

Under the BTO, you must first pay the Retiree Medical Plan's deductible before the Retiree Medical Plan pays 80% of the eligible charge. After your expenses reach the out-of-pocket maximum, the Retiree Medical Plan pays 100% of the additional eligible charges for covered services the rest of the plan year.

The following benefit summary shows how the Retiree Medical Plan pays benefits for covered services under the BTO.

Baxter Traditional Option (BTO)	
Plan year Deductible • Individual • Family	 $500 $1,000
Coinsurance	80% after deductible
Plan year out-of-pocket maximum (including deductible) • Individual • Family	 $2,900 $5,800
Maximum benefits • Lifetime overall benefits	 Unlimited
Preventive care	Wellness—Plan offers certain standard "wellness-type" benefits, at 100%. No deductible.

Baxter Traditional Option (BTO)	
Precertification requirements	• **You initiate the precertification review process at least one business day before any scheduled admission or within two business days of an emergency admission for inpatient hospital services, skilled nursing facility services, services received in a coordinated home care program and private duty nursing services. When utilizing a contracting provider, the provider will initiate the review process.** • Plan reduces coverage to 50% of eligible charges after deductible if you do not precertify an admission at a non-contracted provider. • Plan does not pay benefits for services determined not to be medically necessary.
Diagnostic X-ray and laboratory (facility and professional services)	80% after deductible
Inpatient hospital (facility services) • Semi-private room • Private room • Intensive care unit	80% after deductible Limited to semi-private room rate Limited to semi-private room rate Limited to intensive care unit room rate
Inpatient hospital (doctor's visits/consultations)	80% after deductible
Inpatient hospital (professional services) • Surgeon • Radiologist • Pathologist • Anesthesiologist	 80% after deductible 80% after deductible 80% after deductible 80% after deductible
Second surgical opinion (voluntary)	80% after deductible
Outpatient surgical (facility services)	80% after deductible
Outpatient (professional services) • Surgeon • Radiologist • Pathologist • Anesthesiologist	 80% after deductible 80% after deductible 80% after deductible 80% after deductible
Outpatient preadmission testing	80% after deductible
Emergency care • Hospital emergency room • Outpatient facility • Other urgent care facility	80% after deductible and $100 copay (copay waived if admitted)
Ambulance (not covered unless medically necessary)	80% after deductible
Skilled Nursing and Rehabilitation (up to 120 days per plan year)*	80% after deductible
Outpatient Short-Term Rehabilitation (up to 60 days per plan year)* • Physical therapy • Speech therapy • Occupational therapy	80% after deductible
Chiropractic therapy	80% after deductible
Outpatient acupuncture (up to 20 visits per plan year)	80% after deductible
Durable Medical Equipment (DME)/Prosthetics	80% after deductible
Home health care (up to 120 visits per plan year)*	80% after deductible

* Additional days or visits may be approved if determined to be medically necessary to improve condition.

Baxter Traditional Option (BTO)	
Temporomandibular joint dysfunction (TMJ)	Not covered
Hospice • Inpatient facility • Outpatient	 80% after deductible 80% after deductible
Maternity • Initial visit to determine pregnancy • All subsequent charges related to prenatal visits, postnatal visits and delivery • Hospital admission	 80% after deductible 80% after deductible 80% after deductible
Organ transplants • Inpatient facility • Physicians services	 80% after deductible 80% after deductible
Mental health/substance abuse	Inpatient and outpatient services covered at 80% after deductible
Infertility treatment/testing (office visit including tests and diagnosis) • Artificial insemination • In-vitro fertilization • Infertility surgery (for diagnostic purposes) • Inpatient facility (for diagnostic purposes) • Outpatient facility (for diagnostic purposes)	80% after deductible Not covered Not covered 80% after deductible 80% after deductible 80% after deductible
Prescription Drug Coverage	CVS Caremark Prescription Drug Program

Participating Provider Option (PPO) and Blue Preferred POS (POS)

The Baxter Retiree Medical Plan offers the Participating Provider Option (PPO) to those who are younger than age 65 and are not Medicare eligible.

The following benefit summary plan shows how the Retiree Medical Plan pays benefits for covered services under the PPO and POS coverage options. Percentages (%) shown in this table represent the percentage of eligible charges the Retiree Medical Plan will pay. The PPO and POS provides higher benefits when you use in-network providers. If you are enrolled in the Blue Preferred POS (POS), Wisconsin doctors and facilities not in the Blue Preferred POS are covered at the out of network benefit level. For care outside of Wisconsin, you can access the PPO network providers.

To find a network provider or to check on the network status of a provider, visit www. bcbsil.com.

Both in-network and out-of-network eligible charges will be applied to satisfy the in-network deductibles and out-of-pocket maximums. In-network charges, however, will not be applied to satisfy out-of-network deductibles and out-of-pocket maximums.

Participating Provider Option (PPO) and Blue Preferred POS (POS)		
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Plan Year Deductible • Individual • Family	 $500 $1,000	 $1,000 $2,000
Office visits • Primary Care • Specialist	 $25 copay $40 copay	 60% after deductible 60% after deductible
Coinsurance	80% (copayments may apply)	60% after deductible
Plan Year out-of-pocket maximum (including deductibles and copayments) • Individual • Family	 $2,900 $5,800	 $5,800 $11,600
Maximum benefits • Lifetime overall benefits	 Unlimited	 Unlimited

Participating Provider Option (PPO) and Blue Preferred POS (POS)		
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Preventive care **Routine Preventive Care: Well-baby, Well-Child, Well-Woman, Adult (Including immunizations and lab services). Colonoscopy, Mammogram, Pap Test**	100%	60% after deductible
Precertification requirements	• Your provider initiates the review process at least one business day before any scheduled admission or within two business days of an emergency admission for inpatient hospital services, skilled nursing facility services, services received in a coordinated home care program and private duty nursing services. • Plan does not pay benefits if admission is not approved. • Plan does not pay benefits for additional days if not certified.	• You initiate the review process at least one business day before any scheduled admission or within two business days of an emergency admission for inpatient hospital services, skilled nursing facility services, services received in a coordinated home care program and private duty nursing services. • $500 penalty applies if you don't precertify a scheduled admission at a non-contracted provider. • Plan does not pay benefits if admission is not approved. • Plan does not pay benefits for additional days if not certified.
Diagnostic X-ray and laboratory (facility services)	80%	60% after deductible

Participating Provider Option (PPO) and Blue Preferred POS (POS)		
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Inpatient hospital (facility services) • Semiprivate room • Private room • Intensive care unit	80% after deductible Limited to semiprivate contract rate Limited to semiprivate contract rate Limited to intensive care unit contract rate	60% after deductible Limited to semiprivate room rate Limited to semiprivate room rate Limited to intensive care unit daily room rate
Inpatient hospital (doctor's visits/ consultations)	80% after deductible	60% after deductible
Inpatient hospital (professional services) • Surgeon • Anesthesiologist • Radiologist • Pathologist	 80% after deductible 80% after deductible 80% after deductible 80% after deductible	 60% after deductible 60% after deductible 60% after deductible 60% after deductible
Second surgical opinion (not required)	$25 primary care physician copay $40 specialist copay	60% after deductible
Outpatient surgical (facility services)	80% after deductible	60% after deductible
Outpatient (professional services) • Surgeon • Anesthesiologist • Radiologist • Pathologist	 80% after deductible 80% after deductible 80% 80%	 60% after deductible 60% after deductible 60% after deductible 60% after deductible
Outpatient preadmission testing	80%	60% after deductible
Emergency care • Hospital emergency room • Outpatient facility • Urgent care facility	 80% after deductible and $125 copay (copay waived if admitted)	 $125 copay (waived if admitted); 80% after in-network deductible and copay, unless determined not to be a true emergency; then 60% after copay and deductible
Ambulance (not covered unless medically necessary)	80% after deductible	80% after deductible unless determined not to be a true emergency, then 60% after deductible

Participating Provider Option (PPO) and Blue Preferred POS (POS)		
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Inpatient skilled nursing and rehabilitation (up to 90 days per plan year)*	80% after deductible	60% after deductible
Outpatient short-term rehabilitation (up to 90 days per plan year)* • Physical therapy • Cardiac rehab • Speech therapy • Occupational therapy	$40 copay per visit	60% after deductible
Chiropractic therapy (up to 20 visits per plan year)	$40 copay per visit	60% after deductible
Outpatient acupuncture (up to 20 visits per plan year)	$40 copay per visit	60% after deductible
Durable Medical Equipment (DME)/Prosthetics	80% after deductible	60% after deductible
Home health care (including private-duty nursing – which is subject to Health plan approval)	80% after deductible (unlimited visits)	60% after deductible (up to 120 visits per plan year reduced by any in-network visits)*
Hospice • Inpatient • Outpatient	 80% after deductible 80% after deductible	 60% after deductible 60% after deductible
Maternity • Initial visit to determine pregnancy • All subsequent charges related to prenatal visits, postnatal visits, and delivery • Hospital admission	 $25 copay; $40 for specialist 80% after deductible 80% after deductible	 60% after deductible 60% after deductible 60% after deductible
Organ transplants • Inpatient facility • Physician's services	 80% (100% at a Blue Distinction Centers for Transplant (BDCT)) after deductible 80% (100% at a Blue Distinction Centers for Transplant (BDCT)) after deductible	 60% after deductible 60% after deductible

* Additional days or visits may be approved if determined to be medically necessary to improve condition.

Participating Provider Option (PPO) and Blue Preferred POS (POS)		
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Mental health/substance abuse	Inpatient services covered at 80% after deductible Outpatient visits: no charge after $25 per visit copay Group therapy: no charge after $25 per visit copay	Inpatient services covered at 60% after deductible Outpatient services covered at 60% after deductible Group therapy: covered at 60% after deductible
Infertility treatment/testing (office visit including tests and diagnosis)	$40 copay	60% after deductible
• Artificial insemination	Not covered	Not covered
• In-vitro fertilization	Not covered	Not covered
• Infertility surgery (for diagnostic purposes)	80% after deductible	60% after deductible
• Inpatient facility (for diagnostic purposes)	80% after deductible	60% after deductible
• Outpatient surgical facility (for diagnostic purposes)	80% after deductible	60% after deductible
Temporomandibular joint dysfunction (TMJ) – Non-surgical Limited benefit provided on a case-by-case basis. Always excludes appliances and orthodontic treatment.		
Doctor's office	$40 specialist's office visit copay 80% no deductible for x-ray/lab if billed by a separate outpatient diagnostic facility	60% after deductible
Vision exams	Not covered	Not covered
Allergy testing, serum, shots	$40 copay or the actual charge (whichever is less). No charge for injection only, when no physician visit occurs.	60% after deductible
Prescription drug coverage	CVS Caremark Prescription Drug Program	

Health Savings Account (HSA (1 and 2)) Options

The HSA Plan is a consumer driven health plan paired with a Health Savings Account (HSA). If you enroll in either of the **HSA (1 and 2)** options you may establish an HSA with a bank of your choice and make tax-deductible contributions. The annual contribution limit is subject to the annual IRS maximum - $3,650 for individual coverage or $7,300 for family coverage in 2021. If you will be 55 or older at any time during the 2023 plan year, you can contribute an additional $1,000. In some states, these contributions may not be tax-free at the state level.

You are not eligible to contribute to or receive HSA contributions if:

- **You are enrolled in Medicare;**
- **You are enrolled in coverage that is not a high deductible health plan (such as coverage under your spouse's general use health care flexible spending account); or**
- **You can be claimed as another person's tax dependent.**

HSA (1 and 2) funds can only be used to pay for qualified medical eligible expenses incurred by you or by dependents you can claim on your federal tax return.

If you do not use up the funds in your HSA to pay for qualified medical expenses in the current plan year, you can allow the account to accumulate over time. Unused funds roll over from year to year and can be used to pay for future medical expenses.

Under the HSA (1 and 2) options, you are responsible for 100% on non-preventive medical care and prescription drug costs up to the deductible (brand diabetes medications, preventive care and preventive generic drugs on the CVS Caremark Generic Preventive Drug List are not subject to the deductible). Under HSA (1) if you choose coverage for yourself and any dependents, the network and out-of-network deductibles may be met by any combination of family members. , but no benefits will be payable for any covered person until the entire applicable family deductible has been met. Coinsurance for the family will apply until the full family out-of-pocket maximum has been met. Under HSA (2) you or a family member must pay all of the costs up to the individual deductible amount before this plan begins to pay. Coinsurance for you will apply until your out-of-pocket limit is met. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

The following benefit summary shows how the Retiree Medical Plan pays benefits for covered services under the HSA (1 and 2) options. Percentages (%) shown in this table represent the percentage of eligible charges the Retiree Medical Plan will pay. The HSA (1 and 2) plans utilizes the PPO network and provides higher benefits when you use in-network providers.

To find a PPO network provider or to check on the network status of a provider, visit www. bcbsil.com or call Blue Cross through HRCentral Support (1-844-249-8581 English Toll-Free, or 1-844-249-8803 Spanish Toll-Free).

Both in-network and out-of-network eligible charges will be applied to satisfy the in-network deductibles and out-of-pocket maximums. In-network charges, however, will not be applied to satisfy out-of-network deductibles and out-of-pocket maximums. Prescription drug expenses

under the CVS Caremark Prescription Drug Program will contribute to the in-network deductible and out-of-pocket maximum.

Health Savings Account (HSA 1) Plan			Health Savings Account (HSA 2) Plan	
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Plan Year Deductible				
• Individual	$2,000	$4,000	$5,000	$10,000
• Family	$4,000	$8,000	$10,000	$20,000
Office visits				
• Primary Care	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Specialist	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Coinsurance	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Plan Year out-of-pocket maximum (including deductibles and copayments)				
• Individual	$4,000	$8,000	$6,000	$12,000
• Family	$8,000	$16,000	$12,000	$24,000
Maximum benefits				
• Lifetime overall benefits	Unlimited	Unlimited	Unlimited	Unlimited

Health Savings Account (HSA 1) Plan			Health Savings Account (HSA 2) Plan	
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Preventive care **Routine Preventive Care: Well-baby, Well-Child, Well-Woman, Adult (Including immunizations and lab services), Colonoscopy, Mammogram and Pap Test**	100%	60% after deductible	100%	60% after deductible
Precertification requirements	• Your provider initiates the review process at least one business day before any scheduled admission or within two business days of an emergency admission for inpatient hospital services, skilled nursing facility services, services received in a coordinated home care program and private duty nursing services. • Plan does not pay benefits if admission is not approved. • Plan does not pay benefits for additional days if not certified.	• You initiate the review process at least one business day before any scheduled admission or within two business days of an emergency admission for inpatient hospital services, skilled nursing facility services, services received in a coordinated home care program and private duty nursing services. • $500 penalty applies if you don't precertify a scheduled admission at a non-contracted provider. • Plan does not pay benefits if admission is not approved. • Plan does not pay benefits for additional days if not certified.	• Your provider initiates the review process at least one business day before any scheduled admission or within two business days of an emergency admission for inpatient hospital services, skilled nursing facility services, services received in a coordinated home care program and private duty nursing services. • Plan does not pay benefits if admission is not approved. • Plan does not pay benefits for additional days if not certified.	• You initiate the review process at least one business day before any scheduled admission or within two business days of an emergency admission for inpatient hospital services, skilled nursing facility services, services received in a coordinated home care program and private duty nursing services. • $500 penalty applies if you don't precertify a scheduled admission at a non-contracted provider. • Plan does not pay benefits if admission is not approved. Plan does not pay benefits for additional days if not certified.
Diagnostic X-ray and laboratory (facility services)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient hospital (facility services)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Semiprivate room	Limited to semiprivate contract rate	Limited to semiprivate room rate	Limited to semiprivate contract rate	Limited to semiprivate room rate
• Private room	Limited to semiprivate contract rate	Limited to semiprivate room rate	Limited to semiprivate contract rate	Limited to semiprivate room rate
• Intensive care unit	Limited to intensive care unit room rate	Limited to intensive care unit room rate	Limited to intensive care unit room rate	Limited to intensive care unit room rate

Health Savings Account (HSA 1) Plan			Health Savings Account (HSA 2) Plan	
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Inpatient hospital (doctor's visits/ consultations)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient hospital (professional services)				
• Surgeon	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Anesthesiologist	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Radiologist	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Pathologist	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Second surgical opinion (not required)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient surgical (facility services)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient (professional services)				
• Surgeon	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Anesthesiologist	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Radiologist	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Pathologist	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient preadmission testing	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency care • Hospital emergency room • Outpatient facility • Urgent care facility	80% after deductible	80% after in-network deductible, unless determined not to be a true emergency; then 60% after copay and deductible	80% after deductible	80% after in-network deductible, unless determined not to be a true emergency; then 60% after copay and deductible
Ambulance (not covered unless medically necessary)	80% after deductible	80% after deductible unless determined not to be a true emergency, then 60% after deductible	80% after deductible	80% after deductible unless determined not to be a true emergency, then 60% after deductible
Inpatient skilled nursing and rehabilitation (up to 90 days per plan year)*	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient short-term rehabilitation (up to 90 days per plan year)* • Physical therapy • Cardiac rehab • Speech therapy			80% after deductible	60% after deductible

* Additional days or visits may be approved if determined to be medically necessary to improve condition.

