Plan Document and Summary Plan Description for the RTI International Retiree Health Plan

Amended and Restated as of February 1, 2025

RTI reserves the right to terminate, modify or revoke the RTI International Retiree Health Plan and the benefits described in this document and/or to modify the premium rates charged to Retirees and/or other covered individuals at its discretion. The Plan is exempt from the requirements under the Patient Protection and Affordable Care Act.

RTI International Retiree Health Plan

Amended and Restated as of February 1, 2025

Introduction

Eligible "Retirees" (as defined in Section 1) who separate from Research Triangle Institute ("RTI" or "RTI International") or any Affiliate may continue group medical coverage and/or the group dental coverage as well as continue to cover any eligible dependents per the terms and conditions of the RTI International Retiree Health Plan (the "Plan").

This document describes the eligibility requirements and benefits under the Plan. This document constitutes both the Plan document and the summary plan description. It describes all features of the Plan effective as of February 1, 2025, unless otherwise indicated. For all rules of the Plan which applied prior to February 1, 2025, please refer to the applicable prior version of the Plan.

Please refer to this document first for any questions you may have about the Plan. If you need more information, please call RTI Employee Services (919-541-1200 or 1-800-334-8571, ext. 2-1200).

Administrative Information and Termination

Health benefits currently available through the Plan are listed in Appendix A.

Please refer to plan summaries and other information listed under the Benefits section on RTI Insider for more information about benefit options and costs. Former employees can access plan summaries and other information via https://www.rti.org/rti-international-retirees or by contacting RTI Employee Services at (919) 541-1200 or hrhelp@rti.org. However, please note that, to the extent there are any conflicts between the Plan and any summary information, the terms of the Plan control.

RTI reserves the right to terminate the Plan for current or future Retirees, spouses, and dependents, in whole or in part, at any time. RTI reserves the right to modify or revoke the Plan and the benefits described in this document and/or to modify the premium rates charged to Retirees, spouses, and dependents at its discretion.

Important Things for <u>All Retirees</u> to Know about the Plan

- The Plan applies only to U.S. based employees who meet the participation and eligibility requirements described below at the time their employment with their Employer terminates.

- An election to obtain Plan benefits must be made on the date your employment with your Employer terminates or, if you elect COBRA coverage under one of the group health plans offered through COBRA, following the termination of such COBRA coverage.

- Retiree health coverage is available only through the U.S. domestic medical and dental plans and not through any of RTI's international medical or dental plans. High Deductible /HSA plans are not available to Retirees. Since the health coverage offered is through U.S. domestic plans, an eligible retiree must reside in the U.S. in order to access any benefits under the Plan.

- Spousal coverage is available only to the spouse to whom you are married on the date your employment with your Employer terminates.

- Dependent coverage is available to your eligible dependents who meet the Plan's definition of a dependent.

- After the initial enrollment election is made, you may subsequently add or drop your spouse (as defined above) and/or eligible dependents during Open Enrollment or midyear due to a qualified life status change.

- If you and/or your covered spouse are age 65 and older, the individual(s) who is/are age 65 or older must be enrolled in Medicare Part A and Part B once eligible for retirement in order to be enrolled in the medical component of the Retiree Plan. You are responsible for paying any applicable Medicare premium costs directly to the Social Security Administration.

- Under age 65 retiree and/or dependent coverage premium payments must be made to RTI's designated third party billing administrator(s). Medicare eligible retiree and/or dependent coverage premium payments must be made to the individual Medicare Supplement, Medicare Advantage, dental or visions carriers selected through RTI's designated exchange provider.

- Failure to pay the premiums within the specified time period, no later than the 15th day of the month following the month in which the premium is otherwise originally due, will result in immediate termination of benefits under the Plan retroactive to the 1st of the month following the last month in which the premium was paid.

- Medicare eligible retirees enrolled in individual health plans must pay their premiums as required by the individual insurers.

- If you become employed by another company or organization and enroll under its group health coverage, your RTI group coverage ends and **cannot** be reinstated. Medicare eligible retirees who become employed by another company or organization who wish to end their individual coverage provided by RTI's designated exchange provider are responsible for disenrolling from their individual health plans.

- Prior coverage under RTI's group health plan for active employees is not required for participation under the Plan.

SECTION 1: ELIGIBILITY AND PARTICIPATION

Eligibility and Participation in the Plan: Retirees

1. Eligibility

Except as set forth in Appendix E, to be eligible for benefits under the Plan, on the date your employment with your Employer terminates, you must be a Retiree, as defined below.

