Baxter International Inc.

Retiree Health Reimbursement Account Plan

Summary Plan Description

2024

For Non-English Speaking Retirees

This booklet contains a summary in English of your plan rights and benefits under Baxter's Retiree Health Reimbursement Account Plan. 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.

This summary is intended to describe the main features of the Baxter Retiree Health Reimbursement Account Plan (the "Plan"). The complete terms and conditions of the Plan are described in the plan document, as it may be amended from time to time. The plan document (as amended) is the official governing document for the Plan. 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 dependent). 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 it is a guarantee that the Plan or Plan benefit levels will continue or remain unchanged in future years. Baxter International Inc. has the right—and sole discretion—to suspend, amend, or terminate the Plan and the 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 Plan, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under the Plan will be paid only if the Plan Administrator or its designee decides, in its discretion, that the applicant is entitled to them.

Contents

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 benefits to you during your retirement years. Retirees and their dependents who have become eligible for Medicare due to age (*i.e.*, have reached the age of 65) do not participate in the Baxter Retiree Medical Plan. However, such retirees will be able to acquire their own Medicare supplemental health insurance through the individual insurance market, using the Via Benefits (formerly OneExchange) insurance exchange if they wish. If an eligible retiree or dependent purchases qualifying 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" or "Plan") described in this booklet. In addition, as a retiree you may be eligible for life insurance through a separate plan sponsored by Baxter, as well as any vested benefits you earned under the retirement plans. Those retiree life insurance and retirement benefits are described in separate summary plan descriptions, which are available by calling HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free).

Each time "Baxter" appears in this booklet, Baxter International Inc. and all of its subsidiaries, divisions, and facilities that have adopted the Plan are included.

This booklet is a summary of the Baxter Retiree Health Reimbursement Account Plan. It describes your benefits in effect on January 1, 2024. If you have any questions about any of the information in this booklet, call the Plan's Third-Party Administrator, **Via Benefits**, at **855-241-5718**.

Who Is Eligible

You and your family members may be eligible for Plan coverage.

You

If you retire from Baxter, you may be eligible for the Plan if you meet all of the following requirements, as further described below:

- you meet the definition of an "eligible retiree" at the time of your retirement;
- you are eligible to enroll in Medicare due to age 65;
- you are enrolled in Medicare Part B coverage; and
- you purchase a qualifying health insurance policy to supplement your Medicare coverage (*e.g.*, a MediGap policy, Medicare Supplemental policy or Medicare Advantage plan) through Via Benefits (formerly OneExchange), unless you qualify for one of the exceptions described below under "Purchasing a supplementary insurance policy through Via Benefits."

Individuals who were not classified by Baxter as an employee for federal payroll tax withholding purposes, or who were not eligible for the Baxter Medical Plan as an employee prior to retirement, are not eligible for the Plan. Individuals covered by a collective bargaining agreement are also ineligible unless the applicable bargaining agreement provides for Plan coverage. Leased employees and staffing agency employees performing services for Baxter, and individuals who are classified by Baxter as an independent contractor or consultant, are not eligible to participate in the Plan, even if the individual is deemed by a court or government agency to be a Baxter employee.

How the Plan defines "eligible retiree"

If you were a participant in the Baxter Retiree Medical Plan prior to January 1, 2015, and were Medicare-eligible due to age on January 1, 2015, you were considered an eligible retiree under this Plan as of that date.

If you retired on or after January 1, 2015, but before reaching the age of 65 and enrolled in pre-65 coverage under the Baxter Retiree Medical Plan, you are automatically considered an eligible retiree once you become Medicare-eligible due to age and can participate in the HRA as long as you continuously maintain your Retiree Medical Plan coverage until your Medicare eligibility date. Retirees over the age of 65 generally are not eligible for coverage under the Baxter Retiree Medical Plan.

If you retired from Baxter on or after January 1, 2015 and are 65 or older at the time of your retirement, or if you retired from Baxter prior to age 65 but did not previously enroll in the Baxter Retiree Medical Plan, you are an eligible retiree if you meet any of the following requirements.

- You retired from Baxter on or after January 1, 2017, and you had at least 65 credits under the Baxter Retiree Medical Plan as of December 31, 2016. **Employees hired or transferred to a participating Baxter employer on January 1, 2016, or later, and employees with less than 65 credits as of December 31, 2016, are not eligible to participate in this Plan or the Baxter Retiree Medical Plan.**

- You retired from Baxter **on or after October 1, 1997, but before January 1, 2017,** and you had at least 65 credits under the Baxter Retiree Medical Plan at the time your employment terminated.

- You retired from Baxter **on or after January 1, 1990, but before October 1, 1997,** 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 such pension plan.

- You retired from 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.