Health Savings Account (HSA 1) Plan			Health Savings Account (HSA 2) Plan	
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
• Occupational therapy				
Chiropractic therapy (up to 20 visits per plan year)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient acupuncture (up to 20 visits per plan year)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment (DME)/Prosthetics	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Home health care (including private-duty nursing – which is subject to Health plan approval)	80% after deductible (unlimited visits)	60% after deductible (up to 120 visits per plan year, reduced by any in-network visits) *	80% after deductible (unlimited visits)	60% after deductible (up to 120 visits per plan year, reduced by any in-network visits) *
Hospice				
• Inpatient	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Outpatient	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Maternity				
• Initial visit to determine pregnancy	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• All subsequent charges related to prenatal visits, postnatal visits, and delivery	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Hospital admission	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Organ transplants				
• Inpatient facility	80% (100% at a Blue Distinction Centers for Transplant (BDCT)) after deductible	60% after deductible	80% (100% at a Blue Distinction Centers for Transplant (BDCT)) after deductible	60% after deductible
• Physician's services	80% (100% at a Blue Distinction Centers for Transplant (BDCT)) after deductible	60% after deductible	80% (100% at a Blue Distinction Centers for Transplant (BDCT)) after deductible	60% after deductible
Mental health/substance abuse	80% after deductible	60% after deductible	80% after deductible	60% after deductible

Health Savings Account (HSA 1) Plan			Health Savings Account (HSA 2) Plan	
Plan Feature	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**	**Services Provided by a Network Provider**	**Services Not Provided by a Network Provider**
Infertility treatment/testing (office visit including tests and diagnosis)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Artificial insemination	Not covered	Not covered	Not covered	Not covered
• In-vitro fertilization	Not covered	Not covered	Not covered	Not covered
• Infertility surgery (for diagnostic purposes)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Inpatient facility (for diagnostic purposes)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
• Outpatient surgical facility (for diagnostic purposes)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Temporomandibular joint dysfunction (TMJ) – Non-surgical Limited benefit provided on a case-by-case basis. Always excludes appliances and orthodontic treatment. • **Doctor's office**	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Vision exams	Not covered	Not covered	Not covered	Not covered
Allergy testing, serum, shots	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Prescription drug coverage	CVS Caremark Prescription Drug Program – see the Prescription Drug Program section for further information • Plan pays 80% (60% for non-preferred brand) after you meet the deductible Select generic preventive drugs are not subject to the deductible, though coinsurance applies			

No Coverage option

You may elect to decline coverage. Doing so means you will not have any medical coverage under the Baxter Retiree Medical Plan. Effective April 1, 2003, if you decline coverage after having previously enrolled in retiree coverage, you will not be able to elect coverage again in the future. Retirees who have never elected Baxter Retiree Medical coverage and those who had previously elected coverage but waived for the 2002-2003 plan year will still be eligible to join the plan. However, if you enroll and subsequently waive coverage, you will not be eligible to elect coverage again in the future.

Receiving Care

A medical professional's review of a diagnosis or treatment is an accepted part of health care, and part of the Baxter Retiree Medical Plan. Throughout the review process, your relationship with your physician is respected.

Even though another medical professional or the medical management department for your Retiree Medical Plan option may suggest alternatives for your care, it's important to remember that you and your physician of choice are ultimately responsible for your health care decisions. Whether you are covered under the PPO, POS, **HSA (1 and 2)**, BTO, or an HMO, there are a few important things to remember before you receive care.

HMO

An HMO is a group of health care providers (physicians, clinics, and hospitals) that provide health care services in exchange for a prepaid fee or premium. Services include office visits, hospitalization, surgery, and many other types of care. In an HMO:

- You may choose a PCP or a site from a list of participating physicians in your area. Your PCP then coordinates all of your medical care.
- Your PCP provides your routine care and can refer you to specialists associated with the HMO when necessary.
- In addition to the premiums, the cost of which you and Baxter share, you may be charged a copayment for each office visit, hospitalization, or other covered service.
- You are not covered for any services that are not provided by your selected PCP (PCP referral to specialist is generally required) or not received within the HMO network (except in the case of emergencies).

For more information about the HMO options available to you, contact HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free). Remember, HMOs are insured products and are subject to state insurance laws. Some HMOs may cover services that the other Retiree Medical Plan options do not. Each HMO for which you are eligible to enroll is required to provide you, upon request, with a written description of services provided to members, the procedures to follow to obtain these services, when services may be denied, and eligibility conditions unique to the HMO (and which apply in addition to the general eligibility rules described in this summary). To obtain this information or for more information on the services, precertification guidelines, and coverage levels under each HMO available to you, call the HMO. In addition, please see your certificate of coverage from your HMO for additional information.

BTO, POS, HSA (1 and 2) and PPO precertification requirements

You are responsible for precertifying all hospital admissions, skilled nursing facility services, services received in a coordinated home care program, and private duty nursing services, as well as inpatient mental health and substance abuse treatments. You are responsible for initiating the precertification process within the time limits described below. Call the Blue Cross Medical Management department at 1-800-772-6896 to precertify care. If you follow the required procedures, the Retiree Medical Plan pays the highest level of covered charges allowed under your Retiree Medical Plan option (after any applicable deductible). However, if you don't precertify, penalties may apply, as described in the charts in the "Your Medical Plan Options"

section. Any penalties you are required to pay cannot be used to satisfy any applicable deductibles or out-of-pocket maximums.

Precertification is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Retiree Medical Plan.

Keep in mind that you always make the final decision regarding your health care. Precertification determination is in no way a reflection on the value or the appropriateness of the services you seek. Rather, it is a determination of medical necessity based on the claims administrator's medical management criteria, and a statement of fact regarding what the Retiree Medical Plan does and does not cover.

BTO, POS, HSA (1 and 2) and PPO Utilization Review Program
The claims administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under the Retiree Medical Plan. The Utilization Review Program requires a review of the following covered services **before** such services are rendered:

- Inpatient hospital services—including hospital preadmission review, emergency admission review, and pregnancy/maternity admission review
- Skilled nursing facility services
- Services received in a coordinated home care program
- Private duty nursing services

Advance review of any of these covered services is not a guarantee of benefits.

Failure to contact the claims administrator as required or to comply with the determinations of the claims administrator will result in a reduction in benefits. The toll-free telephone number for medical pre-notification is on your Blue Cross and Blue Shield identification card. Please read the provisions below very carefully.

The provisions of this section do not apply to mental illness and substance abuse rehabilitation treatment. Mental illness and substance abuse rehabilitation treatment are subject to the provisions specified in the section below entitled "Claims administrator's mental health unit."

➢ **Inpatient hospital preadmission review**

- **General**

  Whenever a nonemergency or non-maternity inpatient hospital admission is recommended by your physician, in order to receive maximum benefits under the Retiree Medical Plan, you must call the claims administrator's medical pre-notification number. This call must be made at least one (1) business day prior to the hospital admission.

If the proposed hospital admission or health care services are determined to be not medically necessary, some days, services or the entire hospitalization will be denied. The hospital and your physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your physician and the hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency admission review**

  In the event of an emergency admission, in order to receive maximum benefits under the Retiree Medical Plan, you or someone who calls on your behalf must notify the claims administrator no later than two (2) business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Pregnancy/maternity admission review**

  In the event of a maternity admission, in order to receive maximum benefits under the Retiree Medical Plan, you or someone who calls on your behalf must notify the claims administrator no later than two (2) business days after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

  Even though you are not required to call the claims administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the claims administrator will provide you information on support programs to assist you during pregnancy.

➢ **Skilled nursing facility preadmission review**
Whenever an admission to a skilled nursing facility is recommended by your physician, in order to receive maximum benefits under the Retiree Medical Plan, you must call the claims administrator's medical pre-notification number. This call must be made at least one (1) business day prior to the scheduling of the admission.

➢ **Coordinated home care program preadmission review**
Whenever an admission to a coordinated home care program is recommended by your physician, in order to receive maximum benefits under the Retiree Medical Plan, you must call the claims administrator's medical pre-notification number. This call must be made at least one (1) business day prior to the scheduling of the admission.

➢ **Private duty nursing service review**
Whenever private duty nursing service is recommended by your physician, in order to receive maximum benefits under the Retiree Medical Plan, you must call the claims administrator's medical pre-notification number. This call must be made at least one (1) business day prior to receiving services.

BTO, POS, HSA (1 and 2) and PPO case management
Case management is a collaborative process that assists you with the coordination of complex care services. It provides a coordinated approach to the management of serious and/or complicated health care problems. Medical case management is designed to coordinate patient

care in the most appropriate medical setting while providing support and education to the patient and family when serious illness or prolonged hospitalization is involved.

The medical case manager initiates participation when case management is appropriate. The medical case management program generally:

- **provides access to medical case managers (with specialized backgrounds) to help evaluate a patient's problem;**
- **helps assure continuity of treatment, both in and out of the hospital;**
- **helps coordinate all major professional areas involved;**
- **helps assure that the patient—and where appropriate, the family—is involved in making decisions about necessary treatment;**
- **helps make the most of the patient's rehabilitation opportunities;**
- **reviews the need for future services; and**
- **suggests cost-effective alternative services.**

Your case manager is available to you as an advocate for cost-effective interventions. Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the claims administrator determines that the alternative services are medically necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Retiree Medical Plan.

Provision of alternative benefits in one instance will not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits will not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Retiree Medical Plan.

BTO, POS, HSA (1 and 2) and PPO length of stay/service review
Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Retiree Medical Plan.

Upon completion of the preadmission or emergency review, the claims administrator will send a letter to your physician and/or the hospital confirming that you or your representative called the claims administrator and that an approved length of service or length of stay was assigned. An extension of the length of stay/service will be based solely on whether continued inpatient care or other health care service is medically necessary. In the event that the extension is determined not to be medically necessary, the authorization will not be extended. Additional notification will be provided to your physician and/or the hospital regarding the denial of payment for the extension.

BTO, POS, HSA (1 and 2) and PPO utilization review procedure
The following information is required when you contact the claims administrator:

- The name of the attending and/or admitting physician;

- The name of the hospital where the admission has been scheduled and/or the location where the service has been scheduled;
- The scheduled admission and/or service date; and
- A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the claims administrator:

- Will review the information provided and seek additional information as necessary.
- Will issue a determination that the services are either medically necessary or are not medically necessary.
- Will provide notification of the determination.

Claims administrator's mental health unit
The claims administrator's mental health unit has been established to perform preadmission review and length of stay review for your inpatient hospital services for the treatment of mental illness and substance abuse. The mental health unit is staffed primarily by physicians, psychologists, and registered nurses.

Review under any of the provisions below is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Retiree Medical Plan.

Failure to contact the mental health unit or to comply with the determinations of the mental health unit will result in a reduction of benefits. The mental health unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

➢ **Inpatient hospital preadmission review**
Whenever a non-emergency inpatient hospital admission for the treatment of mental illness or substance abuse is recommended by your physician, you must, in order to receive maximum benefits under the Retiree Medical Plan, call the mental health unit. This call must be made at least one (1) business day prior to the hospital admission.

If the proposed hospital admission does not meet the criteria for medically necessary care, it will be referred to a physician in the mental health unit. If the mental health unit physician concurs that the proposed admission does not meet the criteria for medically necessary care, some days or the entire hospitalization will be denied. Your physician and the hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your physician and the hospital. The mental health unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

➢ **Emergency mental illness admission review**
In the event of an emergency mental illness admission, you or someone who calls on your behalf must, in order to receive maximum benefits under the Retiree Medical Plan, notify the mental

health unit within two (2) business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

➢ **Partial hospitalization treatment program review**
Whenever an admission to a partial hospitalization treatment program is recommended by your physician, you must, in order to receive maximum benefits under the Retiree Medical Plan, call the mental health unit. This call must be made at least one (1) business day prior to the admission.

➢ **Length of Stay Review**
Upon completion of the preadmission or emergency admission review, the mental health unit will send you a letter confirming that you or your representative called the mental health unit. A letter assigning a length of service or length of stay will be sent to your physician and/or the hospital.

An extension of the length of stay/service will be based solely on whether continued inpatient care or other health care service is medically necessary as determined by the mental health unit. In the event that the extension is determined not to be medically necessary, the length of stay/service will not be extended, and the case will be referred to a mental health unit physician for review.

BTO, POS and PPO mental health unit procedure
When you contact the mental health unit, you should be prepared to provide the following information:

- the name of the attending and/or admitting provider;
- the name of the hospital or facility where the admission and/or service has been scheduled;
- the scheduled admission and/or service date; and
- a preliminary diagnosis or reason for the admission and/or service.

When you contact the mental health unit, the mental health unit:

- will review the medical information provided and follow-up with the provider;
- may determine that the services to be rendered are not medically necessary.

Review results
Ordinarily, medical plan review of a hospital admission or treatment should be complete within 48 hours after you or your provider calls. It may take longer, however, if medical records or other information is needed. Approval of a procedure or hospital stay is generally valid for a limited amount of time (usually up to 90 days, with the exception of maternity). If the procedure is not performed within the required time period, a new review is required.

What the Retiree Medical Plan Covers

In general, each Baxter Retiree Medical Plan option covers most of the same types of services. The following describes the services the Retiree Medical Plan covers.

For additional detail about how your particular Plan coverage option might pay for a certain service, or the limits that may apply, see the benefit summary for your Plan option in the "Your Baxter Retiree Medical Plan Options" section of this booklet.

If you select an HMO, review your HMO materials or contact the HMO directly to learn how the HMO might pay for a particular service.

In-hospital covered charges
A hospital must be a qualified institution as defined by the Retiree Medical Plan, and as determined by your Retiree Medical Plan option's claims administrator. Generally, eligible hospital charges include:

- Hospital room and board, based on the negotiated or semi-private room hospital rate. The Retiree Medical Plan pays for a private room if medically necessary due to a contagious or a suspected contagious disease, or when isolation is medically necessary because of a weakened immune system. (If the hospital has no semi-private room available, the Retiree Medical Plan pays benefits based on the eligible charge for semi-private rooms, or the hospital's private room rate—whichever is lower). Plan benefits for a mother and newborn will not be reduced below a hospital stay of 48 hours following a vaginal birth, or 96 hours following a cesarean section. The stay may be shorter if the decision is made by the physician and agreed to by the mother.
- All services and supplies furnished and billed by the hospital for inpatient care. Services can include, but are not limited to, the operating room, oxygen, drugs, surgical dressings, X-rays and laboratory work.
- Anesthetics and their administration, except when administered by the surgeon or assistant surgeon during surgery.
- Outpatient testing performed at the hospital, no more than ten days before and in connection with a covered hospitalization (where such tests are not repeated after admission).
- Licensed local ambulance services to or from the nearest hospital equipped to provide the needed treatment.
- Local air ambulance services, when your Retiree Medical Plan option's claims administrator determines it is medically necessary to transfer a patient to a medical facility equipped to handle a life-threatening condition.
- Inpatient mental health and substance abuse treatments in a qualified facility (see the "Mental Health and Substance Abuse Treatments" section for details.)