- A "Retiree" is an "Eligible Employee" whose age plus full years of Creditable Service, on the date employment with their Employer terminates, equals or exceeds 65, with a minimum age of 55 and a minimum of 5 full years of Creditable Service. For purposes of the Plan, Creditable Service is based on your "Benefits Service Date," as that date is maintained in RTI's Human Resources systems.

- An "Eligible Employee" means an individual whose most recent RTI hire date was prior to January 1, 2021, and, on the date of employment with their Employer terminates, was employed by their Employer and was classified by their Employer as an employee, as shown on payroll records, but excluding the following classes of individuals:

    - Nonresident Aliens with no U.S. source income
    - Resident Aliens with no U.S. source income
    - Employees who are classified as a Third Country National (TCN) or a Local National (LN) in RTI's systems
    - Interns and temporary employees
    - Employees assigned to the Data Collection Staff business segment as classified in RTI's accounting system

  For purposes of the Plan, "Employer" means RTI or any Affiliate. "Affiliate" means any affiliate or subsidiary of RTI that is authorized to adopt the Plan and that has in fact adopted the Plan.

  Any individual who was initially hired prior to January 1, 2021, whose employment with their Employer terminates, and who is thereafter rehired on or after January 1, 2021, will not be an Eligible Employee under the Plan.

  Any individual who transfers employment from RTI to an Affiliate, or vice versa, without any break in service does not incur a termination of employment with their Employer for purposes of the Plan.

2. Participation

Except as set forth in Appendix E, to participate in the Plan as a Retiree, you must elect retiree coverage within 45 days of the date your employment with your Employer terminates or, if you elected COBRA coverage, within 45 days of the date your COBRA coverage terminates. If you fail to do so, you cannot participate in the Plan at a later date. See the Continuation of Coverage under COBRA section below for more details.

If you participate in the Plan, subsequently become employed by another company or organization, and enroll under that company or organization's group health coverage, your eligibility under the Plan will end and ***cannot*** be reinstated.

Eligibility and Participation in the Plan: Spouses and Dependents

If you are a Retiree, your spouse and eligible dependent(s) are eligible for benefits under the Plan, subject to the following requirements:

1. Your spouse must have been your legal spouse on the date your employment with your Employer terminated. Domestic partners are ineligible, unless otherwise required by law.

2. Only the following classes of children are eligible as dependents:

    - Any child of yours who is less than 26 years of age;
    - Any child of yours who is 26 years or older, if the child is (a) unmarried, (b) primarily financially supported by you, and (c) incapable of self-sustaining employment due to a disability that arose while a covered dependent under any RTI health plan or previously under any prior group health plan with no break in coverage under such plan.

    The term "child" means a child born to you or legally adopted by you. The term "child" also includes (i) a stepchild or (ii) a child for whom you are the legal guardian and whose official residence is with you.

3. As long as you are living, you can add your spouse and dependent(s) to coverage during appropriate enrollment periods. However, at your death, your under age 65 spouse and dependent(s) are only eligible for medical coverage if they were enrolled in medical coverage under the Plan on the date of your death and only eligible for dental coverage if they were enrolled in dental coverage under the Plan on the date of your death. If, at your death, your over age 65 spouse or dependent were enrolled in any coverage offered through RTI's designated exchange provider, they may continue enrollment in any coverage available to them on the exchange.

4. Coverage for your spouse ends on the earlier of their date of death or date of remarriage.

5. Coverage for your dependents ends upon their death or when they no longer meet the Plan's eligibility requirements for dependents.

Health Plan Credits

As a Retiree, you are entitled to health plan credits at the time your employment with your Employer terminates. Specifically, and except as set forth in Exhibit E, you are entitled to $1,000 for each full year of Creditable Service that you were entitled to as of December 31, 2020, up to a maximum health plan credit of $20,000. Any service with your Employer after December 31, 2020, will continue to count for purposes of Creditable Service, but will not count for calculating your applicable health plan credits. For Retirees who are under age 65, the cost of your retiree coverage is deducted from your medical plan credits until all your health plan credits are exhausted; once you exhaust your health plan credits, you pay the full cost of the retiree coverage under the Plan. For Retirees who are Medicare eligible, your health plan credits will be available to you through a Health Reimbursement Arrangement ("HRA").

Health plan credits may be used towards the payment of your retiree medical premiums. Effective January 1, 2024, health plan credits for Retirees who are Medicare-eligible may be used to reimburse for costs associated with expenses listed in Appendix B. Health plan credits may not be used for *spouse or dependent* medical premiums, unless the spouse is a Surviving Spouse (discussed below). Health plan credits can be

used only to purchase coverage for RTI-sponsored plans or plans selected through RTI's designated exchange provider.