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 employer *minus* one (due to the one-year eligibility 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, or if you were hired as part of an acquisition or purchase. To get an accurate statement of your Retiree Medical Plan credits, you must call HRCentral Support (1-844-249-8581 English Toll-Free or 1-844-249-8803 Spanish Toll-Free) for an individualized statement. You may also log in to YourBenefits.Baxter.com to view your Baxter Retiree Medical Plan credits.

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 complete one year of eligibility service if you are working for a participating Baxter employer on the first anniversary of your hire date. You may request a current list of the participating employers by writing to the Plan Administrator.

If you have completed one year of eligibility service, you will earn age credits. You receive one age credit for each full year of age. You earn a new age credit each year on your birthday until you elect coverage under either the Baxter Retiree Medical Plan or this Plan. 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. You receive age credit whether or not you are working for a participating Baxter employer.

Employees with less than 65 total credits as of December 31, 2016, will not earn additional credits and will not be eligible to participate in the Plan or the Baxter Retiree Medical 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 Baxter employer as of that date. 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 towards earning credits. 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.

Note: Retirees who participate in the American Hospital Supply Corporation retiree medical plan prior to 1985 when American Hospital Supply merged with Baxter Travenol Laboratories Inc. to form Baxter International Inc. (PMA retirees), and certain other retirees who are treated as PMA retirees, will continue to participate in the Retiree Medical Plan even after they turn 65, and will not participate in the Plan.

When do you become eligible for Medicare?
The second requirement for participation in the Plan is that you must be eligible for Medicare coverage by reason of your age. In general, you will become eligible for Medicare on the first day of the month that includes your 65th birthday. However, if your 65th birthday falls on the first day of a month, you will become eligible on the first day of the month preceding the month that includes your birthday. For example, if you turn 65 on March 2, 2024, you will be eligible for Medicare on March 1, 2024. However, if you turn 65 on March 1, 2024, you will be eligible for Medicare on *February* 1, 2024. This date determines when you are no longer eligible to participate in the Baxter Retiree Medical Plan and become eligible to participate in the Plan.

When must you enroll in Medicare Part B?
The third requirement for participation in the Plan is that you must be enrolled in Part B of Medicare (the optional part of Medicare that covers outpatient and general medical costs not involving hospitalization). In general, you can enroll in Part B during the seven-month period that begins three months before the month in which you reach age 65. You can delay enrolling if you are covered by a group health plan when you first become eligible. If you don't enroll when you are first eligible, or when your group health coverage ends, you can still enroll during Medicare's open enrollment period, which is the first three months of every year. However, you will be charged a higher premium.

If you are participating in the Retiree Medical Plan when you turn 65, you must enroll in Part B as soon as you become eligible at age 65 as described above. If you do not enroll when you first become Medicare-eligible due to age, you will permanently lose eligibility for the Plan.

If you retire after age 65, so that you never participate in the Retiree Medical Plan (but would have been eligible if you had retired before age 65), you can enroll in Part B and purchase a qualifying policy through Via Benefits at any time and participate in the Plan.

You are not eligible to participate in the Plan prior to age 65 if you are covered by Medicare due to disability. Once you turn age 65, you can purchase a policy through Via Benefits and become eligible for the HRA.

Purchasing a supplemental insurance policy through Via Benefits
The fourth requirement for participation in the Plan is that you must purchase a supplemental insurance policy – either a MediGap insurance policy, Medicare Supplement insurance policy, or Medicare Part C (Medicare Advantage) plan – through Via Benefits. There are a number of different types of policies available through Via Benefits, and you can select whichever one you determine is right for you, but you must purchase a qualifying policy in order to participate in the Plan. Consult the materials provided by Via Benefits for more information on the types of policies available.

If you are participating in the Baxter Retiree Medical Plan when you become eligible for Medicare, you must purchase the policy within 60 days after your Medicare eligibility date. If you wait more than 60 days, you will not be eligible to participate in the Plan, even if you later purchase a policy.

If you don't retire until after you are age 65, so you never participate in the Baxter Retiree Medical Plan, you can enroll in the Plan by purchasing a policy through Via Benefits at any time (if you are an eligible retiree and have enrolled in Medicare Part B).

Once you have purchased a policy and are a participant in the Plan, you must continue to maintain coverage under a qualifying Via Benefits policy in order to continue participation in the Plan. If you do not remain enrolled in a qualifying Via Benefits policy, your participation in the Plan will automatically terminate, and you will have six months to submit any reimbursement claims for expenses incurred while you were a Plan participant. After six months, any unused balance in your HRA Account will be forfeited, even if you are able to resume participation in the Plan.