Surgical covered charges
After the deductible (if applicable), the Baxter Retiree Medical Plan covered charges generally include:

- Surgeons (and assistant surgeons when medically necessary as determined by your Retiree Medical Plan option's claims administrator) and anesthesiologists charges, which could include:

  — acupuncture when used as a form of anesthesia during covered inpatient surgery;

  — a final pre-operative office visit;

  — visits by the surgeon on the day of surgery;

  — administration of anesthetics; and

  — all post-operative care by the surgeon required by and directly related to the procedure.

- Surgical services provided by a physician whether the surgery is performed in a hospital, physician's office, or at an approved outpatient surgical center, as determined by your Retiree Medical Plan option's claims administrator.

- Expenses associated with multiple surgeries. When two or more major related surgical procedures are performed during the same operative session, the Retiree Medical Plan bases the eligible charge on the **full value of the major procedure and half of the lesser procedure**, provided the procedure adds significant time or complexity to the care. If the lesser procedure is merely incidental, the Retiree Medical Plan covers the eligible charge for the major procedure. If the two procedures are unrelated, the Retiree Medical Plan covers both procedures separately. You can verify coverage of all procedures beforehand by contacting your Retiree Medical Plan option's claims administrator.

- Assistant surgeon's fees, if covered for a particular procedure. To see if the Retiree Medical Plan will cover an assistant surgeon's fees for your procedure, call your Retiree Medical Plan option's claims administrator.

- Coverage for physical complications at all stages of mastectomy, including lymph edemas.

- Gender reassignment surgery for individuals who are at least 18 years of age, if diagnosed with persistent gender dysphoria. Before undertaking gender reassignment surgery, important medical and psychological evaluations, medical therapies and behavioral trials must be undertaken. Contact the claims administrator for a pre-determination and additional information on the medical criteria.

Out-of-hospital covered charges
The Retiree Medical Plan only covers services determined by the claims administrator to be medically necessary. Some outpatient services require medical review before benefits can be determined. It is your responsibility to make sure any pre-authorization requirements are satisfied before services are provided. You can also request a pre-determination review for a recommended procedure or test to make sure it meets the Retiree Medical Plan's medical

necessity criteria by contacting the claims administrator. Pre-determination review can help you understand your coverage and is recommended for certain outpatient procedures including MRI, PET Scans and CT Scans.

Generally, covered charges for out-of-hospital services include:

- Office visits to a physician for treatment of illness or accidental injury.
- Speech therapy by a licensed speech therapist, to restore speech lost or impaired due to surgery, illness (other than a mental, psychoneurotic, or personality disorder), or injury. In addition, the Retiree Medical Plan covers developmental therapy. For details and plan limits, see the benefit summary for your Retiree Medical Plan coverage option in the "Your Baxter Retiree Medical Plan Options" section of this booklet.
- Medically necessary outpatient chiropractic care, including services related to the diagnosis and/or treatment of the musculoskeletal system. Certain limits apply. For details, see the benefit summary for your Retiree Medical Plan coverage option in the "Your Baxter Retiree Medical Plan Options" section of this booklet.
- X-ray and laboratory examinations needed to diagnose an illness or injury.
- Surgical dressings, casts, splints, trusses, braces, and crutches.
- Prosthetic medical appliances needed to replace or substitute for a defective vital bodily function, including:

  — artificial limbs, arms, legs, and terminal devices such as a hand or hook;

  — the first pair of contact lenses or frames and lenses after cataract surgery;

  — artificial heart valves, cardiac pacemakers, artificial joints and other surgical materials (including screw nails, sutures and wire mesh); and

  — breast reconstruction or initial breast prostheses after a mastectomy, including surgery and reconstruction of the other breast to produce a symmetrical appearance and coverage for prostheses at all stages of mastectomy, including lymph edemas.

  The Retiree Medical Plan pays benefits for replacement of prosthetic medical appliances if, due to a change in the participant's physical condition, the replacement is necessary.

- Clinic fees in connection with treatment in immediate care centers.
- Anesthetics and their administration.
- Blood and blood plasma (blood replacement to a hospital by a blood bank is not covered).
- Electronic heart pacemaker.
- Ambulance services, when medically necessary due to a patient's condition or when other means of transportation are not sufficient for the patient's condition.

- Medically necessary outpatient acupuncture care. Certain limits apply. For details, see the benefit summary for your Retiree Medical Plan coverage option in the “Your Baxter Retiree Medical Plan Options” section of this booklet.

- Oxygen and rental of equipment for its administration.

- Treatment by a licensed physical therapist (including occupational therapists), including orthoptics and visual therapy for medical (not educational) reasons. The Retiree Medical Plan pays benefits provided a physician orders and supervises the treatment. Certain limits apply. For details, see the benefit summary for your Retiree Medical Plan option in the “Your Baxter Retiree Medical Plan Options” section of this booklet.

- Medical supplies, when ordered by a physician, such as colostomy bags and hypodermic needles. Medical supply quantities at any one time are limited to the amount necessary for a three-month period.

- Rental or purchase (as determined by your Retiree Medical Plan option) of durable medical equipment, including wheelchairs, hospital beds, iron lungs, kidney dialysis machines, and other equipment. The Retiree Medical Plan pays benefits provided a physician orders the equipment as medically necessary to maintain health for a specific condition. The Retiree Medical Plan covers the initial purchase only when long-term use is planned, the equipment cannot be rented, or the rental price is more than the purchase price.

Other covered charges
The Retiree Medical Plan pays benefits for a number of other medical services.

- Physician’s inpatient visits, up to one visit per day by the primary attending physician, provided the Retiree Medical Plan covers the hospitalization. The Retiree Medical Plan covers additional visits if medically necessary. (Charges associated with a physician’s visit related to surgery are generally included in the surgical fee.)

- Eligible charges for a pathologist’s and/or radiologist’s services.

- Immunizations, when required for travel purposes, when required by state law or regulations, and when administered by a physician or under the immediate direction of a physician.

- Radiation therapy and chemotherapy services, including the administration of inpatient or outpatient radiation therapy and chemotherapy to treat malignancies or leukemia; and drugs administered directly for the treatment.

- Organ transplant/prosthetic procedures, including services associated with an approved organ transplant such as immunosuppressive medications, organ procurement costs, and services related to prosthetics.

  Benefits are available to both the recipient and donor of a covered human organ transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.

- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

- You must contact the claim administrator by telephone before your transplant surgery has been scheduled.

Benefits will be provided for:

- Inpatient and outpatient covered services related to the transplant surgery.

- the evaluation, preparation and delivery of the donor organ (organ storage fees are not covered).

- the removal of the organ from the donor.

- the transportation of the donor organ to the location of the transplant surgery.

Benefits will be limited to the transportation of the donor organ in the United States or Canada.

- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion (two companions if the recipient is a dependent child). For benefits to be available, your place of residency must be more than 50 miles from the hospital where the transplant will be performed. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant. The maximum amount that will be provided for lodging is $50 per person per day.

Renal Care

- Covered persons who have chronic kidney disease will have access to case management support and education on available dialysis options. Covered persons who participate in the claim administrator's case management program prior to beginning dialysis and choose peritoneal dialysis (PD) will be eligible to receive a monthly incentive payment of $125 while undergoing PD treatment. Payment is made quarterly and is taxable. Covered persons who engage in the case management support but do not elect PD due to medical reasons may still be eligible for the incentive payment.

- Maternity charges, including hospital costs associated with pregnancy. The Retiree Medical Plan pays benefits for eligible physician's services like any other surgical procedure, and generally covers hospital nursery charges and circumcision as part of a covered newborn's charges. Since the Retiree Medical Plan treats a newborn as a separate dependent (unless a network negotiated rate is charged for both mother and baby), the

newborn's charges are subject to a separate deductible. Depending on your particular situation, who provides the care, and your Baxter Retiree Medical Plan coverage option, newborn charges may be handled differently. Contact the claims administrator for more information. To cover a newborn, be sure to call HRCentral Support within 60 calendar days of your child's birth.

- Charges associated with wearing a wig or hairpiece (when hair is lost due to a medical illness or injury).

- Convalescent nursing home care provided the confinement is precertified under your Plan coverage option and you or your covered dependent is under the continuous care of the attending physician. An attending physician must certify in writing that 24-hour-a-day nursing care is essential, and care must be provided in a licensed qualified convalescent nursing home. Covered charges for convalescent nursing home care include:

  - medically necessary room and board and other services; and

  - the maximum daily covered charge for the confinement (if a negotiated rate does not exist, the Retiree Medical Plan limits benefits to the eligible semi-private room charge for convalescent nursing homes).

Certain limits apply. For details, see the benefit summary for your Retiree Medical Plan coverage option in the *"Your Baxter Retiree Medical Plan Options"* section of this booklet. The claims administrator may authorize additional days if it determines the treatment to be medically necessary, and if it expects the treatment to continuously improve the condition.

Home health care
The Retiree Medical Plan pays benefits for certain services and supplies provided in a person's home by a qualified home health care agency. The home health care agency must be approved by the claims administrator, and you must meet the following conditions:

- If you or your covered dependent begins a home health care program after confinement in a hospital or convalescent nursing home, the physician must submit a home health care treatment plan. The plan must meet the home health care criteria as established by your Baxter Retiree Medical Plan option.

- The home health care agency must bill and furnish services and supplies for the same illness that caused the confinement, a related illness, or for an illness requiring home health care instead of hospitalization.

- A physician must order the services as part of the home health care plan.

Once the home health care plan's objectives are met, the Retiree Medical Plan stops paying home health care benefits.

Qualifying home health care agency services
The Plan pays benefits for the following home health care agency services:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse.

- Part-time or intermittent services by a home health aide or licensed practical nurse that are primarily for the care of the covered person.

- Physical, occupational, or speech therapy by a licensed therapist.

- Medical supplies, drugs, and medications lawfully dispensed and ordered by a physician.

- Laboratory services performed by or on behalf of a hospital.

The Retiree Medical Plan considers each visit by a member of a home health care team (other than a home health aide) as one visit. In addition, the Plan considers every four hours of service by a home health aide as one visit. The claims administrator may authorize additional days if it determines the treatment to be medically necessary, and if it expects the treatment to continuously improve the condition. Certain limits apply. For details, see the benefit summary for your Plan coverage option in the *"Your Baxter Retiree Medical Plan Options"* section of this booklet.

Hospice care
The Plan pays benefits, up to six months, for certain inpatient or at-home services and supplies provided by a hospice care program. Hospice care programs are designed to care for and treat a terminally ill person. The Retiree Medical Plan pays benefits, provided:

- the covered person meets the Retiree Medical Plan's definition of a terminally ill individual—that is, the individual is expected to live for six months or less;

- the Baxter Retiree Medical Plan claims administrator approves the hospice care program;

- the primary attending physician certifies the person's terminal illness through the appropriate Baxter Retiree Medical Plan option;

- a supervising physician directing the hospice care program orders the hospice services or stay; and

- the hospice care program bills the charges.

Covered services
The Retiree Medical Plan pays benefits for the following:

- hospice facility room and board charges (including necessary services and supplies), up to the negotiated or semi-private room rate;

- outpatient hospice facility charges;

- physician or professional service charges from a psychologist, social worker, or family counselor for individual or family counseling;

- pain relief treatments, including drugs, medicines, and medical supplies;

- part-time or intermittent nursing care;
- physical, occupational, and speech therapy;
- medical supplies;
- drugs and medicines lawfully dispensed on a physician's written prescription; and
- laboratory services.

Services not covered
The Retiree Medical Plan does not pay benefits for the following:

- purchase of durable medical equipment, unless the purchase is less costly than rental;
- volunteer services, which are services that would normally be provided free of charge;
- private-duty nursing, either in a hospital or private home;
- services related to legal and/or financial advice; and
- services of a person who ordinarily resides in the home of the terminally ill person.

Hospice bereavement benefit
The Baxter Retiree Medical Plan also provides a hospice bereavement benefit for counseling services for covered family members during the three-month bereavement period immediately following the covered person's death. The Retiree Medical Plan pays benefits if the deceased was a member of the family, was covered by the Retiree Medical Plan, and was in the hospice care program prior to death.

Mental Health and Substance Abuse Treatments

How the Retiree Medical Plan pays benefits
To qualify for coverage, a mental health or substance abuse facility must be licensed or certified to furnish services.

In addition, a professional providing psychotherapeutic treatments must be a licensed psychiatrist, psychoanalyst, licensed marriage or family therapist, or a state-licensed psychologist or social worker. If no state licensing is required, a social worker with a master's degree in social work may provide the counseling services. The Retiree Medical Plan does not cover learning disability treatments (see "What the Retiree Medical Plan Does Not Cover").

Inpatient treatment
Treatment and hospital stays must be approved in advance—and throughout the treatment—for the Retiree Medical Plan to pay the full level of benefits, be sure to remember the following:

> All inpatient mental health and substance abuse treatment must be precertified. Otherwise, penalties may apply. (See *the applicable chart for your Baxter Retiree Medical Plan option in the* "Your Baxter Retiree Medical Plan Options" section of this booklet.)

- Call the claims administrator to precertify your inpatient stay. (See *Claims administrator's mental health unit* and *Mental health unit procedure* in the "Receiving Care" section for details).
- If you do not contact the claims administrator or do not follow the Retiree Medical Plan's precertification guidelines, penalties may apply. Penalty amounts cannot be used to satisfy any applicable deductibles or out-of-pocket maximums. (See the applicable chart for your Baxter Retiree Medical Plan option in the "Your Baxter Retiree Medical Plan Options" section for details.)
- If claims administrator does not approve the treatment as medically necessary, or the facility does not meet the Retiree Medical Plan's requirements, the Retiree Medical Plan does not pay benefits.

Prescription Drug Program

The Baxter Retiree Medical Plan pays benefits for Federal Drug Administration (FDA) approved prescription medications you or your dependent may take while hospitalized unless you are Medicare-eligible and elect BTO without prescription drug coverage. The Prescription Drug Program, administered by CVS Caremark, pays benefits for other covered prescription drugs and services, after you pay certain deductibles and copayments.

If you enroll in the PPO, POS, HSA (1 and 2) or BTO coverage option, the Retiree Medical Plan pays prescription drug benefits through the CVS Caremark Prescription Drug Program. If you enroll in an HMO option prescription drugs are covered according to the specific HMO provisions.

The Prescription Drug Program provides coverage through the **Retail Network Pharmacy Program** for short-term prescriptions and the **Mail Service Pharmacy Program** for long-term prescription needs. Drugs determined as "non-formulary" based on the prescription claims administrator's current formulary are not covered by the Plan. The prescription drug formulary includes the Advanced Control Specialty Drug Formulary. Additionally, specialty oral, intranasal and injectable medications are available to you exclusively through the PrudentRx Solution in conjunction with **CVS Caremark Specialty Pharmacy**.

If you have questions about how the Prescription Drug Program works, or about your copayment or prescription order, visit www.caremark.com or call CVS Caremark Customer Care toll-free at 1-866-282-3463. Or, you can call CVS Caremark through HRCentral Support (1-844-249-8581 English Toll-Free, or 1-844-249-8803 Spanish Toll-Free).

Your prescription

Before you leave your physician's office, check your prescription(s) to be sure the following pieces of information are clearly legible: full first and last name of the patient; physician's name; exact strength of medication; exact daily dosage; and exact quantity.

Mail Service Pharmacy Program

Under the Mail Service Pharmacy Program, if you have an ongoing condition that requires prescription drugs, you can have up to a 90-day supply of your prescription mailed directly to your home. Maintenance medications can also be filled for a 90-day supply at any at CVS Pharmacy locations at the mail service cost. See the Ordering from the Mail Service Pharmacy Program section for information on how to start Mail Service.