If you or your Surviving Spouse do not elect to enroll in retiree medical coverage when initially eligible, any unused health plan credits ***will be forfeited.*** This means that unused credits will ***not*** be paid out in cash, nor can they be used to pay for or reimburse for insurance premiums paid or other expenses incurred, outside of RTI-sponsored plans or plans offered through RTI's designated exchange provider.

Surviving Spouse

If you are a Retiree and legally married on the date of your death to the individual who was your spouse on your employment termination date ("Surviving Spouse"), and your Surviving Spouse is enrolled in medical coverage under an RTI-sponsored plan or plans on the date of your death, your Surviving Spouse may use one-half of any health plan credits that you earned but had not yet used or had not been allocated as of the date of your death. If your Surviving Spouse is under age 65 on the date of your death, they may only use these health plan credits towards retiree medical premiums for RTI-sponsored plans and not towards retiree dental premiums. If your Surviving Spouse is age 65 or older, they may use health plan credits for reimbursement for expenses incurred as defined in Appendix B. Unused medical premium credits above one-half of the medical premium credits earned by the Retiree ***will be forfeited and will not*** be paid out in cash, nor can they be used to pay for or reimburse for insurance premiums paid or expenses incurred outside of RTI-sponsored plans or plans offered through RTI's designated exchange provider.

See the Continuation of Coverage under COBRA section below for applicable time periods following your death by which a Surviving Spouse must enroll in the Plan.

Premium Costs and Payment

For Retirees who are under age 65, you and your spouse pay an age-adjusted premium for retiree medical coverage. Unless you or your Surviving Spouse have available health plan credits, all retiree medical premiums for you, your spouse, and your dependent(s) must be paid directly to RTI's designated billing administrator(s). Retiree dental premiums for you, your spouse, and your dependent(s) at all times must be paid directly to RTI's designated billing administrator(s).

For Retirees who are Medicare eligible, you and your spouse may purchase individual Medicare plans through RTI's designated Medicare exchange provider. All premium payments for coverage you and/or your spouse purchase through RTI's dedicated Medicare exchange provider must be made directly to the carrier. Any premiums paid for your medical coverage purchased through RTI's designated Medicare exchange are reimbursable through your HRA account, if you have available health plan credits. You may also enroll in dental and vision plans through RTI's designated Medicare exchange provider and, if you do, you will pay premiums directly to these individual insurers. Vision premiums are reimbursable from your HRA, but any premiums you pay for dental coverage are not reimbursable through your HRA account.

Enrollment Changes

You can make changes in enrollment for retiree coverage during open enrollment or midyear, as described below.

1. *Making Changes During Open Enrollment*

   For Retirees who are under age 65, each year during annual open enrollment, you may submit an annual enrollment form to the designated third party administrator(s) to make changes to coverage for you, your spouse (if eligible), and your dependent(s) (if eligible) as permitted by the insurance carriers. If you do not submit an enrollment form, you, your spouse, and your dependent(s) will continue to be enrolled in the same Plan option in effect for the previous calendar year. If you waive medical or dental coverage during the annual enrollment period, you will not be eligible to rejoin the waived component of the Plan. For example, if you waive medical coverage for yourself during annual enrollment, you will no longer be eligible to enroll in the medical component of the Plan at a later date.

   For Retirees who are Medicare eligible, you may make changes to plans during the Medicare Open Enrollment Period each year. RTI's designated Medicare exchange provider will provide support in selecting and enrolling in plans.

2. *Making Changes Midyear*

   For Retirees who are under age 65

   - You may add a new dependent (e.g., a new baby, a legally adopted child, or legal guardianship of a child) if the new dependent meets the Plan's eligibility requirements
   - Your spouse and/or dependent may be added to the medical and/or dental component of the Plan during the year under certain circumstances involving a change in coverage under another group health plan that impacts their eligibility for coverage under the Plan. For example, if your spouse or eligible dependents lose their eligibility under another employer sponsored group health plan, you may be able to enroll them in the medical and dental components of the Retiree Plan.
   - You may drop your coverage or coverage for your spouse and/or dependents any time during the year.

   Note: All changes in coverage will be effective the first day of the month following the month in which you notify RTI, in writing, of any change in status for your dependents, except for special enrollment situations due to a birth or adoption or as mandated by a court order.

   For Retirees who are Medicare eligible:

   - Outside of the Medicare Open Enrollment Period, there are special circumstances that allow you to make changes to your coverage. Contact RTI's designated Medicare exchange provider or visit www.Medicare.gov for support in understanding when you are able to change coverage.
   - You may drop coverage your coverage or coverage for your spouse and/or dependents any time during the year.