Any gap in coverage (measured from the date coverage under the prior qualifying Via Benefits policy terminated through the date of enrollment in the new qualifying Via Benefits policy) of one year or more will make you permanently ineligible for the Plan. For purposes of this one-year gap rule, if you end your qualifying Via Benefits coverage, you must enroll in another qualifying Via Benefits policy within one year. Due to Medicare enrollment rules, coverage under the new Via Benefits policy may not take effect until a later date – usually, January 1 of the following calendar year. However, as long as you complete the enrollment process for a new qualifying Via Benefits policy within one year, your participation in the Plan will resume (even if there is a lapse in your Via Benefits insurance coverage for longer than one year). If your Plan coverage is reinstated (*i.e.*, you are enrolled in Medicare Part B and a qualifying supplemental health insurance policy within the one-year limit) your prior HRA Account balance will be restored, but you may not use amounts in your HRA Account for expenses incurred during the gap period. You can change from one policy to another policy purchased through Via Benefits, but if you drop your policy and don't replace it with a new policy purchased through Via Benefits before one year has passed, your HRA Account balance will be forfeited, and you will be ineligible to participate in the Plan in the future, even if you acquire a new policy purchased through Via Benefits.

There are two exceptions to the requirement that you must be enrolled in a supplementary policy through Via Benefits in order to participate in the Plan. First, if you are covered by Medicaid, you are not required to purchase a supplemental policy which would jeopardize your Medicaid eligibility. Second, the supplemental policy plans offered by Kaiser Permanente were not offered through Via Benefits prior to June 2020. If you participated in the Kaiser HMO while you were in the Retiree Medical Plan prior to June 2020, you were permitted to purchase a supplemental policy from Kaiser without going through Via Benefits, and you were still eligible for the HRA. However, supplemental policy plans offered by Kaiser Permanente must now be purchased through Via Benefits in order to be eligible for the HRA.

Your eligible dependent

If you are an eligible retiree, your spouse/domestic partner may be eligible to participate in the Plan. In order to be eligible for the Plan, your dependent must be eligible for Medicare due to age and enrolled in Medicare Part B and must purchase and continuously maintain an insurance policy through Via Benefits. If your eligible dependent was enrolled in Retiree Medical Plan coverage prior to age 65, your dependent must maintain continuous Retiree Medical Plan coverage until your dependent's Medicare eligibility date to be eligible for the Plan.

Your eligibility for the Plan and that of your eligible dependent are determined separately based on your individual ages, and whether each of you purchases a qualifying insurance policy. For example, assume that you retire when you and your spouse/domestic partner are both under 65, and you both begin to participate in the Retiree Medical Plan:

- If you turn 65 while your spouse/domestic partner is not yet 65, you will stop participating in the Retiree Medical Plan and will have the opportunity to purchase a Via Benefits insurance policy and begin participating in the HRA, but your spouse/domestic partner can continue to be covered by the Retiree Medical Plan until he or she is age 65. Once your spouse/domestic partner turns 65, he or she will stop participating in the Retiree Medical Plan and will have his or her own opportunity to purchase a policy and become covered by the HRA, regardless of whether you chose to do so.

- On the other hand, if your spouse/domestic partner is older than you, and reaches age 65 first, he or she will stop participating in the Retiree Medical Plan and have the opportunity to purchase a policy and become covered by the HRA but you will remain in the Retiree Medical Plan until you reach age 65. If your spouse/domestic partner fails to timely enroll in Medicare Part B and purchase qualifying supplemental coverage through Via Benefits, your spouse/domestic partner will lose eligibility for the HRA, even if you later become a participant in the HRA once you reach age 65.

Eligible Spouse/Domestic Partner

Your spouse or domestic partner is eligible for the HRA unless your spouse or domestic partner is covered as a Baxter retiree or employee. Your spouse is the individual to whom you are legally married under applicable state law and from whom you are not legally separated. An individual is considered to be your spouse only if he or she would be recognized as your spouse under federal tax law. Your domestic partner is someone of the same or opposite sex with whom you have a committed relationship of mutual caring and support. The partnership must meet the following requirements as of the date coverage is scheduled to begin:

- Neither partner is legally married to or legally separated from someone else, 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
- The partners are not related by blood in a way that would prevent them from being married to each other.

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 and your partner are in a civil union, you will be treated as domestic partners under the Plan.

You must certify that your partner qualifies as a domestic partner by completing the process established by the Plan Administrator. Note that unless your domestic partner is also your dependent for income tax purposes, any portion of your HRA Account that is used to provide coverage or benefits for your domestic partner will be taxable income to you.

Survivor coverage

If you are eligible for coverage under the Baxter Retiree Medical Plan at the time of your death, or if you were covered by the Retiree Medical Plan until you reached age 65 and you died after age 65, and your spouse/domestic partner has not yet reached age 65 at the time of your death, he or she can continue to be covered by the Retiree Medical Plan until age 65, at which time your spouse/domestic partner can purchase his or her own Via Benefits insurance policy and become covered by the HRA. However, if your former spouse/domestic partner remarries (or enters into a new domestic partnership), his or her new spouse or domestic partner is not eligible.