Under the Mail Service Pharmacy Program any prescription requesting a preferred or non-preferred brand medication when an FDA-approved generic equivalent is available will be filled with the generic equivalent unless the prescription is indicated as "dispense as written." A preferred or non-preferred brand-name drug is used only if no generic substitute is available. If a generic is available and your prescription is "dispense as written," CVS Mail Pharmacy will contact the prescriber to determine if the generic equivalent can be substituted. If the preferred or non-preferred brand is requested when a generic equivalent is available, you will pay the difference between the cost of the preferred or non-preferred brand and generic medication; along with the generic copayment.

You can appeal to pay only the preferred or non-preferred brand coinsurance on your mail-order prescription by having your physician complete a Dispense as Written (DAW) Penalty Exception Form and submitting it to CVS Caremark. Additionally, if your physician feels a non-preferred brand is necessary, he/she can request an exception if there is a medical reason for the request. CVS Caremark will provide the clinical review and determine whether the preferred or non-preferred brand is necessary. For additional information or to receive the DAW Exception Form, contact CVS Caremark at 1-866-282-3463.

Retail Network Pharmacy Program

Under the **Retail Network Pharmacy Program**, you may choose whether to receive an FDA-approved generic substitute if one is available. If you choose a preferred or non-preferred brand name drug when a generic is available, you will pay the difference between the preferred or non-preferred brand and generic medication, along with the generic copayment. (See Retail Network Pharmacy Program section below.)

You can use your ID card at any participating pharmacy anywhere in the U.S. To locate a participating pharmacy in your area, visit www.caremark.com or call CVS Caremark Customer Care toll-free at 1-866-282-3463. Or, you can call CVS Caremark through HRCentral Support (1-844-249-8581 English Toll-Free, or 1-844-249-8803 Spanish Toll-Free).

The following drugs are not available under the Retail Network Pharmacy Program, and must be obtained through the Caremark Mail Service Pharmacy Program to be covered:

- Prescription vitamins with a diagnosis (except for prenatal vitamins, which can be obtained through the Retail Network Pharmacy Program).
- Retin-A (participants over age 36 need an approved diagnosis for prescription).

Mandatory Mail for Maintenance Drug

If you take a long-term maintenance drug, you can fill up to two prescriptions of 30 days at a network retail pharmacy. After that, you can choose to have 90-day supplies of your long-term medications delivered by CVS Caremark Mail Service Pharmacy or pick them up at any CVS Pharmacy. You can continue to receive 30-day supplies of long-term medications at any network pharmacy, but you must first contact CVS Caremark and opt-out of 90-day refills.

Specialty Pharmacy program

Specialty oral, intranasal and injectable medications and care management services are provided through the CVS Caremark Specialty Pharmacy program and the Prudent Rx Solution. A clinical review is required for specialty medication requests. CVS Caremark Specialty Pharmacy will obtain the necessary clinical information to conduct the review. See the "PrudentRx Solution for Specialty Medications" section below for more details.

Amount you pay under the PPO, POS and BTO Options

Your prescription drugs are offered through a three-tier structure, which provides coverage at different copay or coinsurance amounts. Generic drugs are available to you at the lowest copayment level (Tier 1). Brand-name drugs that have been selected by CVS Caremark for their

clinical and cost-effectiveness are considered preferred (Tier 2) and cost you more than generics, but less than non-preferred brands. Brand-name drugs that are considered non-preferred (Tier 3) cost more than preferred brands. In most cases, Tier 3 non-preferred brand drugs have different brand or generic drug alternatives in Tiers 1 and 2 that treat the same condition and are clinically effective and cost less.

Specialty medications are offered through the PrudentRx Solution. See the "PrudentRx Solution for Specialty Medications" section below for more details.

Plan Year Out of Pocket Maximum
There is a separate out-of-pocket maximum which applies to the Prescription Drug Program. Once your combined copays and coinsurance for your prescription drugs reach $2,000 for individual or $4,000 for family, the Retiree Medical Plan will pay 100% of eligible drug expenses for the rest of the plan year.

Retail Network Pharmacy Program
You should use the Retail Network Pharmacy Program when your prescription is for 30 days or less of medication (or it's your first prescription of a maintenance medication). If you take a long-term maintenance medication, see the information under Mandatory Mail for Maintenance Drug section for additional requirements on filling maintenance medications. Show your Prescription Drug Program ID card at any participating pharmacy and you will pay the following for your prescription:

Type of Prescription Drug	Amount You Pay*
Tier 1 - Generic	$10
Tier 2 – Preferred brand name, when a generic equivalent **is not** available	25% coinsurance (the minimum amount you pay is $30 and the maximum is $75).
Tier 3 – Non-preferred brand name, when a generic equivalent **is not** available	40% coinsurance (the minimum amount you pay is $50 and the maximum is $125).
Specialty, PrudentRx Eligible	0%through the PrudentRx Solution, if enrolled; otherwise, 30% coinsurance
Brand name, when a generic equivalent is available	$10, plus the difference in cost between the brand name and generic equivalent

**The amount you pay will not exceed the actual drug cost*

Mail Service Pharmacy Program
If you have an ongoing condition that requires prescription drugs, you can have up to a 90-day supply of your prescription mailed directly to your home. Maintenance medication can also be filled for a 90-day supply at any CVS Pharmacy locations at the mail service copay/coinsurance structure. To qualify your physician must write the prescription for a 90-day supply of medication.

Type of Prescription Drug	Amount You Pay*
Tier 1 - Generic	$25
Tier 2 – Preferred brand name, when a generic equivalent **is not** available	25% coinsurance (the minimum amount you pay is $75 and the maximum is $185).

Tier 3 – Non-preferred brand name, when a generic equivalent **is not** available	40% coinsurance (the minimum amount you pay is $125 and the maximum is $300).
Brand name, when a generic equivalent **is** available**	$25, plus the difference in cost between the brand name and generic equivalent

** the amount you pay will not exceed the actual drug cost*

** See the Mail Service Pharmacy Program section above for additional information

Amount you pay under the HSA (1 and 2) Options:

Under the HSA (1 and 2) coverage options, there is a combined medical and prescription drug deductible and out of pocket maximum requirement. With the exception of generic drugs on the CVS Caremark Generic Preventive Drug List, you are required to pay 100% of the prescription drug cost up to **HSA (1 and 2)** deductible. See the HSA (1 and 2) Plan Summaries under the Your Medical Plan Option Section for details.

Your prescription drugs are offered through a three-tier structure. Generic drugs are Tier 1. Brand-name drugs that have been selected by CVS Caremark for their clinical and cost-effectiveness are considered preferred (Tier 2). Brand-name drugs that are considered non-preferred (Tier 3), in most cases have different preferred brand or generic drug alternatives that treat the same condition and are clinically effective and cost less.

Specialty medications are offered through the PrudentRx Solution. See the "PrudentRx Solution for Specialty Medications" section below for more details.

You should use the Retail Network Pharmacy Program when your prescription is for 30 days or less of medication (or it's your first prescription of a maintenance medication). If you have an ongoing condition that requires prescription drugs, you can have up to a 90-day supply of your prescription mailed directly to your home. Maintenance medications can also be filled for a 90-day supply at any at CVS Pharmacy locations. To qualify your physician must write the prescription for a 90-day supply of medication. If you take a long-term maintenance medication, see the information under Mandatory Mail for Maintenance Drug section for additional requirements on filling maintenance medications.

Type of Prescription Drug	Amount You Pay Retail or Mail Service*
Tier 1 - Generic	20% after you meet the deductible (drugs on the CVS Caremark Generic PDL and brand diabetes medications/supplies are not subject to the deductible)
Tier 2 - Preferred brand name, when a generic equivalent **is not** available	20% coinsurance after you meet the deductible
Tier 3 - Non-preferred brand name, when a generic equivalent **is not** available	40% coinsurance after you meet the deductible
Specialty, PrudentRx Eligible	$0 through the PrudentRx Solution, if enrolled; otherwise, 30% coinsurance, after you meet the deductible.

Brand name, when a generic equivalent is available**	20% of the generic equivalent cost, plus the difference in cost between the brand name and generic equivalent, after you meet the deductible

** the amount you pay will not exceed the actual drug cost*

** See the Mail Service Pharmacy Program section above for additional information

Ordering From the Mail Service Pharmacy Program
Visit www.caremark.com or call CVS Customer Care toll-free at 1-866-282-3463 to request they contact your doctor for a mail service prescription. You will need to provide your Identification number (from your ID card), your doctor's name and telephone number, payment information and the medication name. You can also complete and mail a CVS Caremark Mail Order Form with your original prescription and payment information. Ask your physician for a written prescription for a 90-day supply of medication (plus up to three refills, when appropriate). Refills are not allowed for certain controlled substances.

A registered pharmacist reviews, fills, and verifies each order. Throughout processing, the order is checked before shipping to ensure you receive the correct quantity and dosage strength of the medication.

The Mail Service Pharmacy Program ordinarily processes orders and delivers medications by first class mail or UPS approximately 10 to 14 days after receipt of the first order. Refills are generally processed the same day they are received. If you need a maintenance medication right away, ask your physician to complete two prescriptions—one to be filled immediately for a 30-day supply; the other to be sent to CVS Caremark for processing and filling.

If your physician writes a prescription that allows refills, you can elect to have refills sent to you automatically.

PrudentRx Solution for Specialty Medications
In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the Baxter International Inc. and Subsidiaries Welfare Benefit Plan ("Plan") has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the Plan's specialty drug list are included in the program and will be subject to a 30% co-insurance. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution, unless the member has a health savings account (HSA). For members with HSAs: (i) for drugs listed on the plan's HDHP Preventive Drug List, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution; and (ii) for all other drugs, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution *after* the member's deductible has been satisfied.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require Participants to sign up to take advantage of the copay assistance that they provide for their medications. If a Participant chooses to opt out of the program, you must call 1-800-578-4403. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. Eligible members who choose to decline enrollment in an available manufacturer copay assistance program will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum, unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

Additional information about covered drugs if you are enrolled in the PPO, POS, HSA(1 or 2) or BTO Option

Covered over-the-counter (OTC) drugs
In general, the program does not cover over-the-counter (OTC) drugs, except for the following when you have a prescription from your doctor:

- Diabetic supplies – including blood glucose meters.
- Niacin (vitamin B3).
- Aspirin with doctor prescription for pregnant women who are at least 12 years old and at high risk for preeclampsia.
- Folic acid with doctor's prescription for women ages 55 and under.

Utilization Management Programs if you are enrolled in the PPO, POS, HSA (1 and 2) or BTO plan

Utilization management programs such as prior authorization, quantity limits, and clinical step therapy may apply for select drugs to ensure cost-effective and safe use of drugs.

Quantity / Treatment Limits
Some prescription drugs have quantity or treatment limits. These include:

- Drugs for treatment of anti-nausea, anti-influenza, and antimigraine
- Lidocaine – topical products
- PPIs (Ulcer Drugs)
- Opioids
- Topical Corticosteroids and antifungals
- Corticosteroid Inhalers
- Doxepin
- Drugs for treatment of insomnia
- Diabetic drugs in the GLP-1 Agonist class (i.e., Ozempic, Victoza, Rybelsus, etc.)
- Specialty oral, intranasal and injectable medications

Clinical Review / Prior Authorization or Clinical Step Therapy
Some prescription drugs will require prior authorization review by CVS Caremark, or have a clinical step therapy requirement, including but not limited to:

- Hormone therapy
- Specialty oral, intranasal and injectable medications
- Medications for ADHD (age 19 and older), Medications for Narcolepsy
- Oral (SL) Immunotherapy
- Opioids including Oral and Intranasal Fentanyl Drugs
- Hyperinflated Drugs[‡‡]
- Compounds exceeding $300
- Solodyn
- Select brand migraine medications
- Oxiconazole cream and lotion

[‡‡] Participants should use Check Drug Cost Tool on caremark.com to determine if any specific drug is subject to PA.

- Dermatological drugs
- Elidel and Protopic
- Kerendia
- Opzelura
- Brand Epinephrine Agents

Drugs not covered
The CVS Caremark Prescription Drug Program does not cover some prescription drugs, supplies, devices and services, including:

- Respiratory therapies (aero chambers, nebulizers).
- Diet medications.
- Drugs used for cosmetic purposes (e.g., Anti-Wrinkle Agents).
- Nicotine gums and patches.
- Nutritional and diet supplements.
- Progesterone suppositories and capsules.
- Infertility and impotence/erectile dysfunction prescription drugs.
- Drugs determined as "non-formulary" based on the prescription claims administrator's current formulary are not covered by the Retiree Medical Plan.
- Topical analgesics in strengths typically used in over the counter analgesics
- Drugs and products that are unapproved by the Federal Food, Drug and Cosmetic Act or which may be marketed contrary to the Federal Food, Drug and Cosmetic Act. Coverage will remain for select unapproved products that are legally marketed or deemed clinically necessary (where no alternatives exist).
- Medications classified as Medical Devices and Artificial Saliva by the US Food and Drug Administration
- Certain drugs that have limited clinical value and which have clinically appropriate, lower-cost alternatives (e.g., brand name or generic drugs that are combinations of existing generic or over-the counter drugs, new formulations of existing drugs).
- Certain medications will only be covered under the medical benefit based on unique characteristics or administration requirement.

If you are Medicare-eligible
If you are Medicare-eligible, the following will apply:

- You may elect coverage under the Baxter Retiree Medical Plan (which includes prescription drugs) or under Medicare Part D, but not both.

If you elect the HMO option under the Baxter Retiree Medical Plan, you will receive the prescription drug coverage that is provided by your specific HMO.

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

If you or a covered dependent is having a baby, the Baxter Retiree Medical Plan 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.

Additionally, the Retiree Medical Plan cannot require that a provider obtain authorization from the Retiree Medical Plan for prescribing a length of stay that does not exceed the above periods.

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).

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

The Retiree Medical Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for a mastectomy-related services, and the complications resulting from a mastectomy (including lymphedema). These benefits include all stages of reconstruction and surgery to achieve breast symmetry, and prostheses. Normal Plan co-payments, deductibles and coinsurance may apply.

HIPAA privacy

As a participant in the Retiree Medical Plan, your "protected health information" is subject to safeguard under the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, the Retiree Medical Plan has adopted policies that restrict the use and disclosure of your protected health information. Generally, use and disclosure is limited to payment and health care operation functions, and only the "minimum necessary" information may be used or disclosed.

This is only a brief summary of HIPAA. As a 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 the privacy officer.

Special Enrollment Rules

If you decline enrollment in the Retiree Medical Plan for yourself or your dependents, because of other health coverage and you later lose that other coverage, you may be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 31 days of the date your other coverage ends.

Your loss of other health insurance 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 Retiree Medical 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, commencement of a domestic partnership or the start of your legal obligation to provide support for a child you plan to adopt, you may be able to enroll yourself and your new dependent(s), provided that you request enrollment within 31 calendar days of the marriage, or commencement of a domestic partnership or within 60 calendars days of the birth, adoption, legal guardianship or the start of your legal obligation to provide support. If you do not enroll within 31or 60 calendar days, as applicable, you must wait until the next annual enrollment to elect coverage.

What the Retiree Medical Plan Does Not Cover

The Retiree Medical Plan does not cover certain types of medical services and supplies or services for certain conditions. Out-of-pocket expenses for such services do not count toward any applicable annual deductibles or out-of-pocket maximums.

The Retiree Medical Plan does not cover the following:

- Any charge in excess of the eligible charge, as determined by your Retiree Medical Plan option's claims administrator.
- Expenses relating to an injury or illness resulting from any activity for wage or profit.
- Expenses relating to a work-related illness or injury that would be covered by workers' compensation or an occupational disease law or similar law.
- Services or supplies furnished by or on behalf of the United States government (or any other government), unless payment by the Baxter Retiree Medical Plan is legally required; or any charge that would be eligible for payment under any law or government program under which the person is or could be covered.
- Any services provided for learning disabilities.
- Charges for services in residential treatment centers.
- Charges for applied behavior analysis (ABA).
- Charges for wearing apparel for normal use, such as orthopedic shoes, non-prescription arch supports, wigs, and toupees. (Wigs and hairpieces may be covered when hair is lost due to a medical illness or injury.)
- Fertility treatments (such as artificial insemination, in-vitro fertilization, and fertility drugs).
- Charges for funeral arrangements.
- Charges for pastoral counseling.
- Charges for financial or legal counseling, including estate planning or the drafting of a will.
- Charges for physician's services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process, or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the surgical and non-surgical treatment for, or prevention of, temporomandibular joint dysfunction (TMJ). The Retiree Medical Plan also does not cover other treatments for conditions of the joint linking the jawbone and skull or the muscles, nerves and other tissues related to that joint. This exclusion does not apply to charges made for treatment or removal of a malignant tumor.