Continuation of Employee Coverage Prior to Participation in the Plan

You may elect to continue the medical and dental coverage you had as an active employee before enrolling in the Plan. You and your eligible dependents will be offered continuation of coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), provided you were a participant in the U.S. group health plan for active RTI employees on the day before you retire. You may continue this coverage

under COBRA provided you pay the COBRA premiums during the continuation period. Your spouse and/or dependents can remain on COBRA coverage during the continuation period even if you elect to drop COBRA coverage and enroll in the Plan.

However, once COBRA coverage ends, you, your spouse, and/or your eligible dependents will have 45 days from the date of losing COBRA coverage, to enroll in the Plan. If you do not enroll yourself within 45 days of losing COBRA coverage, then you will forfeit your Retiree Health Plan Credits and will no longer be eligible for the Plan. Likewise, if you do not enroll your spouse and/or dependents within 45 days of losing their COBRA coverage, your dependents will no longer be eligible for the Plan until the following plan year subject to an election during the applicable enrollment period (except as set forth under the section entitled "Making Changes During the Year").

If you waive COBRA coverage for yourself or your spouse and/or your dependents waive their COBRA coverage**,** you, your spouse, and your eligible dependents will have 45 days from the date of losing your active coverage, to enroll in the Plan. If you do not enroll yourself within the 45 days, then you will forfeit your Retiree Health Plan Credits and you and your dependents will no longer be eligible for the Retiree Health Plan.

Continuation of Retiree Coverage Once Enrolled in the Plan

Once enrolled in the Plan, if your coverage under the Plan subsequently ends for any reason, you will not be offered continuation coverage under COBRA; however, an eligible dependent or spouse who loses coverage under the Plan may, under certain circumstances, be eligible to elect COBRA coverage, for a period of up to 36 months, from the date the coverage ends.

Note: You or your dependent(s) must notify RTI Employee Services (919-541-1200; 1-800-334-8571, extension 21200; or hrhelp@rti.org) *within 60 days* of the loss of dependent status. If this requirement is not met, your dependent(s) will be ineligible for COBRA coverage.

SECTION 2: HOW THE PLAN IS ADMINISTERED

How the Plan is Administered

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plans. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, including any ambiguity, prescribing applicable procedures, determining eligibility for and the amounts of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator or its delegate also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Benefits for Retirees who are Medicare eligible are accessed through HRAs. Benefits for participants under age 65, are self-funded by RTI and administered by a third-party claims administrator. Each insurance company or claims administrator, as applicable, is responsible for (1) determining eligibility for and the amount of any benefits payable under the applicable program; and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to the applicable programs listed above.

Circumstances That May Affect Benefits

Your benefits under the Plan will cease when your participation in the Plan terminates. The benefits of your spouse and/or eligible dependents will cease when their participation in the Plan terminate.

Your benefit, and the benefits of your spouse and/or eligible dependents, will also cease upon termination of the Plans or nonpayment (or late payment) of the required premiums under the Plan.

Amendment or Termination of the Plan

RTI reserves the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by RTI or any of its delegates.

SECTION 3: BENEFIT CLAIMS PROCEDURES

Claims for Benefits

- *For Retirees who are under age 65 - Claims for Benefits Provided by an Insured Underlying Program*. To obtain benefits under an insured benefit, you or your spouse or dependents must apply to the insurance company with the insurer's claim requirements. Please refer to the insurance booklet attached to the Plan.

- *For Retirees who are under age 65 - Claims for Benefits Provided under the Medical and/or Dental Components of the Plan*. To obtain benefits under the self-funded medical and/or dental components of the Plan, you or your spouse or dependents must apply to the claims administrator in accordance with the requirements of the medical and/or dental components of the Plan. Please refer to the self-funded medical and dental booklets attached to the Plan.

- *For Retirees who are Medicare eligible - Claims for reimbursement from HRA*. To obtain benefits under your HRA, you or your spouse or your dependents must apply to the claims administrator. Please refer to Appendix D.

Claims Regarding Eligibility

Except as otherwise provided in the applicable booklets described above which are attached to the Plan and incorporated by reference as part of the Plan, an eligible employee or the spouse or dependent of such employee who believes they are eligible to participate in the Plan may apply to the Plan Administrator for a formal eligibility determination in accordance with this Section. Provided, however, that this Section will not apply to an eligibility claim under an insured program if the Plan Administrator determines that the Insurance Company is responsible for making the eligibility determination under the provisions of the insured program

Any claim under this Section will be in writing and will set forth the facts the employee, their spouse, and/or their dependents (the "Claimant") believes entitle them to participate in the Plan.

If the Plan Administrator denies a Claimant's eligibility claim, the Plan Administrator will provide written or electronic notice of the denial to the Claimant within 90 days after submission of the claim. The notice will be written in a manner calculated to be understood by the Claimant and will include the following:

- the specific reason or reasons for the denial;
- specific references to the Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and
- an explanation of the applicable claim review procedures.