Relationship between Via Benefits and the Plan

Although the HRA is only available for eligible retirees and their dependents who purchase supplementary insurance policies through Via Benefits, it is important that you keep in mind that neither Via Benefits, nor any of the insurance policies that may be available through Via Benefits, is part of the Plan, or of any other employee benefit plan sponsored or administered by Baxter. This means:

- Baxter has no responsibility for the level of benefits provided by any of the insurance policies available through Via Benefits. If you believe that an insurance company has failed to cover a procedure, medicine, or other service that should have been covered, you will need to deal directly with the insurance company involved. Neither Via Benefits nor Baxter will have any ability to cause the insurance company to change its decision.

- Via Benefits is a privately owned and operated insurance exchange, which is completely independent of Baxter. Representatives of Via Benefits are not employed by and do not represent or speak for Baxter, and Baxter does not supervise or oversee the advice provided by Via Benefits. Via Benefits is not directly compensated by Baxter but is funded exclusively by commissions paid to it by the insurance companies whose policies are offered through Via Benefits.

- Baxter does not endorse or recommend any particular insurance plan, program, provider, or agent. Individuals are encouraged to investigate individual insurance plans themselves and make their own informed decision about which individual insurance plan is best for them. It is possible that other insurance policies offered outside of Via Benefits may be more suitable for an individual retiree's needs. The insurance plan that you select is your own individual plan and is not sponsored or maintained by Baxter and is not part of any plan or program established or maintained by Baxter.

Under no circumstances whatsoever will Baxter, the Baxter Administrative Committee, HRCentral Support, or any other person or committee affiliated with Baxter have any responsibility or liability for any advice provided by any representative of Via Benefits, or for the failure of any insurance plan or policy acquired through Via Benefits to provide any coverage.

Benefits Provided by the Plan

Expenses reimbursed by the Plan

There are two types of medical expense reimbursement provided by the Plan:

- Certain participating retirees and spouses/domestic partners will have an HRA Account with annual benefit credits provided by Baxter. The HRA Account balance can be used for any qualifying medical expense.

Reimbursements paid by the HRA Account

Benefit credits

An HRA Account is established for each retiree who is entitled to receive benefit credits from Baxter, and for the retiree's spouse or domestic partner. The HRA Accounts are bookkeeping entries and are not separate bank or trust accounts. For purposes of establishing the HRA Accounts, participants are divided into the following groups:

- Group 1 are retirees who either had already retired on or before December 31, 2002, or who were actively employed on December 31, 2002, but had earned 65 points or credits under the Retiree Medical Plan (and who are not part of Group 4) as of that date, and their spouses/domestic partners.

- Group 2 are retirees who were actively employed on December 31, 2002, and had not yet earned 65 points or credits under the Retiree Medical Plan, and their spouses/domestic partners.

- Group 3 are retirees who were hired after December 31, 2002, but prior to January 1, 2016, and their spouses/domestic partners. A participant who was employed by Baxter prior to December 31, 2002, terminated employment but did not retire, and was rehired after December 31, 2002, is also in Group 3. Group 3 participants do not receive annual benefit credits, regardless of their number of points or credits under the Retiree Medical Plan.

- Group 4 are retirees who terminated prior to January 1, 1990, and who at the time of termination were at least age 55 and had at least ten years of service under the Baxter International Inc. and Subsidiaries Pension Plan or Baxter International Inc. and Subsidiaries Pension Plan II, and their spouses/domestic partners.

The amount of benefit credits that will be credited to your HRA Account each year will depend on which group you are in, and (except for Group 4) on the number of credits (points) you have earned under the Baxter Retiree Medical Plan (see the "How the Plan defines 'eligible retiree'" section above for information on Retiree Medical credits) as of the first day of the year, as shown in the chart below.

Retiree Medical Plan Credits*	Group 1 Benefit Credit	Group 2 Benefit Credit	Group 3 Benefit Credit	Group 4 Benefit Credit
Less than 75	$0	$0	$0	$740
75-79	$500	$290	$0	$740
80-84	$740	$500	$0	$740
85 or more	$1640	$500	$0	$740

* Not applicable to Group 4.

(Note that these are the amounts of benefit credits that are in effect for 2024. Baxter reserves the right to change the amount of benefit credits in any future year.)

Your benefit credits will be added to your account on the first day of each year in which you are a participant. If you become a participant in the middle of a year, your credit for the year will be pro-rated based on the number of full months during which you are a participant.

If your spouse or domestic partner is a participant, he or she may also be eligible to have an HRA Account and to receive benefit credits. If you and your spouse or domestic partner both have an HRA Account, they will be combined into a family account. That way, the entire balance in the family account can be used for either of your expenses, and if one of you passes away, the other can continue to use the account balance.