- Charges for services in connection with foot conditions such as weak, strained, or flat feet, any instability or imbalance of the foot, or any metatarsalgia or bunion; unless the charges are in connection with an open cutting operation and meet other eligibility requirements of the Retiree Medical Plan. Physicians' services necessary to diagnose a condition are covered for these services.

- Charges for physicians' services (except those to diagnose the condition) in connection with corns, calluses, or toenails (except for the partial or complete removal of nail roots).

- Charges for hearing aids or examinations for their fitting or prescription. Physicians' services necessary to diagnose the related condition are covered.

- Services provided by a licensed practitioner not acting within the scope of his or her license.

- Personal care items, such as facial tissues, diapers, admission kits, and other convenience items.

- Charges for shipping, handling, postage, interest, finance charges, or the completion of claim forms.

- Eye care charges for or in connection with eye surgery, such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring).

- Charges for non-medically necessary services or supplies for medical care of a diagnosed sickness or injury, including tests.

- Charges for or in connection with services or supplies that are experimental, investigational or unproven. A drug, device, equipment, procedure or treatment is experimental, investigational or unproven if:

    - there are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;

    - it has not received marketing approval (permission for commercial distribution) from the United States (U.S.) Food and Drug Administration (FDA);

    - it has received marketing approval but the equipment, drug, device and/or supply is not being used for the purpose or manner for which it was initially rendered;

    - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

    - the treatment facility's written protocol or protocols; the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment; or the written informed consent used by the treating facility or by another facility studying

the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

FDA review and approval of devices only addresses safety of the device. The FDA does not address efficacy. Therefore, the Retiree Medical Plan does not necessarily recognize benefit coverage for FDA approved devices unless well-designed controlled studies in the peer-reviewed medical literature demonstrate efficacy and improved health outcomes from use of the device

This exclusion does not apply with respect to services or supplies (other than drugs) received in connection with a disease, if:

- the disease can be expected to cause death within one year, in the absence of effective treatment; and
- the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. The results of a panel of independent medical professionals' review is taken into account. The panel includes professionals who treat the type of disease involved.

This exclusion does not apply to drugs that:

- have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
- are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
- have demonstrated through scientific evidence that the drug is effective or shows promise of being effective for the disease.

- Massage therapy.
- Sex therapy.
- Services and supplies provided free of charge or for which there would be no charge in the absence of medical coverage.
- Travel, except when required as a recipient of an organ transplant as described in the "What the Retiree Medical Plan Covers" section of this booklet.
- Services or supplies needed as a result of an act of war, declared or undeclared.
- Services provided by family members.
- Any charge incurred prior to the date coverage became effective.
- Charges for food or formula for special diets ordered by a physician, except when feeding is enteral.

- Cosmetic surgery and all related charges (except when necessary to repair bodily damage caused by an injury or illness).

"Cosmetic surgery" means cosmetic, reconstructive or corrective plastic surgery or other procedures or treatment performed to improve appearance or to correct a deformity without restoring a physical body function. For the purposes of this coverage, psychological factors (for example, poor self-image or difficult social or peer relations) are not relevant and do not constitute a physical body function.

- Charges for custodial care—which is homemaker or caretaker services—whether or not performed under a physician's orders, that is primarily for the purpose of meeting personal needs (such as turning or moving). This type of care involves primarily personal care but may require skilled nursing and skilled rehabilitation services. In addition, the care is performed at the direction and under the supervision of a licensed registered nurse or a licensed practical nurse. The Retiree Medical Plan also does not cover respite care furnished while the person's family or usual caretaker cannot or will not attend to the person's needs.

- Charges for homemaker or caretaker services not solely related to the care of a person, including sitter or companion services, transportation, housecleaning, or house maintenance.

- Charges for services, equipment, or treatments provided primarily for the personal comfort and convenience of the patient.

- Home health care charges that are not part of a home health care plan, home health care services of a person who usually lives with you and is a member of your family, charges for a period when a person is not under the continuing care of a physician, home health care services of a social worker, and transportation related to home health care.

- Hospice care charges for:

  - the services of a person who is a member of the participant's family or who normally resides in the participant's home;

  - any period for which the participant is not under a physician's care; or

  - any curative or life-prolonging procedure.

- Chiropractic charges associated with maintenance or preventive treatments of dislocations.

- Dental services in connection with treatment of the teeth or periodontium, unless charges are:

  - related to dental work due to an injury to sound natural teeth; or

  - facility-type charges for services performed in a hospital (including room and board and services and supplies), a free-standing surgical facility, or in the outpatient department of a hospital in connection with a covered oral surgery. Oral surgery is limited to the following services:

  - Surgical removal of completely bony impacted teeth.
  - Excision of tumors and cysts of the jaws, cheeks, lips and tongue, roof and floor of the mouth.
  - Surgical procedures required to correct accidental injuries of jaws, cheeks, lips, tongue, roof and floor of the mouth when such injuries occur on or after the coverage date.
  - Excision of exostoses of the jaws and hard palate provided such procedure is not done in preparation for a prosthesis;
  - Treatment of fractures of facial bone
  - External incision and drainage of cellulitis
  - Incision of accessory sinuses, salivary glands, ducts
  - Reduction of dislocation or excision of the temporomandibular joints
- Organ transplant/prostheses charges associated with the following:
  - penile prostheses;
  - replacement of external prostheses due to wear and tear, loss, theft or destruction; and
  - biomechanical external prosthetic devices.
- Therapy charges to improve general physical condition, including cardiac and pulmonary rehabilitation, and any other therapy not generally recognized as effective or appropriate.
- The CVS Caremark Prescription Drug Program does not cover some prescription drugs, supplies and services. See the "Prescription Drug Program" section of this booklet for additional information.
- Certain vision and hearing expenses, including:
  - eyeglasses, hearing aids or examinations for prescription or fitting (except as otherwise provided in this booklet);
  - magnification aids, tinting or anti-reflective coatings, prescription sunglasses or light sensitive lenses;
  - eye examinations required by an employer as a condition of employment;
  - any eye examination required by law; and
  - safety glasses or lenses required for employment.

The preceding list provides a general description of services and supplies not covered by the Baxter Retiree Medical Plan. There may be additional services and supplies that the Retiree Medical Plan does not cover. The standards for covering different services and supplies may be changed from time to time without notice. If you have any question as to whether a particular service or supply is covered, check with the claims administrator before incurring the expense.

Coordination of Benefits

The Baxter Retiree Medical Plan coordinates benefits with other health care plans under which you or your dependents are covered (such as a spouse covered under his or her employer's plan or Medicare). In these instances, the plans work together through what is called a "coordination of benefits" or "nonduplication of benefits" provision.

If you or your covered dependents are eligible to receive benefits under more than one group plan, the total benefits under the plans cannot exceed the total allowable expense under the Baxter Retiree Medical Plan. For example, if the Baxter Retiree Medical Plan normally covers 80% of an eligible charge and another plan pays 70%, the Baxter Retiree Medical Plan would pay only an additional 10%. If the other plan pays 80%, the Baxter Retiree Medical Plan pays no additional benefits. "Allowable expenses" are the eligible charges covered in whole or in part under at least one of the plans.

The following types of plans normally are coordinated with the Baxter Retiree Medical Plan:

- Governmental benefit programs provided or required by law, including Medicare and Medicaid.
- No-fault automobile insurance plans.
- Plans provided by an employer, union, trust, or other similar provider.
- Other group health care plans by which you or your dependents are covered, including student coverage provided through a school above the high school level.

The coordination of benefits provision normally does not apply to individual or private insurance plans.

The Baxter Retiree Medical Plan requires information regarding other group health insurance coverage for you and any of your covered dependents. Your Retiree Medical Plan option's claims administrator may periodically request other insurance information from you. This request may occur in connection with a submitted claim; if so, you will be advised that the other insurance information (including any explanation of benefits from the other insurance carrier) is required before the submitted claim will be processed for payment. If the requested information is subsequently received by your Retiree Medical Plan option's claim administrator, the claim will be processed.

The claims administrator, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide them with any information they request to coordinate your benefits.

Determining the primary plan for non-Medicare eligible participants

When you or your covered dependent files a claim, the primary plan pays its benefits without regard to any other plans. The secondary plan or plans adjust their benefits so that the total benefits available do not exceed the allowable expenses.

In general, a plan with no coordination of benefits rules pays benefits first. If both plans have coordination of benefits rules, the first of the following rules will determine the order of payment:

- The plan covering the patient as an employee/retiree (rather than as a dependent) is the primary plan.
- For a dependent child, if both parents have group medical coverage for the child and the parents are not separated or divorced, the plan of the parent whose birthday (excluding the year of birth) comes first during the calendar year is the primary plan. For example, if the father was born on August 16 and the mother on June 11, the mother's plan is primary and would pay benefits first. Or, if the father was born on January 16 and the mother on March 20, the father's plan is primary. This is known as the "birthday rule." If both parents have the same birthday, then the plan that has had coverage in effect for the dependent child for the longest period is primary.
- In the case of divorce or separation, and a court decree places financial responsibility for the dependent child's medical care on one parent, that parent's plan always pays first. Baxter requires you to provide copies of the court documents to show this responsibility. If there is no court order, (a) the plan of the parent with custody of a dependent child pays benefits for the child first, (b) the plan of the person married to the parent with custody pays second, and (c) the plan of the parent without custody pays third. If (a) through (c) do not apply, the plan covering the individual for the longest period is primary.
- If a participant's stepchild or the child of a participant's domestic partner is also covered under a plan of the child's parent, the plan of the parent will be primary.
- The plan that covers a person as an employee who is neither laid off nor retired is primary. If the other plan does not have this rule, this rule is ignored.
- If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another plan, the plan covering the person as an employee or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, this rule is ignored.
- The plan that covered the person longer is primary.

Coordination with Medicare

As long as you or your covered dependent is eligible for Medicare (regardless of age), the Baxter Retiree Medical Plan coordinates with both Medicare Parts A and B coverage, regardless of whether you or your covered dependent elects Medicare coverage. Please note that the Baxter Retiree Medical Plan does not coordinate with Medicare Part D.

You should send all your bills to Medicare first, because Medicare is the "primary" provider of benefits. After Medicare has paid benefits, send the Explanation of Benefits you received from Medicare to your Retiree Medical Plan coverage option. The Baxter Retiree Medical Plan figures benefits as if it were the primary payor. Then, the Retiree Medical Plan subtracts any covered charges paid by Medicare for those same claims. Finally, the Retiree Medical Plan pays the difference between the Medicare payment and what the Retiree Medical Plan would have paid. If Medicare's payment is greater than or equal to what the Retiree Medical Plan provides, then the payment under the Retiree Medical Plan is zero.

This is why the Baxter Retiree Medical Plan is called the "secondary" provider of benefits. Keep in mind that your benefits from the Retiree Medical Plan and Medicare together won't be more than what the Retiree Medical Plan would have paid. The chart below is an example of how this works, assuming you have $1,000 of charges after deductibles have been met.

	For Medicare-Eligible Retirees or Dependents	**For Non-Medicare-Eligible Retirees or Dependents**
Covered charges after deductibles:	$ 1,000	$ 1,000
Medicare pays:	$ 500	$ 0
Baxter's Plan pays:	$ 300	$ 800
You pay:	$ 200	$ 200

The Baxter Retiree Medical Plan adjusts its payment based on what Medicare pays. Continuing with this example, if Medicare paid $800, the Retiree Medical Plan pays nothing. In this way, combined coverage from Medicare and the Baxter Retiree Medical Plan equals coverage without Medicare.

Medicare does not cover claims from a provider who has opted out of Medicare. When you see a provider who has opted out of Medicare, the Baxter Retiree Medical Plan will estimate the amount that Medicare would have paid for the services and subtract that amount from any benefits payable from the Retiree Medical Plan.

Remember, when filing a claim with the Baxter Retiree Medical Plan, you must submit the Medicare Explanation of Benefits.

Creditable Prescription Drug Coverage – Medicare Part D

Medicare prescription drug coverage is available to everyone eligible for Medicare through Medicare Part D prescription drug plans. Baxter has determined that the prescription drug coverage under the Retiree Medical Plan (if elected) is, on average for all participants, expected to pay as much or more than the standard Medicare prescription drug benefit. Therefore, because your existing drug coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a late penalty if you do not enroll in Medicare prescription drug coverage upon first becoming eligible for Medicare. You can choose to join a Medicare prescription drug plan later without incurring a penalty. If you decide to enroll in a Medicare prescription drug plan and drop your medical and prescription drug coverage under the Retiree Medical Plan, be aware that you will not be able to get this coverage back. Participants

eligible for Medicare receive an annual creditable coverage notice from Baxter that includes more information. For a free copy of the notice, contact HRCentral Support.

Filing a Health Care Claim

To receive benefits from the Retiree Medical Plan, you or your authorized representative must file claims directly with the appropriate claims administrator. Generally, if you receive services from a network provider, your provider will submit claims on your behalf. If your provider does not file a claim on your behalf, you may get a claim form from the www.YourBenefits.Baxter.com website. Routine requests for information regarding your benefits under the Retiree Medical Plan and other similar inquiries will not be considered benefit "claims" that require processing under ERISA. If you wish to make a claim for Retiree Medical Plan benefits in accordance with your rights under ERISA, you must do so in writing to the appropriate claims administrator, as described in this section.

An "authorized representative" means a person you authorize, in writing in accordance with the Retiree Medical Plan's procedures, to act on your behalf with respect to Plan claims and appeals. An assignment of benefits to your doctor or other health care provider does not constitute a designation of an authorized representative for this purpose. However, in urgent care situations, a health care provider with knowledge of your medical condition will be permitted to act as your authorized representative without formal designation. All communications from the Retiree Medical Plan will be directed to your authorized representative unless your written designation provides otherwise.

You may file a claim after you or your covered dependent pays the provider, or you may authorize the claims administrator to pay the provider directly. (Providers may require payment at the time of service.)

Be sure to file claims within 12 months of the date you or your dependent receive services.

HMOs normally do not require you to file claims. If for some reason you need to file a claim, however, your HMO can provide you with the necessary claim forms. **Keep in mind:** Filing claims is ultimately your responsibility. Be sure to follow up with your providers to ensure that your claim has been filed.

You have 12 months from the date of service to file a claim otherwise no payment will be made.

Explanation of benefits
If you file a claim for medical care benefits, you will receive a detailed statement (called an explanation of benefits, or EOB) from the claims administrator. The EOB will explain what amounts have been paid and what amounts have not been paid. The statement will explain the reason why a claim has not been paid.

If you have questions about claims
If you have questions about your claims, contact the appropriate claims administrator. The claims administrator can help you file a claim and can check on the status of an outstanding claim.

Requested information
You may be asked to provide the following information when filing claims with your Retiree Medical Plan option:

- the patient's name, birth date, and relationship to you;
- your name, Social Security number, address, and home telephone number;
- other insurance information for you and your covered dependents;
- the reason for hospitalization, surgery, or outpatient psychiatric or substance abuse treatment;
- the physician's name, address, and telephone number; and
- the hospital's name, address, and telephone number.

The information you provide is kept confidential. Throughout your treatment, your Retiree Medical Plan option's claims administration department works with your physician and may contact your physician's office for additional information such as:

- the diagnosis; and
- the way the physician proposes to treat the condition.

Claims while hospitalized
If you or a covered dependent is hospitalized or confined at home under the care of a doctor from one plan year into the next, the Retiree Medical Plan pays for any eligible claims based on the Baxter Retiree Medical Plan coverage option and coverage level in effect at the start of the hospitalization and continues through the end of the hospitalization. The Retiree Medical Plan does not require that a new deductible be met for the charges, and coinsurance levels stay the same. However, the retiree share of the premium cost for the applicable coverage option.