If special circumstances require an extension of time for processing the initial claim, the Plan Administrator will provide to the Claimant a written or electronic notice of the extension and the reason therefore before the end of the initial review period. In no event will the extension of time exceed 90 days.

If a claim for eligibility is denied, the Claimant or their duly authorized representative, at the Claimant's sole expense, may appeal the denial by submitting a notice of appeal to the Plan Administrator within 60 days of receipt of the notice of denial. The written notice of appeal should include any additional information the Claimant deems relevant to the eligibility claim, as well as any arguments the Claimant wishes to make in support of the eligibility claim. The Plan Administrator will provide to the Claimant, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant's eligibility claim. The appeal will be reviewed by the Plan Administrator. The Plan Administrator's review of the appeal will take into consideration all comments, documents, records and other information submitted by the Claimant in connection with the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

The Plan Administrator will provide written or electronic notification of the decision on review within 60 days of receipt of the request for review unless special circumstances require an extension of time for processing, in which case a decision will be rendered as soon as possible, but no later than 120 days after receipt of the request for review. If an extension of time is required, written or electronic notice of such extension will be provided to the Claimant before the end of the initial response period, and the notice will indicate the special circumstances requiring an extension and the date by which the Plan Administrator expects to render the decision on review. The Plan Administrator's notice will be written in a manner calculated to be understood by the Claimant and, if the decision is adverse to the Claimant, will include:

- the specific reasons for the adverse decision;
- reference to specific Plan provisions on which the decision is based;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim; and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

A Claimant whose eligibility claim is denied in whole or in part may file suit in a state or federal court. However, the Claimant must file suit no later than 180 days after the Plan Administrator makes a final determination to deny the Claimant's appeal and must file suit in the U.S. District Court for the Middle District of North Carolina. The Claimant must also exhaust the administrative remedies under the Plan (including the claim and appeal procedures outlined above) before bringing a civil action.

In exercising its responsibility and authority under this eligibility claims procedure, the Plan Administrator will have the discretionary authority and responsibility to:

- interpret and construe the Plan and any rules or regulations under the Plan,
- determine the eligibility of employees, their spouses and dependents covered by the Plan, and
- make factual determinations in connection with any of the foregoing.

SECTION 4: HIPAA COMPLIANCE

Information about the use and disclosure of Protected Health Information is found in Appendix C.

SECTION 5: RIGHTS UNDER ERISA

As a participant in an ERISA plan, you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- Obtain copies of the Plan documents and other program information upon written requests to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report).

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. These people, called fiduciaries, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to make good any losses they have caused the program.

No one, including RTI or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining Plan benefits or exercising your rights under ERISA.

If your claim for a benefit under the Plan is denied in whole or in part, then you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request materials from the Plan Administrator 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 per day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim to be frivolous), the court may order you to pay these costs and fees.

If you have any questions about this statement or 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.

SECTION 6: OTHER INFORMATION

For Retirees who are under age 65:

The cost of the benefits will be funded in part by RTI contributions through health plan credits and in part by your premium contributions. RTI will determine and periodically communicate your share of the cost of the benefits provided through each of the group medical and group dental programs (the "Underlying Programs") under the Plan. The costs for such Underlying Programs may change from time to time and in the sole discretion of RTI.

With respect to the self-funded arrangements, RTI intends that its contribution will be sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. With respect to the insured arrangements, RTI will pay its contributions and your contributions to the applicable insurance companies.

For Retirees who are Medicare eligible:

The cost of the benefits will be paid by Retirees and dependents directly to insurers. Retirees may request reimbursement of their expenses, as defined in Appendix B, through their HRA, if funds are available.

For all Retirees:

The Plans will also provide benefits as required by any qualified medical child support order ("QMCSO") (defined in ERISA § 609(a)) under a welfare program which otherwise constitutes a group health plan. The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

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

Compliance with Federal Laws

To the extent required, the Plan will be operated in accordance with the requirements of applicable federal laws, including but not limited to ERISA, HIPAA, COBRA, the Family and Medical Leave Act of 1993, the Uniformed Services Employment and Reemployment Rights Act of 1994, the Mental Health Parity Act of 1996, and the Newborns' and Mothers' Health Protection Act of 1996. The Plan is exempt from the requirements under the Patient Protection and Affordable Care Act.