You can begin using the balance in your HRA Account on the first day of the year (or when you become a participant). If you don't use the entire balance in the year, you can carry over the unused portion to future years. However, when you die, or if you allow your Via Benefits policy to lapse, your participation will end, and claims must be submitted within six (6) months after the date of death or policy lapse. Any unused balance in your HRA Account will be forfeited after six months (unless you have a family account in which case your spouse/domestic partner can continue to use the account after your death). If your participation lapsed because you did not maintain qualifying supplemental insurance coverage through Via Benefits, but you re-enroll in qualifying coverage within one year, you may receive additional benefit credits as described above, but any forfeited amounts will not be restored.

Eligible medical expenses

Your HRA Account balance can be used to reimburse you for the insurance premium on your Via Benefits insurance policy or can be used for any other eligible medical expense. An eligible medical expense is an expense incurred by you for medical care that is deductible for federal income tax purposes (generally, expenses related to the diagnosis, care, mitigation, treatment, or prevention of disease). If you have a spouse/domestic partner who is eligible to receive benefit credits, your family HRA Account balance can also be used to reimburse the insurance premium on your spouse's/domestic partner's Via Benefits insurance policy and your spouse's/domestic partner's other eligible medical expenses. Some common examples of eligible medical expenses include:

- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;

- Chiropractor treatments;
- Hearing aids;
- Wheelchairs;
- Medicare premiums; and
- Premiums for medical, prescription drug, dental, vision or long-term care insurance.

Some examples of common items that are *not* eligible medical expenses include:

- Baby-sitting and childcare;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not eligible medical expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." When reviewing the IRS Publication, keep in mind that medical expenses are deductible only if you itemize your deductions and your total medical expenses for the year exceed 7.5% of your income. You can be reimbursed from your HRA Account even if you don't qualify to deduct your expenses. (Also keep in mind that you can't deduct a medical expense if you are reimbursed for it.) If you need more information regarding whether an expense is an eligible medical expense under the Plan, contact the Third-Party Administrator.

Only eligible medical expenses incurred while you are a participant in the HRA may be reimbursed from your HRA Account (or your family HRA Account). Similarly, only eligible medical expenses incurred while your eligible spouse/domestic partner is a participant in the Plan may be reimbursed from his or her HRA Account (or your family account). Eligible medical expenses are "incurred" when the medical care is provided, not when you or your participating spouse/domestic partner are billed, charged, or pay for the expense. Thus, an expense that has been paid but not incurred (*e.g.*, pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may *not* be reimbursed from an HRA Account:

- co-pays and coinsurance amounts for prescription drugs covered by your Medicare Part D prescription drug plan expenses incurred *prior to the date* that you became a participant in the Plan;
- expenses incurred *after the date* that you cease to be a participant in the Plan; and
- expenses that have been reimbursed by another plan or for which you intend to seek reimbursement under another health plan.
-
- If you die while a participant of the Plan, a surviving spouse/domestic partner participant or your estate may request reimbursement of eligible health care expenses incurred before your death (up to your remaining HRA Account balance) and while you were participating in the

Plan, as long as a request for reimbursement is filed within six (6) months following the date of your death.

Catastrophic

Filing a Claim for Reimbursement

In order to be reimbursed out of your HRA Account , you must first pay the expense and then submit a reimbursement form. The Plan does not provide for direct payment to insurance companies or other medical providers. For reimbursements from your HRA Account, claims must be submitted within six (6) months after the date of your death or loss of eligibility due to policy lapse. Any unused balance in your HRA Account will be forfeited after six months (unless you have a family HRA Account, in which case your spouse/domestic partner can continue to use the account balance after your death).

The Plan's Claim Submissions Agent is:

Willis Towers Watson
P.O. Box 981156
El Paso, TX 79998-1158
Fax: 1-844-930-0236

The reimbursement form must be mailed or faxed to the Claims Submission Agent, along with a copy of your insurance premium bill, an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from the Third-Party Administrator by calling Via Benefits at 855-241-5718 or by visiting My.Viabenefits.com/Baxter. Your claim is deemed filed when it is received by the Claims Submission Agent (Willis Towers Watson). (Do *not* mail your form to the Third-Party Administrator as this may result in a delay in processing.)

Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered benefit "claims" that require processing under the Plan's claims and appeals procedures. If you wish to make a claim for reimbursement in accordance with your rights under ERISA and the Plan's claims and appeals procedures, you must do so in writing and by following the claims submission requirements described in this section.

Either you or your authorized representative may file claims for Plan reimbursement benefits. An "authorized representative" means a person you authorize, in writing, to act on your behalf. An assignment of benefits to your doctor or other health care provider does not constitute a designation of an authorized representative for this purpose. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably practicable following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Auto reimbursement and recurring claims

For your Via Benefits insurance plan premiums, you can also utilize either "auto reimbursement" or a "recurring claim form," both of which reduce the need to submit monthly reimbursement requests. Under auto reimbursement, the insurance company notifies the Plan when you pay a premium, and you are automatically reimbursed without the need to file a form. Auto reimbursement can be elected when you first purchase a policy through Via Benefits and can take up to three months to set up. Not all insurance carriers offer this option. Talk to your Via Benefits benefit adviser when you select your policy to determine if this is available.

