foryourbenefit-REI.com

FOR YOUR BENEFIT

REI Full Benefits Plan
Summary Plan Description

Effective January 1, 2023

SUMMARY PLAN DESCRIPTION

This document, along with the benefit booklets and certificates of coverage describing your coverage, constitutes your Summary Plan Description (SPD) for the Recreational Equipment Inc. Benefits Plan ("Plan"), also known as the full benefits plan. An SPD is your basic resource when it comes to understanding all the ins and outs of the Plan. In the SPD, you'll find detailed information about the health, life, disability and other benefits available REI employees who are eligible for benefits under the Plan, including:

- Information on eligibility, enrollment and benefits;
- Contact information and an administrative facts section detailing all the technical information about our benefit program; and
- A glossary to explain some of the defined terms used in the SPD.

The SPD is available on **www.foryourbenefit-rei.com**. You may also request a paper copy from the Employee Service Center at 1-800-999-4734 or **hrhr@rei.com**.

Note: If you are enrolled in a Health Maintenance Organization (HMO), you can get information about that plan in your HMO's certificate of coverage. You can request it from your health plan or find it at **www.foryourbenefit-rei.com**.

REI employees who are not eligible for this Plan may be eligible for benefits under the Recreational Equipment, Inc. Access Benefits Plan. The benefits provided by the Access Benefits Plan are found in a separate SPD available on **www.foryourbenefit-rei.com** or from the Employee Service Center.

This SPD is effective January 1, 2023. The following additional documents are also part of the SPD for benefits offered under the Plan:

- REI Choice POS II High Deductible Health Plan – Saver Plan Schedule of Benefits and Benefits Booklet
- REI Choice POS II High Deductible Health Plan – Custom Saver Health Plan Schedule of Benefits and Benefits Booklet
- REI Choice POS II – Choice Health Plan Schedule of Benefits and Benefits Booklet
- REI Choice POS II – Custom Choice Health Plan Schedule of Benefits and Benefits Booklet
- ESI Plan document
- Delta Dental PPO National Coverage Plan Benefit Booklet
- VSP Group Vision Care Plan Benefits Booklet

The applicable certificates of insurance coverage, with respect to each insurance benefit (basic and supplemental life, basic and voluntary accidental death and dismemberment, business travel accident, and long term disability). All applicable Kaiser Health Maintenance Organization certificates of coverage, with respect to benefits provided by an HMO.

The Plan provides how the Plan terms should be interpreted if there is a conflict between this SPD and any other documents that comprise the Plan. REI reserves the right to modify, amend or terminate the Plan, any component plan or any benefit at any time.

The Plan and component benefits are designed to comply with all applicable state and federal laws, statutes and regulations. If any of these change, or there's a discrepancy between the laws and the plans, the Plan will comply with the applicable legal requirements. This SPD is not a contract of employment or guarantee to continue employment for any period of time.

BENEFITS PLAN OPTIONS

Here's a quick look at the Plan benefit options available to all eligible employees and family members. Additional details can be found later in this SPD.

COVERAGE	DESCRIPTION
Health – Medical, Dental and Vision Plan Options	
Medical	All REI medical plans offer preventive care benefits, comprehensive medical coverage and prescription drugs. Health Maintenance Organization (HMO) medical plans are available in specific geographical regions and their coverage varies.
Dental	Core dental coverage is available to you and eligible family members. Additional orthodontia benefits are also available.
Vision	Vision coverage is available to you and eligible family members. The plan pays benefits for covered services such as routine eye exams, frames and lenses from any licensed vision care provider.
Well-Being Programs	
Quit for Life®	Quit for Life – tobacco cessation program is available at no charge to you and your covered family members over age 18. The program includes phone-based counseling, unlimited toll-free access to quit coaches, and delivery of recommended nicotine replacement products (such as the patch, gum or lozenges). In addition, if you are enrolled in an REI medical plan and actively participate in Quit for Life, your copays for smoking cessation drugs will be waived.
RethinkCare	RethinkCare's program provides digital training and resources for: • Personal well-being – for you and your dependents to improve mental, emotional, and physical well-being, • Professional resilience – for you and your dependents to grow teamwork, emotional intelligence and leadership skills for current and future work endeavors, and • Parental success – for parents and other caregivers raising children with learning and behavior challenges with support and online research-based resources. Parents and caregivers have access to live tele-consultation with behavioral health experts to answer questions and provide guidance and training to best support children in reaching their top potential.
Commuter benefits	Enroll at any time. REI pays for the full cost of public transit passes up to the monthly IRS limit. Employees may pay for parking through pre-tax payroll deductions, up to the monthly IRS limit.