General Information About the Plan

Plan Sponsor/Employer:	Research Triangle Institute ("RTI" or "RTI International") 3040 Cornwallis Road, PO Box 12194 Research Triangle Park, NC 27709
Plan Administrator:	Employee Benefits Committee Attn.: Sr. VP, Global Total Rewards & HR Operations Research Triangle Institute 3040 Cornwallis Road, PO Box 12194 Research Triangle Park, NC 27709 (919) 541-6000
Name of Plan:	RTI International Retiree Health Plan (formerly known as Medical and Dental Insurance for Retirees Age 55 or Older, RTI Policy 2525)
Plan Effective Date:	The Plan was originally effective July 1, 1993, and was most recently amended and restated effective February 1, 2025.
Employer Tax ID #:	56-0686338
Plan Number:	509
Type of Plan:	Welfare – Retiree Health
Funding:	Some benefits under the Plan are fully insured and are paid pursuant to the terms of insurance policies issued by insurance companies. Other benefits (including the HRA benefit for Retirees who are Medicare eligible) are self-funded and are paid from the general assets of the Plan Sponsor. The Sponsor has established the Research Triangle Institute Post Retirement Health Benefits Trust (the "Trust") to set aside funds to pay for benefits under the Plan. The trustee of the Trust is: Principal Custody Solutions 510 N Valley Mills Drive, Suite 400 Waco, TX 76710-6075 The Trust is intended to qualify as a voluntary employee benefits association under Section 501(c)(9) of the Internal Revenue Code.
Type of administration:	Self-funded with contract administration and insured
Plan Year:	12-month period beginning January 1 and ending December 31. Plan records are kept on a Plan Year basis.
Service of Legal Process:	General Counsel Research Triangle Institute Post Office Box 12194 Research Triangle Park, NC 27709-2194

Insurance Companies/ Claims Administrators:	See https://www.rti.org/rti-international-retirees
HRA Claims Administrator:	Plan Administrator
Named Fiduciary:	Employee Benefits Committee

Benefits hereunder are provided pursuant to an insurance contract and pursuant to benefit schedules or other descriptions in the case of the self-funded arrangements. If the terms of this Plan document conflict with the terms of such insurance, schedule or other description, then the terms of such other document will control, rather than this document, unless otherwise required by law. The Plan is not subject to the Patient Protection and Affordable Care Act.

Further Information

If you have questions about any of the information in the booklet, please contact Human Resources by calling RTI Employee Services at (919) 541-1200 or (800) 334-8571, ext. 2-1200.

RTI reserves the right to terminate, modify or revoke the Plan and the benefits described in this booklet or to modify the premium rates charged to Retirees or other covered individuals at its discretion.

APPENDIX A

RTI International Retiree Health Plan – Listing of Benefits
(Amended and Restated Effective January 1, 2024)

The following are the Health Benefits offered under the RTI International Retiree Health Plan:

1. Retiree Pre- Age 65 - Self-Insured Medical: administered by CIGNA

2. Retiree Pre-Age 65 - Self-Funded Dental: administered by Ameritas

3. Retiree Pre-Age 65 - Fully Insured Vision: insured by VSP; administered by Ameritas

4. Retiree who is Medicare eligible - Individual Medicare Supplement, Medicare Advantage, Medicare Part D (Pharmacy), Dental and Vision benefits offered through RTI's designated Medicare exchange provider; Alight Retiree Health Solutions (the HRA is administered by Your Spending Account™)

APPENDIX B

RTI International Retiree Health Plan – Listing of Expenses Eligible for Reimbursement Under the Plan's HRA Issued to Medicare-Eligible Retirees and Eligible Surviving Spouses

(Amended and Restated Effective January 1, 2024)

The following expenses are reimbursable from the Medicare-eligible Retiree's HRA, if incurred on or after January 1, 2024:

- Premiums paid for Medical, Pharmacy, or Vision coverage
- Premiums paid for Medicare Part B coverage
- Medicare Part B and D Income-Related Monthly Adjustment Amounts (IRMAA)
- Medicare late enrollment penalties
- Premiums paid for Dental coverage or combined Dental/Vision/Hearing (DVH) coverage
- Out-of-pocket costs (copays and deductibles) associated with medical or pharmacy coverage, as detailed on your YSA account's eligible out of pocket expenses list
- Allowable Long-Term Care expenses

APPENDIX C

Notice of Research Triangle Institute RTI International Retiree Health Plan Health Information Privacy Practices

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

This Notice is effective as of January 1, 2021.

The **RTI International Retiree Health Plan (the "Plan")** provides health benefits to eligible Retirees of **RTI International (the "Company")** and their eligible dependents (including the Retiree's spouse) as described in the Plan. The Plan creates, receives, uses, maintains, and discloses health information about participating Retirees and dependents in the course of providing these health benefits. For purposes of this Notice, the term "Plan" only applies to the Self-Funded Medical and Self-Funded Dental components of the Plan.