A recurring claim form is available for regular periodic payments, such as insurance premiums. Once you file a recurring claim form, you will be automatically reimbursed for each scheduled payment without being required to submit individual claim forms. You can obtain a recurring claim form, and additional information about eligibility for recurring claims payment, from the Third-Party Administrator.

If your claim is denied

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, and your Plan coverage may be cancelled, to the extent permitted by law.

When Coverage Ends

Under certain circumstances, your Plan coverage may end.

Your coverage under the Plan, or that of your participating dependent, ends upon the earliest of the following events:

- the last day of the month in which you or your participating dependent discontinues Via Benefits insurance policy coverage (unless you obtain a new policy through Via Benefits without a gap of one year or more) or Medicare Part B coverage;
- the date of your death or your dependent's death, as applicable;
- with respect to your participating dependent, the date your dependent becomes an employee of Baxter;
- for you and your participating dependent, the date you (the retiree) are rehired by Baxter;
- with respect to your participating dependent, the date your dependent ceases to be an eligible spouse or domestic partner under the Plan's eligibility rules; or
- the last day of the month in which you or your dependent submits a falsified, altered, or fraudulent claim.

Coverage also may end if Baxter discontinues the Plan or amends the Plan so that you are no longer eligible.

If your HRA Account ends because you lose your qualifying Via Benefits coverage, your Plan participation will be prospectively reinstated, and you may earn additional HRA Account benefit credits, as long as you enroll in replacement coverage within one year. However, if you have a coverage gap of six months or more before you resume participation in the Plan, your outstanding HRA Account balance, if any, will be forfeited. If you have an enrollment gap of one year or more, you will lose Plan coverage and can never get it back.

If you (the retiree) return to employment with Baxter and you become eligible for health coverage under the Baxter Medical Plan as an active employee, your participation in this Plan will be suspended. During this suspension, neither you nor your spouse or domestic partner will receive new benefit credit allocations, and any eligible health care expenses you or your spouse or domestic partner incur will not be eligible for reimbursement from the Plan (regardless of whether your spouse or domestic partner is covered as your dependent under the Baxter Medical Plan). Once you again retire from employment with Baxter, your HRA Account will be reinstated, and you or your spouse or domestic partner will again be eligible to participate in the Plan.

If you or your spouse or domestic partner lose coverage under the Plan for any other reason, your coverage cannot be reinstated.

If you die and your surviving spouse/domestic partner is a participant in the Plan, your spouse/domestic partner will become the sole owner of your family HRA Account, including all remaining amounts in the account. If your participation ends for other reasons (*e.g.*, because you discontinue qualifying supplemental insurance coverage through Via Benefits) but your spouse/partner's participation continues, the Third-Party Administrator will reduce the balance of your family HRA Account by the portion attributable to you. Your spouse/domestic partner will become the sole owner of your family HRA Account. Similarly, if your participating spouse/domestic partner loses Plan coverage, the Third-Party Administrator will reduce the balance of your family HRA Account by the portion attributable to your spouse/domestic partner.

Your Legal Right to Continue Coverage Under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section 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 Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact Via Benefits, at 855-241-5718.

Although COBRA does not apply to 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 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 and your spouse or domestic partner could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for the 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 Plan because any of the following qualifying events happen:

- You become divorced or legally separated from your spouse; or
- Your domestic partnership terminates.

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 Plan, you will become a qualified beneficiary with respect to the bankruptcy. Your spouse or domestic partner (including a surviving spouse or surviving domestic partner)| will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Third-Party Administrator (Via Benefits) has been notified that a qualifying event has occurred. When the qualifying event is Baxter's commencement of a proceeding in bankruptcy, Baxter must notify the Third-Party Administrator of the qualifying event.

You must give notice of some qualifying events

For the other qualifying events (*i.e.*, divorce of the retiree and spouse or termination of a domestic partnership), you (or your dependent) must notify the Third-Party Administrator within 60 days after the qualifying event occurs. **If you (or your dependent) fail to notify the Third-Party Administrator of these events within the 60-day period, the Plan is not obligated under COBRA to provide continued coverage to the affected qualified beneficiary(ies).**

How is COBRA coverage provided?

Once the Third-Party Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. COBRA coverage must be timely elected within 60 days as described in the qualifying event notice. Covered retirees may elect COBRA continuation coverage on behalf of their spouses or domestic partners.

If an qualified beneficiary elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. He or she may also be entitled to an increase in his or her HRA Account equal to the amounts credited to the HRA Accounts of similarly situated participants (subject to any restrictions applicable to similarly situated participants) so long as he or she continues to pay the applicable premium.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your divorce or termination of your domestic partnership, 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 a surviving qualified beneficiary dependent).