If your claim is denied
You must submit a written claim to the claims administrator for benefits to be paid.

If a claim is denied—in whole or in part—you or your beneficiaries are entitled to a full review. For more information about the process for reviewing denied claims, see the "Appealing Denied Claims" section of this booklet.

If you misrepresent a claim
When you file a claim for benefits, you certify that the statements you make on the claim form are complete and accurate to the best of your knowledge. If you misrepresent information or file a fraudulent claim, you are responsible for repaying any benefits based on that claim.

Prescription drugs
If you attempt to have a prescription filled through the Retail Network Pharmacy Program and the pharmacist determines that the prescription is not covered, this does not constitute a claim or a claim denial. In order to perfect your claim for the drug, you must purchase it and then file a

claim for reimbursement, which will be subject to processing (and appeal, if applicable) in the same manner as other medical claims.

When Retiree Medical Plan Coverage Ends

Under certain circumstances, your retiree medical coverage may end.

Your coverage under the Baxter Retiree Medical Plan ends on the last day of the month in which

- you or any member of your family submits a falsified, altered, or fraudulent claim (in this case your coverage will end immediately);
- you drop coverage due to a valid qualifying life event;
- you disenroll in coverage for the next plan year during annual enrollment;
- you reach age 65* (coverage terminates on the first day of the month immediately preceding the month in which you turn 65, or the first day of the prior month if you were born on the 1st of the month);
- you stop making payments; or
- You enter the military, naval, or air force of any country or international organization on a full-time active-duty basis (not including scheduled drills or training that lasts for a month or less during any calendar year).

Your dependents' coverage ends on:

- the date your coverage ends (for reasons other than death),
- the last day of the month in which your dependent no longer meets the Retiree Medical Plan's definition of an "eligible dependent". This includes coverage for dependents when legal guardianship (temporary or otherwise) ends (including loss of coverage for failure to satisfy the dependent verification requirements);
- your dependent reaches age 65* (coverage terminates on the first day of the month immediately preceding the month in which you turn 65, or the first day of the prior month if you were born on the 1st of the month); or
- the last day of the plan year if loss of coverage is due to reaching the limiting age. However, coverage may be terminated earlier if you are eligible to make and do make such an election).

*If you are an eligible retiree and you or your dependent are participating in the Baxter Retiree Medical Plan when you become eligible for Medicare (turn age 65), you or your dependent must purchase a Medicare supplemental policy through Via Benefits within 60 days after the day you or your dependent become eligible, using money credited to you through a Health Reimbursement Account (HRA) funded by Baxter if applicable. If you wait more than 60 days, you will not be eligible to participate in the HRA even if you later purchase a policy.

Coverage also may end if Baxter discontinues retiree medical coverage or amends the Retiree Medical Plan so that you and/or your dependent(s) are no longer eligible.

In some cases, coverage may be continued under COBRA as described in the following section, "Your Legal Right to Continue Coverage Under COBRA."

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 Retiree Medical 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 members of your family who are covered under the Retiree Medical Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Retiree Medical Plan and under federal law, you should contact HRCentral Support.

Although COBRA does not apply to domestic partners and children of domestic partners, Baxter will provide continuation benefits that are similar to COBRA continuation coverage, as explained below.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Retiree Medical 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 section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Retiree Medical Plan is lost because of the qualifying event. Under the Retiree Medical Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are the spouse or domestic partner of a covered retiree, you will become a qualified beneficiary if you lose your coverage under the Retiree Medical Plan because any of the following qualifying events happens:

- Your spouse or domestic partner (the Baxter retiree) dies;
- Your spouse or domestic partner (the Baxter retiree) becomes entitled to Medicare benefits (under Part A, Part B, or both);
- You become divorced from your spouse; or
- Your domestic partnership terminates.

Your dependent children and the dependent children of your spouse or domestic partner will become qualified beneficiaries if they lose coverage under the Retiree Medical Plan because any of the following qualifying events happens:

- You (the Baxter retiree) die;
- You (the Baxter retiree) become entitled to Medicare benefits (Part A, Part B, or both);
- You and your spouse divorce;
- Your domestic partnership with the child's parent is terminated; or
- The child stops being eligible for coverage under the Retiree Medical Plan as a "dependent child."

Any dependent who had coverage under the Retiree Medical Plan but subsequently failed to meet the dependent eligibility verification requirements and lost coverage as a result is not eligible for COBRA.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Baxter, and that bankruptcy results in the loss of coverage for you (the Baxter retiree) under the Retiree Medical Plan, you will become a qualified beneficiary with respect to the bankruptcy. Your spouse or domestic partner, surviving spouse or surviving domestic partner, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Retiree Medical Plan.

When is COBRA coverage available?
The Retiree Medical Plan will offer COBRA continuation coverage to qualified beneficiaries only after HRCentral Support has been notified that a qualifying event has occurred. When the qualifying event is the death of the retiree, commencement of a proceeding in bankruptcy with respect to Baxter, or the retiree becoming entitled to Medicare benefits (under Part A, Part B, or both), Baxter must notify HRCentral Support of the qualifying event.

You must give notice of some qualifying events
For the other qualifying events (divorce of the retiree and spouse, termination of a domestic partnership, or a dependent child's loss of eligibility for coverage as a dependent child), you (or your dependent) must notify HRCentral Support within 60 days after the qualifying event occurs. **If you (or your dependents) fail to notify HRCentral Support of these events within the 60-day period, the Retiree Medical Plan is not obligated under COBRA to provide continued coverage to the affected qualified beneficiary(ies).**

How is COBRA coverage provided?
Once HRCentral Support 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. COBRA coverage must be timely elected as described in the qualifying event notice. Covered retirees may elect COBRA continuation coverage on behalf of their spouses or domestic partners, 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 retiree, the retiree's entitlement to Medicare benefits (under Part A, Part B, or both), your divorce, termination of your domestic partnership, or a dependent child's loss of eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. COBRA continuation coverage can continue for the life of the retiree if the qualifying event is Baxter's bankruptcy (or up to 36 months after the retiree's death, for surviving qualified beneficiary dependents).

Termination of COBRA 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:

- Baxter no longer provides group health plan coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- The qualified beneficiary becomes entitled to Medicare; or
- The qualified beneficiary becomes covered under another group health plan (provided pre-existing condition exclusions or limitations under the group health care 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 retiree contributions) for coverage of a similarly situated participant or beneficiary who is not receiving continuation coverage. Baxter reviews the cost of Plan coverage each plan year. If the cost of Plan coverage changes for retirees and their dependents during your continuation period, your required monthly premiums may also change during your continuation period in the manner allowed by law. You will be notified of any changes in premium rates during your continuation period.

The qualified beneficiary 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.

If you have questions
Questions concerning the Retiree Medical Plan or COBRA continuation coverage rights should be addressed to HRCentral Support. 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 the Retiree Medical Plan informed of address changes
In order to protect your family's rights, you should keep HRCentral Support 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 HRCentral Support.

Plan Contact Information

HRCentral
HR Services and Health & Welfare
DEPT 00470
P.O. Box 1590
Lincolnshire, IL 60069-1590
Phone: English Toll-Free 1-844-249-8581 or Spanish Toll-Free 1-844-249-8803
Fax: 1-847-554-5020

The Baxter Retiree Life Insurance Plan

Life Insurance Introduction

Baxter offers life insurance coverage to eligible retirees under the Baxter Retiree Life Insurance Plan.

As of your retirement date, you have $5,000 in paid-up life insurance coverage as long as you were hired prior to January 1, 2016, had 65 or more credits as of December 31, 2016, and meet the definition of a "retiree" as defined under the Baxter Retiree Medical Plan and Baxter continues to offer the Baxter Retiree Life Insurance Plan. Baxter pays the full cost of this coverage. If you retired before November 25, 1985, however, you're covered under the terms of the Baxter Retiree Life Insurance Plan, if any, in effect at that time. If you were covered under the Security Life of Denver Split Dollar Plan, please contact HRCentral Support for additional information about your Retiree Life Insurance benefits.

This section is a summary of the Baxter Retiree Life Insurance Plan, in effect for the plan year beginning January 1, 2023. If you have any questions about any of the information in this section, contact HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free).

If you are an eligible Welch Allyn retiree and participated in retiree life insurance plan or policies maintained by Welch Allyn, Inc. as of December 31, 2022, you are eligible to participate in the Welch Allyn Retiree Life Insurance Plan as of January 1, 2023. You should refer to the certificate of coverage that was issued to you by the Plan carrier for details rather than the information contained in this section.

Plan Participation and Cost

The following describes eligibility, benefits and costs associated with Baxter's retiree life insurance coverage.

Who is eligible
You are eligible to participate in the Baxter Retiree Life Insurance Plan as of your retirement if you meet the definition of "retiree" as defined under the Baxter Retiree Medical Plan in the "Who is Eligible" section in the retiree medical portion of this SPD. Your eligibility date is your retirement date from Baxter. Your effective date for coverage is the same as your eligibility date.

You will be asked to name a beneficiary at the time you retire.

If you were hired on or after January 1, 2016, or had fewer than 65 credits as of December 31, 2016, you are not eligible to participate in the Baxter Retiree Life Insurance Plan.

Coverage amount
Your coverage under the Baxter Retiree Life Insurance Plan is group term life insurance coverage equal to $5,000. The Retiree Life Insurance Plan pays benefits regardless of the cause of death.

Cost of coverage
Baxter pays the full cost for your $5,000 retiree life insurance.

Your retiree life insurance coverage is insured by the plan carrier, who makes all benefit payments from the Retiree Life Insurance Plan and all decisions on eligibility for benefits.

Naming a Beneficiary

You should designate a beneficiary under the Baxter Retiree Life Insurance Plan at the time you retire. The beneficiary is the person or persons you name to receive the benefit in the event of your death. If you fail to designate a beneficiary at the time you retire, the beneficiary you most-recently named while you were an active employee under the Baxter Group Basic Life Insurance Plan will be considered to be your beneficiary under the Baxter Retiree Life Insurance Plan.

You may name more than one beneficiary and designate what portion of the entire benefit should be paid to each. For example, John Jones, son—50%; Mary Jones, daughter—50%.

You may change your beneficiary at any time by completing a new Retiree Life Insurance Beneficiary Designation Form. Call HRCentral Support for a form, and return the completed form with your new beneficiary designation to the address below:

HRCentral
HR Services and Health & Welfare
DEPT 00470
P.O. Box 1590
Lincolnshire, IL 60069-1590
Phone: English Toll-Free 1-844-249-8581 or Spanish Toll-Free 1-844-249-8803
Fax: 1-847-554-5020

If you die while covered by the Retiree Life Insurance Plan and you have not named a beneficiary, or your beneficiary dies before you, the Retiree Life Insurance Plan carrier may, at its option pay benefits to those who survive you in the following order:

- the executors or administrators of your estate;
- all to your surviving spouse;
- if your spouse does not survive you, in equal shares to your surviving children; or
- if no child survives you, in equal shares to your surviving parents.

You also may assign your benefits (for example, to a trust). However, this is a one-time irrevocable assignment.

Please note: Your domestic partner will not automatically be your beneficiary if you die. If you wish to name someone other than your spouse as your beneficiary, you must submit a beneficiary designation form, as described above. Similarly, the children of your spouse (whether same or opposite gender) or domestic partner will not automatically be your beneficiaries unless you

have adopted them, and if you wish them to be your beneficiaries you must submit a beneficiary designation.

Filing a Life Insurance Claim

If you die, your survivors should contact HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free) as soon as possible.

HRCentral Support will help your survivors file the necessary forms and documents needed for processing the claim with the insurance company and will answer any questions they have about plan payments. Routine requests for information regarding your benefits under the Retiree Life Insurance Plan and other similar inquiries will not be considered benefit "claims" that require processing under ERISA. If you wish to make a claim for Retiree Life Insurance Plan benefits in accordance with your rights under ERISA, you must do so in writing by following the procedures established by the life insurance carrier.

If a claim is denied

If a claim is denied, in whole or in part, you or your beneficiaries are entitled to a full review.

See "Appealing Denied Claims" later in this booklet.

When Retiree Life Insurance Coverage Ends

Coverage under the Baxter Retiree Life Insurance Plan ends if Baxter no longer offers retiree life insurance coverage or amends the Retiree Life Insurance Plan so that you are no longer eligible.

In some cases, coverage may be continued as described next.

Converting your coverage

If coverage under the Baxter Retiree Life Insurance Plan ends, you may convert your retiree group term life insurance policy to an individual insurance policy without having to provide evidence of insurability. There are some restrictions on the amount of coverage that can be converted. You pay the full cost of the converted policy at the rate charged by the insurance company. Converted coverage may not be identical to your prior coverage.

To convert to an individual policy, you must submit a completed application form within 31 days after group coverage ends. Payment for converted life insurance coverage must be made directly to the plan carrier.

Administrative Information

Retiree Plans' Administrative Information

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

- how to contact the Plan Administrator;
- information about the carriers, claims administrators or insurance companies that provide or administer the Plans and how to contact them; and
- what to do if a claim is denied;
- your rights under ERISA.

If you have any questions about any of the following, call HRCentral Support.

Plan sponsor and Administrator
The Plans are sponsored by Baxter International Inc. The Administrative Committee of Baxter International Inc. is the Plan Administrator. Each year the Compensation Committee of Baxter International Inc.'s Board of Directors appoints the members of the committee. The Plan Administrator has full authority to interpret and administer the Plan, and its decisions are final and binding on all parties. No person has the right to any benefits under the Plan unless the Plan Administrator, or a person to whom the Plan Administrator has delegate the authority, determines that the benefit is payable.

HRCentral Support is your primary source of information about the Plans. HR Central Support can be reached at the address and phone number below:

HRCentral
HR Services and Health & Welfare
DEPT 00470
P.O. Box 1590
Lincolnshire, IL 60069-1590
Phone: English Toll-Free 1-844-249-8581 or Spanish Toll-Free 1-844-249-8803
Fax: 1-847-554-5020

If you have questions HRCentral Support cannot answer satisfactorily, you may contact the Plan Administrator at:

Administrative Committee
c/o Global Employee Benefits Department
Baxter International Inc.
One Baxter Parkway
Deerfield, Illinois 60015
1-224-948-2000

The Plan Administrator, or its designee, has sole discretionary authority to interpret and construe the provisions of the Plans, to determine eligibility for benefits under the Plan, and to resolve any

disputes that arise under the Plans. Benefits under the Plans will be paid only if the Plan Administrator (or its delegate) decides in its sole discretion that the applicant is entitled to them. Decisions of the Plan Administrator will be final and binding.

Baxter's address is the same as that of the Administrative Committee.

Plan identification number
When dealing with or referring to the Plans in terms of claim appeals or other correspondence, you will receive a more rapid response if you identify the Plans fully and accurately. To identify a Plan, you need to use Baxter International Inc.'s employer identification number (EIN): 36-0781620. You also need to know the official plan name and plan number, as shown in the chart below.

Official Plan Name	Plan Number
The Baxter Retiree Medical Plan is a component part of a larger plan whose official name is the Baxter International Inc. Welfare Plan for Retirees and Disabled Individuals (the "Retiree Welfare Benefit Plan")	531
The Baxter Retiree Life Insurance Plan is a component part of a larger plan whose official name is the Baxter International Inc. and Subsidiaries Welfare Benefit Plan for Active Employees (the "Welfare Benefit Plan").	521

Plan year
January 1 through December 31.

Source of benefits funding
The HSA (1 and 2), BTO, PPO, POS coverage options under the Baxter Retiree Medical Plan are self-funded. The HMO options under the Retiree Medical Plan and Retiree Life Insurance Plan benefits are fully insured.

Claims administrators for the Baxter Retiree Medical Plan

Baxter contracts with third party claims administrators to provide a network of providers and administer claims and certain appeals involving a determination of medical benefits under the self-insured Retiree Medical Plan coverage options. The HMO is the claims administrator for insured HMO options for claims and appeals involving a determination of medical benefits.