The Plan is required by law to take reasonable steps to protect your protected health information ("PHI") from inappropriate use or disclosure.

Your PHI is information about your physical or mental health condition, the provision of health care to you, or payment for health care provided to you—but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you.

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time, and if any such change requires a change to the terms of this Notice, the Plan will revise and redistribute this Notice. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives, or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice and will distribute any revisions only to participating Retirees and surviving beneficiaries, if any. If you have coverage under the Plan as a dependent of a Retiree or surviving beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care providers' privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates (as defined below) without obtaining your authorization.

Plan Sponsor: The Company, RTI International, is the Plan Sponsor. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company can solicit premium bids for health benefits or to modify, amend, or terminate the Plan. This summary information omits your name and Social Security number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against

inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

> **Example:** The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third-party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's Business Associates. The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist with or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and that they will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered to be maintained by the Plan. So, when this Notice refers to the Plan's taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use or disclose your PHI for the following purposes without obtaining your authorization.

Your Health Care Treatment: The Plan may disclose your PHI for treatment activities of a health care provider.

> **Example:** If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

> **Example:** The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others:

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost-sharing amounts)
- Processing health care data, such as managing claims, conducting collection activities, and obtaining payment under a stop-loss insurance policy
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges

- Conducting utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use or disclose your PHI for health care operations, which includes a variety of facilitating activities but does not include any communication for which the Plan receives direct or indirect payment from an outside party.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use or disclose your PHI to refer you to a disease management program.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes:

- Quality assessment and improvement activities
- Disease management, case management, and care coordination
- Activities designed to improve health or reduce health care costs
- Contact with health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing, or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan may also use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers, and health care clearinghouses with their health care operations activities that are like those listed above but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship. The Plan's use or disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others:

- Underwriting (so long as genetic information is not used or disclosed for underwriting purposes as required by the Genetic Information Nondiscrimination Act of 2008), premium rating, and performing related functions to create, renew, or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Conducting business management and general administrative activities, including implementation of, and compliance with, applicable laws and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, subpoena, or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request, or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request, or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your consent to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you.

Public Health: The Plan may disclose your PHI for purposes of certain public health activities. For example, if you are exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition, the Plan may then disclose your PHI.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits; civil, administrative, or criminal investigations; inspections; and licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death, or carrying out other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation: The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Disclosure for Breach Notification Purposes. The Plan may use or disclose your PHI to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information.

Authorization to Use or Disclose Your PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. Among other things, this means that the Plan cannot do the following without your authorization: (1) use/disclose psychotherapy notes; (2) use PHI for marketing purposes; (3) sell PHI; or (4) use or disclose PHI for any other purpose not stated above. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example), you cannot revoke your authorization.

The Plan May Contact You

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail. The Plan may also contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights with Respect to Your PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason why you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request must also specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. A request must be honored if it relates to disclosing PHI to a health plan

regarding an item or service for which full payment has been made. Otherwise, the Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement.

To request a restriction, submit your written request to the contact person identified at the end of this Notice. In the request, specify (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously or have agreed to receive this Notice electronically. To obtain a paper copy, call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access yourPHI in the Plan's enrollment, payment, claims adjudication, and case management records or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to the Plan or the Secretary of the U.S. Department of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested

amendment in the Plan's records, and a description of how you may complain to the Plan or the Secretary of the U.S. Department of Health and Human Services.

Right to Receive Notification of a Security Breach: Under the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), the Plan is required to notify you if your "unsecured" PHI has been breached unless there is a low probability that such PHI has been compromised based on a risk assessment as described in the Plan's HIPAA Policies and Procedures. For these purposes, "unsecured" PHI means PHI that is not secured through the use of a technology or methodology (e.g. encryption) specified under HITECH or guidance issued by the U.S. Department of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize or that occurred prior to April 14, 2003, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period that may not be longer than 6 years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting to be provided (for example, on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of their authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the U.S. Department of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

The Plan has designated Marjorie M. Williamson, Senior Vice President, Global Total Rewards and Human Resources Operations, as its Privacy Official for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at:

RTI International
Human Resources
3040 Cornwallis Road
P.O. Box 12194
Research Triangle Park, NC
27709-2194
919.541.6000

APPENDIX D

Claims For Benefits Applicable To Retirees Who Are Medicare Eligible

Procedure If Benefits Are Denied Under The Plan

Any claim for Plan benefits will be made to the Plan Administrator. If the Plan Administrator (or its delegate) denies a claim, the Plan Administrator (or its delegate) will provide notice to the Participant or beneficiary, in writing, within 30 days after the claim is filed. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator (or its delegate), including cases where a reimbursement claim is incomplete. If the Plan Administrator (or its delegate) does not notify the Participant of the denial of the claim within the 30-day period specified above, then the claim will be deemed denied. The notice of the denial of a claim will be written in a manner calculated to be understood by the Claimant and will set forth:

- The reason(s) for the denial;
- Specific reference to the provisions of the Plan on which the denial was based;
- A description of any additional material or information needed to further process the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and time limits applicable to such procedures, as well as the Participant's right to bring a civil action under Section 502 of ERISA following a final appeal;
- A statement of a Participant's right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- A statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon written request.