COVERAGE	DESCRIPTION
Financial Peace of Mind — Insurance Options and Flexible Spending Accounts	
Life Insurance	• Basic life for Part-time Benefit-Eligible Employees – benefit is equal to a flat amount of $20,000. • Basic life for Full-time Benefit-Eligible Employees – benefit is equal to your annual base pay rounded to the next $1,000, up to $850,000. • Supplemental life – optional for you and eligible family members: – You: 1 – 8 times your basic life coverage. Up to $850,000 for full-time employees; combined max. of $1.7 million for basic and supplemental coverage. – Spouse or life partner: $20,000, $50,000, $75,000, $100,000, $150,000, $200,000 or $250,000, not to exceed the employee's combined basic and supplemental life amount. – Children live birth to under age 26: $10,000 or $20,000. Note: If you're age 65 – 69, Basic and Supplemental life benefits are reduced to 65% of the full amount. If you're age 70 or older, they are reduced to 50% of the full amount.
Accidental Death and Dismemberment (AD&D)	Pays benefits for certain serious losses due to an accident. • Basic AD&D for Part-time Benefit-Eligible Employees – Equal to your Basic life benefit. • Basic AD&D for Full-time Benefit-Eligible Employees – Equal to your Basic life benefit. • Supplemental AD&D – optional for you and eligible family members: – You: $25,000; $50,000; $100,000; $150,000; $200,000 or $300,000. – You + Dependents: $25,000; $50,000; $100,000; $150,000; $200,000 or $300,000. Note: If you're age 65 – 69, Basic and Supplemental life benefits are reduced to 65% of the full amount. If you're age 70 or older, they are reduced to 50% of the full amount.
Short Term Disability (STD)	For hourly employees (except hourly HQ and hourly retail and OPO management) eligible for benefits under this Plan: After a five-calendar-day waiting period, pays bi-weekly benefits at 100% of average weekly earnings for up to six weeks and 60% of average weekly earnings for up to an additional 20 weeks for approved non-work-related disabilities.
Salary Continuation	For all salaried/exempt, HQ, and hourly retail and OPO management employees; pays bi-weekly benefits at 100% of average weekly earnings for the first 12 weeks and 80% of your annual base pay for up to an additional 14 weeks for approved non-work-related disabilities.
Long Term Disability (LTD)	For all employees eligible for benefits under this Plan: • Core LTD coverage pays monthly benefits of 40% of annual base pay starting after 26 weeks (180 days) of STD or Salary Continuation (maximum monthly benefit $6,667) with an approved LTD claim. • Voluntary LTD – optional coverage pays an additional monthly benefit of 20% of annual base pay (for a total benefit of 60% of annual base pay and a maximum monthly benefit of $10,000, combined with core LTD) with an approved LTD claim.
Business Travel Accident (BTA)	Automatic for you and accompanying family members; pays benefits for certain serious accidental losses that happen while on a covered business trip.