Medical claims administrator for the PPO, POS, **HSA (1 and 2)**, BTO coverage options:

Blue Cross and Blue Shield of Illinois
1-800-985-6241
300 East Randolph
Chicago, IL 60601

For filing claims

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

For filing appeals

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

- **Pharmacy network and mail order prescription drug** claims administrator for the PPO, POS, BTO and HSA (1 and 2) coverage options:

  CVS Caremark
  2211 Sanders Road
  Northbrook, IL 60015
  1-866-282-3463

  For filing claims

  CVS Caremark
  P.O. Box 52136
  Phoenix, AZ 85072-2136
  For filing appeals

  CVS Caremark
  Appeals Department MC109
  P.O. Box 52084
  Phoenix, AZ 85072-2084
  Fax: 1-866-689-3092

- **HMOs**

  See your ID card for the full address and telephone number.

<u>Plan carriers for the Baxter Retiree Life Insurance Plan</u>

<u>Plan carrier and claims administrator for the Baxter Retiree Life Insurance Plan</u>

The claims administrator and final appeals administrator for requests for benefits under the Baxter Retiree Life Plan is the plan insurance carrier. The Retiree Life Insurance Plan and the Welch Allyn Retiree Life Plan is insured by:

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

For appeals:
Hartford Life and Accident Insurance Company
200 Hopmeadow St.
Simsbury, CT 06089
1-800-523-2233

Eligibility claims administrators
The Plan Administrator retains the discretionary authority to decide claims involving your (and your dependents') eligibility to participate in the Plans, your enrollment in the Plans and the cost of your Retiree Medical Plan premium contributions. The claims administrator for a First Level Claim and the Level 1 appeal of a denied claim relating to eligibility (other than dependent verification), enrollment, COBRA rights, retiree premium contributions, or anything other than a determination of benefits (as applicable) is:

Claims and Appeals Management
DEPT 00470
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 1-847-554-5020

The claims administrator for an initial claim and appeal relating to a dependent verification failure is:

Dependent Verification Center
P.O. Box 1415
Lincolnshire, IL 60069-1415
Fax: 1-855-769-5781

Final appeals administrator
The claims administrator for eligibility, enrollment and cost of medical coverage Level 2 Appeals is the Plan Administrator.

The Plan Administrator has delegated responsibility for making final appeal decisions to the Appeals Subcommittee of the Administrative Committee of Baxter International Inc. The address for the Appeals Subcommittee is:

Appeals Subcommittee
c/o Global Employee Benefits Department
Baxter International Inc.
One Baxter Parkway
Deerfield, IL 60015

1-224-948-2000

Agent for service of legal process
The agent for service of legal process on the Plans is:

Senior Vice President and General Counsel
Baxter International Inc.
One Baxter Parkway
Deerfield, Illinois 60015
Legal process on the plans may also be served on the Plan Administrator.

Plan amendments
The Administrative Committee, as delegated by the Compensation Committee of the Board of Directors of Baxter International Inc., is authorized to amend benefit plans. Also, the Administrative Committee has authorized Baxter's Senior Vice President, Human Resources, to execute and implement plan amendments.

Situations Affecting Your Plan Benefits

Certain situations could affect your benefits under Baxter's retiree benefit plans.

Recovery of overpayments
If for any reason the Baxter Retiree Medical Plan pays a benefit which is larger than the amount allowed, the Retiree Medical Plan has a right to recover the excess amount from the person or agency who received it. The person receiving the benefit must produce any instruments or papers necessary to enforce this right of recovery.

Subrogation and reimbursement
As a condition for receiving benefits under the Baxter Retiree Medical Plan, each covered person agrees to and grants the Retiree Medical Plan the right to subrogation, the right to reimbursement and the right of recovery, as set forth below. Any reference in this section to the "Plan Administrator" means the applicable claims administrator if the relevant authority and responsibility has been delegated by the Plan Administrator to that claims administrator.

Third party liability
The Baxter Retiree Medical Plan has the right to recover benefits paid for services and supplies relating to an illness, injury, disability or death incurred as a result of the actions of a third party who is or may be liable for all or part of such expenses. This right of recovery also extends to claims due to injury, sickness, disability or death to the extent that payment is or may be made under the terms of any "no fault" type of automobile policy, an uninsured or underinsured motorist coverage under an automobile policy, any homeowner's policy, workers' compensation or other similar insurance coverage.

A "third party" includes any person or entity who is or may be liable for your injury, illness, disability or death whether the third party is responsible for the actual injury, illness, disability or death, or is responsible or liable financially as an insurer.

Reimbursement agreement
If you incur expenses that are or may be the responsibility of a third party, you are required, as a prerequisite to receiving Retiree Medical Plan benefits, to sign a reimbursement agreement in a form acceptable to the Plan Administrator acknowledging your obligation to reimburse the Retiree Medical Plan for any benefits or expenses paid by the Retiree Medical Plan from the first dollars recovered from any source. If expenses are incurred by a minor, the Plan Administrator may require the minor's parent or legal guardian to execute the reimbursement agreement and agree to be bound by it. The Plan Administrator may, in its discretion, withhold benefit payments that might otherwise be paid, and/or initiate an action at law or in equity in its own name or in the covered person's name, in order to enforce, secure, or protect the Retiree Medical Plan's rights under this provision. If you elect not to execute a reimbursement agreement, the Retiree Medical Plan is not obligated to provide any benefit payments.

Right of subrogation
Whether or not you execute a reimbursement agreement, you agree, as a condition to participation in and the receipt of benefits under the Retiree Medical Plan, that the Retiree Medical Plan has the right of subrogation with respect to the full amount of benefits paid to you or on your behalf as the result of an injury, illness, disability or death that is or may be the

responsibility of any third party. The Retiree Medical Plan will also have a lien upon any recovery from the third party to the full amount of benefits paid and may, at its option, file suit or intervene in any pending lawsuit to secure and protect its rights. The Retiree Medical Plan's right of subrogation will apply to the first dollar of any recovery obtained from the third party, even if the recovery obtained is less than the amount needed to make you whole. By accepting benefits paid under the Retiree Medical Plan, you grant a lien and assign to the Retiree Medical Plan an amount equal to the benefits paid against any recovery you receive.

Right of reimbursement
Whether or not you execute a reimbursement agreement, if the Retiree Medical Plan provides benefits to you and you recover a payment, either by settlement, judgment, no-fault automobile insurance statute, or otherwise, from any third party or other source, then you must immediately reimburse the Retiree Medical Plan for the full amount of any and all benefits paid in connection with such injury, illness, disability or death, up to the amount of the recovery. This right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of injuries. The Retiree Medical Plan will have a lien upon any such recovery in the amount of benefits or expenses paid by the Retiree Medical Plan. The Retiree Medical Plan's right of reimbursement will apply to the first dollar of any recovery obtained from the third party, even if the recovery obtained is less than the amount needed to make you whole. The Retiree Medical Plan's share of recovery will not be reduced because the covered person has not received the full damages claimed, unless the Retiree Medical Plan agrees in writing to such a reduction. The Retiree Medical Plan's right of reimbursement will apply to a covered person who is a minor.

Procedures for subrogation and reimbursement
If you or your covered dependent suffers a loss, or an injury caused by a third party (*e.g.*, another person hit your car and you were injured), you must do whatever is requested by the Plan Administrator with respect to the exercise of the Retiree Medical Plan's subrogation and reimbursement rights, and you must not do anything to prejudice those rights. As a condition to receipt of benefits under the Retiree Medical Plan, you or your covered dependent must do the following:

Promptly notify the Plan Administrator in writing and provide the following information:

- Name, address and telephone number of the third party and of the attorney representing the third party;

- Name, address, and telephone number of the third party's insurer and any insurer of the covered person;

- Name, address, and telephone number of the covered person's attorney with respect to the third party's act;

- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and the covered person, or his attorney;

- All terms of any settlement offer made by the third party or his insurer or the covered person's insurer;

- All information discovered by the covered person, or his attorney, concerning the insurance coverage of the third party;
- Amount and location of any money that is recovered by the covered person from the third party or his insurer or the covered person's insurer, and the date that the money was received;
- Prior to settlement, all information related to any oral or written settlement agreement between the covered person and the third party or his insurer or the covered person's insurer;
- All information regarding any legal action that has been brought on behalf of a covered person against the third party or his insurer; and
- All other information requested by the Plan Administrator.

Provide any necessary assistance requested by the Plan Administrator.

If requested by the Plan Administrator, sign and return to the Plan Administrator a written agreement to subrogate or reimburse the Retiree Medical Plan.

Comply with the subrogation and reimbursement terms of the Retiree Medical Plan.

Pay the Plan Administrator up to the amount of the benefits you or your covered dependent received under the Retiree Medical Plan for expenses you incurred, subject to applicable law, if you collect damages from the third party that caused your injury. You or your covered spouse or dependent may collect such damages through a lawsuit, settlement, or otherwise.

The amount that the Retiree Medical Plan is entitled to recover will not be reduced or offset by any attorney's fees or other expenses that you incur in recovering any such payment, and the doctrine known as the "common fund" doctrine, which generally requires that each party who is entitled to a share of a judgment or other recovery bear a share of the attorney's fees and other expenses incurred in obtaining the judgment or other recovery, does not apply to the Retiree Medical Plan's right of subrogation or reimbursement.

You and your covered dependents must notify the Plan Administrator before filing suit and must not settle any claim with a third party without giving notice to and obtaining the consent of the Plan Administrator. Any funds recovered by the covered person (or that person's legal representative) from a third party (or the third party's insurer) must and are deemed to be held in constructive trust for the benefit of the Plan to the extent the Plan has not been reimbursed for all related claims paid, and the covered person (or that person's legal representative) will serve as trustee and fiduciary of such trust.

Overpayment recovery
If the Plan pays a benefit on behalf of you or your covered dependent that exceeds the benefit amount you or your covered dependent is entitled to receive, the Plan has the right to:

- **Require the return of the overpayment, and to seek recovery of any excess amounts.**

- **Reduce, by the amount of the overpayment, any future benefit payment made to that person or on behalf of that person.**
- **Employ any other lawful means to recover overpayment on behalf of the Plan, including to reduce future payments to the provider by the amount of the overpayment.**

These rights do not affect any other right of recovery the Plan may have with respect to such overpayment.

Assignment of benefits

Retiree Medical Plan
You cannot transfer or assign your rights under the Baxter Retiree Medical Plan or your benefits or claims under the Baxter Retiree Medical Plan, including to any provider and any such transfers or assignments will be considered void. However, the claims administrator has the right to make any benefit payments directly to your provider on your behalf.

Coverage under the Retiree Medical Plan is expressly non–assignable and non–transferable and will be forfeited if a covered person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Retiree Medical Plan.

As described in the “Filing a Health Care Claim” section of this booklet, only you or your authorized representative may file claims for Plan benefits. An assignment of benefits to your doctor, hospital, or other health care provider does not constitute a designation of an authorized representative for this purpose and does not authorize your doctor, hospital, or other health care provider to bring a legal action for Plan benefits on your behalf.

Retiree Life Insurance Plan
You may assign all of your rights under the Retiree Life Insurance Plan to someone else. Because this is a very serious decision, it is important that you talk to an attorney before assigning your benefits. Contact HRCentral Support if you have further questions.

Qualified medical child support order
If you become divorced, certain court orders could require that you provide health care coverage for your child(ren), even if you do not have custody. If the court order satisfies all of the applicable legal requirements, Baxter makes coverage available to the extent provided by law, and under the Baxter Retiree Medical Plan. The Retiree Medical Plan has adopted written procedures for determining whether an order satisfies the requirements for a qualified medical child support order, a copy of which is available from the Plan Administrator without charge.

Uncashed Checks
Any Retiree Medical Plan benefit payments or reimbursements made by check must be cashed within the time period indicated on the check. If you misplace a benefit payment or reimbursement check, you may request that a check be reissued by contacting the appropriate claims administrator within two years of the original date of issue to request that the check be re-issued. If the two-year period has elapsed, checks cannot be re-issued, the Retiree Medical Plan will have no liability for the benefit payment, the amount of the benefit payment will be deemed

a forfeiture, and no funds will escheat the any state. Therefore, it is important to keep HRCentral Support informed of your current address and to timely deposit your benefits checks.

If the Plans are modified or ended

Baxter hopes to continue the retiree benefit plans in the future but reserves the right to amend or terminate the Plans and benefits offered under the Plans at any time—in whole or in part. If the Plans are ever terminated, suspended, or modified, benefits for services received before the change would be paid in accordance with the Plans' former terms and conditions, but no benefits would be paid for services received after such action, unless specific provisions are adopted.

Appealing Denied Claims

Medical Benefit Claims Process

Initial Claim Decision: When a claim is received for a medical benefit, the claims administrator will decide whether (and/or at what level) the benefit is covered under the Plan. When the medical benefit is provided or denied, you will receive an EOB or other notice explaining how the coverage level was calculated or why benefits have been denied. How fast this notice will be given to you depends on whether the claim is an **urgent care** claim, a **pre-service** claim or a **post-service** claim. The deadline for this notice is no later than:

- For an urgent care claim, 72 hours after the claim is received.
- For a pre-service claim, 15 days after the claim is received.
- For a post-service claim, 30 days after the claim is received.

An "**urgent care claim**" is any medical benefit claim where applying the non-urgent care time frames (i) could seriously jeopardize your health or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain without the care or treatment that is the subject of the claim.

A "**pre-service claim**" is a medical benefit claim that conditions payment of a Plan benefit (in full or in part) on approval of the benefit before you receive the medical care.

A "**post-service claim**" is any other medical benefit claim, for example, a claim for reimbursement after the medical care is received.

Extension of Time for Claim Decision: The 15-day and 30-day periods described above may be extended for up to an additional 15 days if the claims administrator determines that an extension is necessary due to matters beyond the control of the Retiree Medical Plan. If the claims administrator requires an extension of time for making its determination, you will receive a written notice of the extension prior to the end of the 15-day or 30-day period explaining the circumstances requiring the extension and the date by which the claims administrator expects to make a determination on the claim. If an extension of time is needed to decide your pre-service or post-service claim because of your failure to submit information necessary to decide the claim, the written notice of the extension will describe the required information, and you will be given 45 days to provide the required information.

The following special rules apply if your claim is an urgent care claim or a pre-service claim:

- You will be notified of the decision whether or not it is adverse.
- You can be notified of an initial urgent care denial decision orally, if a written or electronic notice is provided no more than 3 days after the oral notice.

Failure to Follow Urgent Care or Pre-Service Claims Procedure: If you fail to follow the procedures for filing an urgent care claim or a pre-service claim, you will be notified of the failure and the proper procedure that you must follow. This notice will be provided no later than 24 hours after the failure for urgent care claims or 5 days after the failure for pre-service claims. This notice may be oral unless you (or your authorized representative) request a written notice. This notice is triggered when:

- You (or your authorized representative) make a communication that is received by a person or organization unit customarily responsible for handling benefit matters; and
- The communication names a specific participant or covered dependent, a specific medical condition and a specific treatment, service or product for which approval is requested.

Notice of Incomplete Urgent Care Claim: If you (or your authorized representative) properly submit an urgent care claim that is missing necessary information, you will receive a notice. This notice will tell you the specific information needed to complete the claim. The notice will be given no later than 24 hours after receiving the claim. You will be given a reasonable time to provide the information but not less than 48 hours. You will be notified of the decision concerning your urgent care claim as soon as possible but no later than 48 hours after the earlier of:

- When the Retiree Medical Plan receives the requested information, or
- The end of the period you were given to provide the information.

Concurrent Care Claim: At times the claims administrator may approve a course of treatment that is provided over time or for a specific number of treatments. If the claims administrator later terminates or reduces the previously-approved course of treatment, it will notify you of this decision so you will have sufficient time to appeal that decision before the course of treatment is reduced or terminated.

If you need to extend a course of treatment that constitutes a claim involving urgent care, you should contact the claims administrator at least 24 hours before the approved course of treatment will expire. If you do so, the claims administrator will provide you with a notice of its decision concerning the requested extension within 24 hours of your request. If you request an extension later, you will receive a notice of the claims administrator's decision based on whether that request is an urgent care, pre-service or post-service claim.