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:

- The date the qualified beneficiary's HRA Account is exhausted and there is no possibility of additional benefit credits;
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- The premium for continuation coverage is not paid on time;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary;
- The date your coverage is terminated for cause, such as for submission of a fraudulent claim; or
- Baxter no longer provides group health plan coverage.

How much does COBRA coverage cost?

In order to continue coverage, a retiree, spouse, or domestic partner qualified beneficiary must pay a monthly premium equal to 91.8% of the amount of credits to which you are entitled for the year, divided by 12. For example, if your benefit credits for the year are $740, your COBRA premium would be 91.8% x $740/12, or $56.61 per month.* The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

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 Plan or COBRA continuation coverage rights should be addressed to the Third-Party Administrator. 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 Plan informed of address changes

In order to protect your family's rights, you should keep the Third-Party Administrator, Via Benefits, informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Third-Party Administrator.

Plan Contact Information:

Via Benefits
10975 South Sterling View Drive
South Jordan, UT 84905
Phone: 1-855-241-5718
my.ViaBenefits.com/baxter

Administrative Information

The Baxter Retiree Health Reimbursement Account Plan is a retiree-only health reimbursement arrangement and a welfare plan 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 submission agents, or insurance companies that provide or administer the Plans and how to contact them;
- what to do if a claim is denied; and
- your rights under ERISA.

If you have any questions about any of the following, call the Third-Party Administrator, Via Benefits.

Plan Sponsor and Administrator

The Plan is sponsored by Baxter International Inc. The Administrative Committee of Baxter International Inc. is the Plan Administrator. 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, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under 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.

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

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

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

Third Party Administrator and Claims Submission Agent

The Third-Party Administrator is your primary source of information about the Plan. The Third-Party Administrator can be reached at the address and phone number below:

Via Benefits
10975 South Sterling View Drive
South Jordan, UT 84905
1-855-241-5718
my.ViaBenefits.com/baxter

Willis Towers Watson act as the Claims Submission Agent responsible for processing HRA reimbursement claims. The activities of the Claims Submission Agent may include receiving, processing, and evaluating your claim, billing Baxter for the amount due under your claim, and paying your claim. The Claims Submission Agent does not guarantee the payment of any claims under the Plan. Baxter, as the Plan sponsor, is ultimately responsible for the payment of your claims.

Eligibility Claims Administrator

The Plan Administrator retains the discretionary authority to determine your (and your dependent's) eligibility to participate in the Plan and the amount of your annual benefits credits.

The Plan Administrator has delegated responsibility for deciding initial claims relating to whether you are an eligible retiree or an eligible retiree's spouse or domestic partner and benefits credit amounts to:

Claims and Appeals Management
DEPT00470
P.O. Box 1407
Lincolnshire, IL 60069-1407
Fax: 1-847-554-5020

The Plan Administrator has delegated responsibility for determining whether you and/or your dependent have purchased qualifying supplemental insurance required to participate in the Plan to the Third-Party Administrator. The Third-Party Administrator is also responsible for determining whether you and/or your dependent have purchased a qualifying Medicare Part D prescription drug plan

Final appeals administrator

The claims administrator for final 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

Plan name identification number

When dealing with or referring to the Plan in terms of claim appeals or other correspondence, you will receive a more rapid response if you identify the Plan fully and accurately. To identify a Plan, you need to use Baxter's employer identification number (EIN): 36-0781620.

The official name of the Plan is the Baxter Retiree Health Reimbursement Account Plan, and the plan number is 541.

Plan year

January 1 through December 31.

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 funding

Plan benefits are paid out of Baxter's general assets. No funding medium of any kind is used for the accumulation of Plan assets, and no insurance company, trust fund, or any other institution maintains a fund through which the Plan is funded or HRA Account reimbursements are provided.

Plan amendments

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

Situations Affecting Your Plan Benefits

Certain situations could affect your benefits under the Plan.

Overpayment recovery

If for any reason 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 seek recovery of any excess amounts;
- reduce, by the amount of the overpayment, any future benefit payment made to that person on behalf of that person; or
- employ any other lawful means to recover overpayment on behalf of the Plan.

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

Assignment of benefits

You cannot transfer or assign your benefits or claims under the Plan, and any such transfers or assignments will be considered void. As described in the "Filing a Claim for Reimbursement" 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.

Uncashed checks

Any reimbursements made by check must be cashed within the time period indicated on the check. If you do not cash a check within that time period, you may contact the Third-Party Administrator to request that the check be reissued. However, if you do not cash your reimbursement check or request a reissued check within 18 months of the original date of issue, the Plan will have no liability for the benefit payment, the amount of the check will be deemed a forfeiture, and no funds will escheat to the state. Therefore, it is important to keep the Third-Party Administrator informed of your current address and to timely deposit your reimbursement checks. If you misplace a reimbursement check, you should contact the Third-Party Administrator as soon as possible.