Right to Request Hearing on Benefit Denial

When the Participant receives a denial of a claim, the Participant will have 180 days following the receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relevant to the claim. If the Participant requests, the Participant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a review of a claim denial is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information will be considered relevant to a claim if it:

- was relied upon in making the claim determination;
- was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

Disposition of Disputed Claims

Upon its receipt of notice of a request for review, the Plan Administrator will make a prompt decision on the review. The decision on review will be written in a manner calculated to be understood by the Claimant and will include specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based. The decision on review will be made not later than 60 days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review. If an extension is necessary, the Claimant will be given written notice of the extension prior to the expiration of the initial 60-day period. If notice of the decision on the review is not furnished in accordance with this provision the claim will be deemed denied and the Claimant will be permitted to exercise his or her right to legal remedies set forth in below.

Preservation of Other Remedies

After exhaustion of the benefit claims procedures described above, a Claimant whose benefit claim is denied in whole or in part may file suit in a state or federal court. However, the Claimant must file suit no later than 180 days after the Plan Administrator makes a final determination to deny the Claimant's appeal and must file suit in the U.S. District Court for the Middle District of North Carolina. The Claimant must also exhaust the administrative remedies under the Plan (including the claim and appeal procedures outlined above) before bringing a civil action.

In exercising its responsibility and authority under this eligibility claims procedure, the Plan Administrator will have the discretionary authority and responsibility to:

- interpret and construe the Plan and any rules or regulations under the Plan,
- determine the eligibility of employees, their spouses and dependents covered by the Plan, and
- make factual determinations in connection with any of the foregoing.

APPENDIX E

Eligibility and Credits for Individuals Whose Termination of Employment with Their Employer Is On or After February 1, 2025 and On or before December 31, 2025

Eligibility

For purposes of this Appendix E only, a Specially Separated Retiree is an individual who meets the definition of Retiree (as defined in Section 1 of the Plan) AND whose separation of employment from their Employer occurs on or after February 1, 2025, and on or before December 31, 2025.

Health Plan Credits

The following special rules apply to individuals who meet the definition of Specially Separated Retiree in this Appendix E:

- For each full year of Creditable Service (as defined in Section 1 of the Plan) that you were continually employed by your Employer, you will be entitled to a Plan credit equal to $2,000.
- The aggregate health care credit under the Plan to which you are entitled under this Appendix E may not exceed $40,000.
- The health care credit discussed in the first and second bullet directly above are in substitution of and not in addition to the health care credit described in Section 1 of the Plan under the heading "Health Plan Credits."

To participate in the Plan as a Specially Separated Retiree, you must elect retiree coverage within 120 days of the date your employment with your Employer terminates or, if you elected COBRA coverage, within 120 days of the date your COBRA coverage terminates. If you fail to do so, you cannot participate in the Plan at a later date. See the" Continuation of Coverage Prior to Participation in the Plan" section.

For Specially Separated Retirees who are under age 65, the cost of your retiree coverage is deducted from your medical plan credits until all your health plan credits are exhausted; once you exhaust your health plan credits, you pay the full cost of the retiree coverage under the Plan. For Specially Separated Retirees who are Medicare eligible, your health plan credits will be available to you through a Health Reimbursement Arrangement ("HRA").
Health plan credits may be used towards the payment of your retiree medical premiums. Health plan credits for Specially Separated Retirees who are Medicare-eligible may also be used to reimburse for costs associated with expenses listed in Appendix B. Health plan credits may not be used for *spouse or dependent* medical premiums, unless the spouse is a Surviving Spouse (discussed under the "Surviving Spouse" section of the Plan). Health plan credits can be used only to purchase coverage for RTI-sponsored plans or plans selected through RTI's designated exchange provider.

If you or your Surviving Spouse do not elect to enroll in retiree medical coverage when initially eligible, any unused health plan credits ***will be forfeited.*** This means that unused credits will ***not*** be paid out in cash, nor can they be used to pay for or reimburse for insurance premiums paid or other expenses incurred, outside of RTI-sponsored plans or plans offered through RTI's designated exchange provider.