Eligibility, Enrollment, and Cost of Coverage Claims: The Plan Administrator is responsible for deciding any disputes relating to your eligibility to participate in the Baxter Medical Plan, your (or your eligible dependent's) enrollment in Plan coverage, or the cost of your Plan coverage. The Plan Administrator has designated the Dependent Verification Center as the claims administrator for initial claims relating to dependent verification failures. The Plan Administrator has designated HRCentral as the claims administrator for all other initial eligibility, enrollment, and cost of coverage claims. The Dependent Verification Center or HRCentral, as applicable, will make initial eligibility, enrollment, and cost-related claims in accordance with the timelines and procedures described above.

Appealing a Denial: If you disagree with the decision of the claims administrator, you may request a full review of the decision. You may make an oral request for an urgent care appeal; otherwise, appeals must be submitted in writing. In support of your claim review, you have the option of presenting evidence and testimony to the claims administrator, by phone. You must submit your request within 180 days after you receive the denial notice. In connection with your appeal, you or your authorized representative can receive reasonable access to and copies (free of charge) of all documents, records and other information relevant to your claim. If the claims administrator considers, generates, or relies on any new evidence during your appeals process or

will base its decision on a new or additional rationale, you or your authorized representative will be provided with such information or rationale as soon as possible and free of charge in time to allow you a reasonable opportunity to respond before a final decision is made on appeal. You may also submit written comments, documents, records and other information relating to your claim. The review on appeal will take into account any information you submit, even if it was not submitted or considered as part of the initial determination, if you want to appeal a decision related to medical benefits, send your appeal to the appropriate claims administrator listed under the *Administrative Information* section of this booklet.

If your claim/appeal is related to Plan eligibility (other than dependent verification failures), enrollment (including COBRA coverage), or the cost of Plan coverage, you should direct your appeal to HRCentral **.** The Plan Administrator has designated HRCentral as the claims administrator for initial appeals of eligibility, enrollment, and cost of coverage claims. For dependent verification claims, submit your appeal directly to the Dependent Verification Center.

Your appeal will be reviewed by someone other than the person who made the first decision on your claim. The claims administrator will disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the claims administrator will consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

After a decision is made concerning your appeal, you will be notified of its findings and decision in writing. This notice will be provided no later than:

- For an urgent care claim, 72 hours after receiving the appeal.
- For a pre-service claim, 15 days after receiving the appeal
- For a post-service claim, 30 days after receiving the appeal.

If your claim relates to a dependent verification failure, then the Appeals Subcommittee will decide your appeal. The Appeals Subcommittee's decision will be final, and you will have exhausted all of your administrative remedies with Baxter and the Baxter Medical Plan. If you disagree with the Appeals Subcommittee's decision on your dependent verification appeal, you may file a lawsuit within six (6) months after receipt of the Appeals Subcommittee's decision.

For all other types of claims, you must seek another level of review before you are permitted to bring suit against Baxter or the Plan.

If you select an HMO, the HMO completely controls the appeals process related to medical benefits. The appeals process is generally called a grievance process. If your claim relates to medical benefits, the first-round appeal represents the final step in administrative review. Refer to your HMO materials or contact your HMO for more information regarding appealing a denial claim. The decision of the claims administer at the first round of appeal will be final, and you will have exhausted all of your administrative remedies with Baxter and the Baxter Retiree Medical Plan.

External Review – Clinical claims involving medical judgment or rescissions of coverage
If the claims administrator's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you or your authorized representative may make a request for an expedited external review of a claim denial (following an initial claim denial, but only for qualifying claims, as described below) or a standard external review (for all other claims) by an independent review organization (IRO).
External review is only available if your claim is denied or partially denied based on:

- Clinical reasons or medical judgment, such as a determination that a service or supply is not medically necessary;
- Experimental or investigational services exclusions or unproven services exclusions;
- Retroactive cancellation of your coverage (referred to as rescission of coverage) for reasons other than failure to pay your contribution toward the cost of your Baxter Retiree Medical Plan coverage, fraud, or intentional misrepresentation; or
- As otherwise required by applicable law.

Within four (4) months after the date of receipt of a notice of a claim or appeal denial from the claims administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

Within five (5) business days following the date of receipt of the external review request, the claims administrator must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the Retiree Medical Plan at the time the health care item or service was requested or provided;
- The denial does not relate to your failure to meet the requirements for eligibility under the Retiree Medical Plan;
- You have exhausted the claims administrator's internal appeal process (not required for expedited review situations described below); and
- You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within one (1) business day after completion of the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four (4) month request period (or 48 hours following receipt of the notice), whichever is later, to perfect the external review request. If your claim is not eligible for external review, the claims administrator will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

Referral to Independent Review Organization
If your claim qualifies, the claims administrator will assign the matter to an independent review organization (IRO). The IRO must provide the following:

a. Utilization of legal experts where appropriate.

b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review.

c. Within five (5) business days after the date of assignment of the IRO, the claims administrator must provide to the assigned IRO the documents and any information considered in denying the claim. Failure by the claims administrator to timely provide the documents and information must not delay the conduct of the external review. If the claims administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the claims administrator's decision. Within one (1) business day after making the decision, the IRO must notify the claims administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one (1) business day forward the information to the claims administrator. Upon receipt of any such information, the claims administrator may reconsider its decision. Reconsideration by the claims administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the claims administrator decides, upon completion of its reconsideration, to reverse its decision and provide coverage or payment. Within one (1) business day after making such a decision, the claims administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the claims administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   (1) Your medical records;

   (2) The attending health care professional's recommendation;

   (3) Reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider;

   (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

   (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

   (6) Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claims administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care 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);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

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

(4) 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; (5) 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 claims administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claims administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

Reversal of the Retiree Medical Plan's decision
Upon receipt of a notice of a final external review decision reversing the claims administrator's decision, the Retiree Medical Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. Request for expedited external review. The claims administrator must allow you or your authorized representative to make a request for an expedited external review with the claims administrator at the time you receive:

- **a.** A claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- **b.** An appeal denial, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the appeal denial concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the claims administrator must determine whether the request meets the reviewability requirements set forth in the *External Review* section above. The claims administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in the *External Review* section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the claims administrator will assign an IRO pursuant to the requirements set forth above. The claims administrator must provide or transmit all necessary documents and information considered in making the decision to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process.

4. Notice of final external review decision. The claims administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the *Referral to Independent Review Organization* section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claims administrator and you or your authorized representative.

No person eligible for benefits under the Retiree Medical Plan has a right to seek review of a denial of medical benefits—or to bring any action to enforce a claim for benefits—in any court, prior to filing a claim for benefits and exhausting all rights described under this section. For claims involving medical judgment or rescissions of coverage, external review is the final step. If your appeal is denied on external review, you will have exhausted all of your administrative remedies with Baxter and the Baxter Retiree Medical Plan. If you disagree with the Retiree

Medical Plan's decision on appeal and the IRO's decision on external review, you may file a lawsuit no more than six (6) months after receipt of the decision on external review.

Second level appeals – Non-clinical claims
If you disagree with the decision on an appeal related to eligibility, enrollment, or the cost of Plan coverage, you have the right to file a second level appeal with the Appeals Subcommittee of the Administrative Committee of Baxter International Inc. You must file a second level appeal if you wish to preserve your right to file a lawsuit for the claimed benefit. Send your second level appeal to the Appeals Subcommittee at the address listed under the Administrative Information section of this booklet. You must submit this request within 180 days after you receive the denial notice from the first appeal.

Your second appeal will be reviewed by someone other than the person who made the original decision on your claim, or who decided the first appeal. The Appeals Subcommittee will provide you with any new or additional evidence considered, relied on, or generated in connection with your appeal sufficiently in advance of the date on which the second level appeal decision is due to give you a reasonable opportunity to respond. In addition, the Appeals Subcommittee will provide you with any new or additional rationale for denying your appeal before issuing a second level appeal decision and will give you a reasonable opportunity to respond. After a decision is made concerning your appeal, you will be notified of its findings and decision in writing.

The Appeals Subcommittee will complete this second level of review within the same timeframe identified above for the initial appeal — that is, 15 days for appeal of a pre-service claim and 30 days for appeal of a post-service claim.

No person eligible for benefits under the Plan has a right to seek review of a denial of benefits—or to bring any action to enforce a claim for benefits—in any court, prior to filing a claim for benefits and exhausting all rights described under this section, or more than six (6) months after receipt of the decision on review. Except as may be otherwise required by law, the final decisions of the claims administrator and the Appeals Subcommittee will be binding on all parties.

This second round appeals process represents the final step in administrative review of a claim for Plan benefits. If your second- round appeal is denied, you will have exhausted all of your administrative remedies with Baxter and the Baxter Retiree Medical Plan.

Claims/Appeals Decision Notices: The notice given to you concerning the decision on either your initial claim or your appeal(s) will include:

- Information sufficient to identify the claim involved, including the date or dates of service, the health care provider, the claim amount (if applicable), and notice regarding the availability of the diagnosis code and its corresponding meaning and/or the treatment code and its corresponding meaning.
- The specific reason or reasons for the decision, including, if applicable, the denial code and its corresponding meaning.
- The specific Plan provisions upon which the benefit decision is based.
- A statement that you are entitled to receive upon request (and free of charge) reasonable access to, and copies of, all document, records and other information relevant to your claim.

- For an initial claim, a description of any additional material or information that is necessary for you to complete your claim and an explanation of why such material or information is necessary.
- If an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request.
- If the decision is based on a medical limit (for example, a decision that the proposed service is not medically necessary or that it is experimental), either an explanation of the scientific or clinical judgment for the decision (applying the Retiree Medical Plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request.
- A description of the appeal procedures, including how to file an appeal or a request for an external review, as applicable. For an urgent care claim, this will include a description of the Retiree Medical Plan's expedited review process.
- A statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals and the external review process.
- A statement of your right to bring suit under ERISA if your claim is denied following a final appeal.

If you decide to pursue any legal action relating to your claim after exhausting your administrative remedies under the Retiree Medical Plan, the evidence that you may present in your case will be strictly limited to the documents, information, and other evidence timely presented to the claims administrator or, IRO as applicable in connection with the Retiree Medical Plan's claims and appeals procedures, as described above.

If you misrepresent a claim
When you file a claim for benefits, you certify that the statements you make on the claim form are complete and accurate to the best of your knowledge. If you misrepresent information or file a fraudulent claim, you are responsible for repaying any benefits based on that claim.

Life Claims Process

If a claim is denied
The claims administrator for the Retiree Life Insurance Plans will make a decision on a claim not later than 90 days after receiving the claim, unless special circumstances require an extension of time, in which case a decision will be made as soon as possible, but not later than 180 days after receiving the claim. If the claims administrator requires an extension of time for making its determination, the claimant will receive a written notice of the extension prior to the end of the original 90-day period explaining the circumstances requiring the extension and the date by which the claims administrator expects to make a determination on the claim.

If a claim for benefits is denied—in whole or in part—the claims administrator will send the claimant a written notice that will:

- specify the reason for the denial;
- reference the pertinent plan provisions on which the denial is based;

- describe any additional material or information necessary for properly completing the claim and explain the necessity of such material or information;
- explain the claim review procedures; and
- include a statement explaining the claimant's right to bring suit under ERISA if the claim is denied following a final appeal.

Appealing a denied claim

If the claim is denied under the procedures described above, the claimant (or his or her authorized representative) may request in writing a review of the denied claim. The claims administrator must receive the written request within 60 days after the receipt of the initial claim denial. In connection with the appeal, the claimant or his or her authorized representative can receive reasonable access to and copies (free of charge) of all documents, records and other information relevant to the claim. The claimant may also submit written comments, documents, records and other information relating to the claim.

> If a claim relates to benefits and the claim is denied, direct the appeal to the Retiree Life Insurance Plan's insurance carrier. If a claim relates to anything other than a determination of benefits (e.g., eligibility, etc.), direct the appeal to HRCentral
> .

If such request is made, the claims administrator will make a full and fair review of the denied claim. The claims administrator will make a decision no later than 60 days after receipt of the request, unless special circumstances (such as further investigation) require an extension of time. If an extension is required, the claims administrator will make a decision as soon as possible, but no later than 120 days after receiving the request for review. The claimant will receive a written notice of the extension before the extension begins. The claimant will be notified in writing of the claims administrator's decision. If the appeal is denied, the notice will:

- specify the reason or reasons for the denial;
- reference the pertinent plan provisions on which the denial is based;
- include a statement explaining the claimant's right to receive access to and copies (free of charge) of all documents and information relevant to the claim; and
- include a statement explaining the claimant's right to bring action under ERISA to recover benefits or enforce his or her rights.

Eligibility, Enrollment, and Cost of Coverage Claims and Appeals: The Plan Administrator is responsible for deciding any disputes relating to your eligibility to participate or enrollment in the Baxter Retiree Life Insurance Plan. The Plan Administrator has designated HRCentral as the claims administrator for initial eligibility and enrollment claims. HRCentral will make initial eligibility and enrollment-related claims decisions in accordance with the timelines and procedures described above.

The Plan Administrator has designated the Appeals Subcommittee of the Administrative Committee of Baxter International Inc. as the claims administrator for eligibility and enrollment appeals. The Appeals Subcommittee will make eligibility and enrollment-related appeals decisions in accordance with the timelines and procedures described above.

Exhaustion of administrative review remedies
This appeal process represents the final step in administrative review. If the appeal is denied, the claimant will have exhausted all of the administrative remedies with Baxter and the Baxter Retiree Life Plan, as applicable.

No person eligible for benefits under the Retiree Life Insurance Plan has a right to seek review of a denial of benefits—or to bring any action to enforce a claim for benefits—in any court, prior to filing a claim for benefits and exhausting all rights described under this section, or more than six (6) months after receipt of the decision on review. Except as may be otherwise required by law, the final decisions of the claims administrator and the Appeals Subcommittee will be binding on all parties.

If you decide to pursue any legal action relating to your claim after exhausting your administrative remedies under the Retiree Life Insurance Plan, the evidence that you may present in your case will be strictly limited to the documents, information, and other evidence timely presented to the claims administrator and/or Appeals Subcommittee, as applicable in connection with the Retiree Life Insurance Plan's claims and appeals procedures, as described above.

Your ERISA Rights

As a participant in the Baxter Retiree Medical Plan and/or the Baxter Retiree Life 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 are entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan Administrator's office and at other specified locations—such as work sites and union halls—all Plan documents. These may include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) filed by the Retiree Welfare Benefit Plan and/or the Welfare Benefit Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

- Obtain, upon written request to the Plan Administrator, copies of all Plan documents governing the operation of the Plans, including the Retiree Welfare Benefit Plan's and/or the Welfare Benefit Plan's most recent annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for these copies.

- Receive a written summary of the Retiree Welfare Benefit Plan's and/or the Welfare Benefit 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 Care Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Retiree Medical 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 Retiree Medical 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 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your ERISA rights.

Enforcing Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why, 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 from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits, which is denied or ignored—in whole or in part after completing the appeals procedure—you may file suit in a state or federal court. In addition, if you disagree with the Retiree Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. You may not bring any legal action to enforce a claim for benefits until you have exhausted all of the appeals rights described in this booklet. Once you have exhausted all available appeals, you must bring any action for benefits within six (6) months after receipt of the final decision on review.

- 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 a 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.

Discrimination is Against the Law

The Baxter International Inc. Welfare Plan for Retirees and Disabled Individuals (the "Retiree Welfare Benefit Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Retiree Welfare Benefit Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Retiree Welfare Benefit Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Plan Administrator.

If you believe that the Retiree Welfare Benefit Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a claim under the Retiree Welfare Benefit Plan. (Refer to your summary plan description for information as to how to file a claim for a benefit.) You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537–7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame 1-844-249-8803.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-249-8581.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-249-8581.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-249-8581.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-249-8581 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-249-8581.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-249-8581.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-249-8581.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-249-8581.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-844-249-8581.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-249-8581 تماس بگیرید.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-249-8581 まで、お電話にてご連絡ください。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-249-8581.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-249-8581.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-249-8581. पर कॉल करें।