If the Plan is modified or ended

Baxter hopes to continue the Plan in the future but reserves the right to amend or terminate the Plan and benefits offered under the Plan at any time, in whole or in part, for any reason. If the Plan is ever terminated, suspended, or modified, benefits for expenses incurred before the change will be paid in accordance with the Plan's terms and conditions as were then in effect. However, if the Plan is terminated or suspended, no benefits would be paid for expenses incurred after such action, unless specific provisions are adopted.

Appealing Denied Claims

Initial Claim Decision

When a claim is received for a HRA reimbursement benefit, the Claims Submission Agent must decide whether (and/or at what level) the benefit is covered under the plan. When the reimbursement benefit is provided or denied, you will receive a notice explaining how the coverage level was calculated or why benefits have been denied. The deadline for this notice is no later than 30 days after the claim is received.

The 30-day period described above may be extended for up to an additional 15 days if the Claims Submission Agent determines that an extension is necessary due to matters beyond the control of the Plan. If the Claims Submission Agent requires an extension of time for making its determination, you will receive a written notice of the extension prior to the end of the 30-day period explaining the circumstances requiring the extension and the date by which the Claims Submission Agent expects to make a determination on the claim. If an extension of time is needed to decide your 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.

If your claim is related to eligibility to participate in the Plan or to the amount of your HRA benefit credits, you should direct your claim to the Eligibility Claims Administrator listed under the Administrative Information section of this booklet. The Eligibility Claims Administrator will inform you of its decisions within the above time limits.

Note: These procedures apply only to questions of participation in the Plan or whether a particular expense was eligible to be reimbursed by the HRA. Any claim related to your enrollment in an insurance policy obtained through Via Benefits, or to whether an expense should be covered by an insurance policy obtained through Via Benefits (or otherwise), must be addressed to the insurance company that issued the policy. The insurance policies purchased through Via Benefits are not employee benefit plans provided by Baxter, and Baxter has no authority over, or responsibility for, the benefits provided by such policies.

Appealing a Denial

If you disagree with the decision of the Claims Submission Agent or the Eligibility Claims Administrator, you may request a full review of the decision . You must submit your request within 180 days after you receive the denial notice. In connection with your appeal, you or your representative can receive reasonable access to and copies (free of charge) of all documents, records, and other information relevant to your claim. You may also submit written comments, documents, records, and other information relating to your claim. If you want to appeal a decision of the Claims Submission Agent or the Eligibility Claims Administrator, send your appeal to the Appeals Subcommittee of the Administrative Committee of Baxter International Inc. at the address listed under the "Administrative Information" section of this booklet.

Your appeal will be reviewed by someone other than the person who made the first decision on 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. For HRA reimbursement

appeals, the Appeals Subcommittee 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 Appeals Subcommittee 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 the Appeals Subcommittee's findings and decision in writing. This notice will be provided no later than 60 days after receiving the appeal. The Appeals Subcommittee's decision will be final, and you will have exhausted all of your administrative remedies with Baxter and the Plan.

No person 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. If you disagree with the Appeals Subcommittee's decision on appeal and you wish to pursue your claim further, you will have the right to bring a civil action in a federal court under Section 502(a) of ERISA. **Any further action taken against the Plan or its fiduciaries must be filed in a court of law not more than six (6) months after receipt of the Appeals Subcommittee's decision.** Except as may be otherwise required by law, the final decisions of 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 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 Submission Agent, Eligibility Claims Administrator, and/or Appeals Subcommittee, as applicable, in connection with the Plan's claims and appeals procedures described above.

Claims/Appeals Decision Notices

The notice given to you concerning the decision on either your initial claim or your appeal will include:

- The specific reason or reasons for the decision.
- 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 Plan's terms to your medical circumstances), or a statement that such an explanation will be provided free of charge upon request.

- For an initial claim, a description of the appeal procedures.
- A statement of your right to bring suit under ERISA if your claim is denied following a final appeal.

Your ERISA and Other Legal Rights

ERISA Rights

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

Receive information about your Plan and benefits

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

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

Continue group health care coverage

- Continue health care coverage for yourself and/or your spouse if there is a loss of coverage under the Plan as a result of a qualifying event. In addition, the Plan voluntarily provides continuation coverage for domestic partners who lose Plan coverage due to dissolution of a domestic partnership. You or your spouse or partner may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent actions by Plan fiduciaries

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

No one, including your employer, your union, and any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 and 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 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 going through the appeals procedure—you may file suit in a state or federal court. You may not bring any legal action to enforce a claim for benefits until you have exhausted all 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 the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance with your questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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.

HIPAA privacy

As a participant in the 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 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 the HIPAA privacy requirements. 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 Plan's privacy officer.