COVERAGE	DESCRIPTION
Tax Based Accounts	Flexible Spending Accounts allow you to pay eligible costs with pre-tax money: • Health Care FSA – for out-of-pocket health, dental, prescription drug and vision care costs for you and your eligible family members. Available to all eligible part-time and full-time employees not enrolled in the REI Saver or Custom Saver Medical Plan. You can contribute up to $2,850 for plan year 2023 on a pre-tax basis. • Limited-Use Health Care FSA – for out-of-pocket dental and vision costs for you and your eligible family members. Available to all eligible part-time and full-time employees enrolled in the REI Saver or Custom Saver Medical Plan. You can contribute up to $2,850 for the 2023 plan year on a pre-tax basis. • Dependent Care FSA – for care of your children under age 13 or other dependents while you're at work. Available only to eligible full-time employees. You can contribute up to the IRS current dependent care FSA limits for the plan year on a pre-tax basis. If you elect the REI Saver or Custom Saver Medical Plan, you can enroll in a Health Savings Account. You can contribute up to the IRS limits through pre-tax payroll deductions. REI will also contribute up to $500 for employee only coverage and up to $1,000 for family coverage. Commuter Benefits: REI pays for the full cost of public transit passes up to the monthly IRS limit. Employees may pay for parking through pre-tax payroll deductions, up to the monthly IRS limit.
Day-to-Day Living — Work/Life Programs	
Employee Assistance Program (EAP)	Available to you and your household members free of charge. The EAP provides solution-focused, confidential help for day-to-day issues like finding dependent care and dealing with financial or legal situations.

CONTENTS

HOW THE BENEFITS PLAN WORKS

REI provides the Recreational Equipment, Inc. Benefits Plan (referred to as "Plan") to regular and seasonal full-time, part-time exempt and part-time hourly employees who meet the benefits hours requirement. The Plan includes a variety of benefits designed to support your health and well-being, financial peace of mind and your day-to-day living now and into the future.

As a benefits-eligible employee, you are offered core benefits by REI at no cost to you. For extra protection, you can choose optional benefits that make the most sense for you and your family.

REI pays a portion of the cost of most of your benefits. For many benefits, your share of the cost of benefits is withheld from your paychecks on a pre-tax basis. This provides a tax savings for you. For other benefits, your share of the cost is withheld from your paychecks on an after-tax basis.

When you first become eligible for the Plan — and each year during open enrollment — you'll receive the following information:

- Overview of the benefit options available to you.
- How much REI will contribute on your behalf for the coming year.
- Your cost for each benefit option.
- Instructions on how to enroll.

Questions About the Plan?

Call REI Health Guide at 1-800-451-2967 for questions about health, wellness and disability (including leaves).

For all other benefit questions, contact the Employee Service Center (ESC):
1-800-999-4734
hrhr@rei.com

HOW MUCH BENEFITS COST

If you're eligible, REI pays the full cost of these benefits:

- Basic Life coverage for you.
- Basic Accidental Death and Dismemberment (AD&D) coverage for you.
- Short Term Disability (STD) coverage for hourly benefits-eligible employees (except hourly HQ and hourly retail and OPO management).
- Salary Continuation (All salaried/exempt, all HQ and all hourly retail and OPO management employees).
- Core Long Term Disability (LTD).
- Employee Assistance Program (EAP).
- Quit for Life (tobacco cessation).
- RethinkCare (well-being support and behavioral health and developmental disability support for children).
- Business Travel Accident coverage for you and your accompanying family members.
- Commuter benefits – transit up to IRS limit.

You and REI share the cost of medical and dental coverage. Both you and REI may contribute to your Health Savings Account if you are enrolled in the REI Saver or Custom Saver Plan and are eligible to make contributions to such an account. All the other benefits (including family coverage) are optional and you must pay the full cost of coverage. These benefits include:

- Coverage such as vision, Supplemental Life and AD&D and Voluntary LTD.
- Flexible Spending Accounts (Health Care, Limited Health Care or Dependent Care).
- Commuter benefits – parking.

When you enroll in any of these benefits that require you to pay in part or whole for the coverage, you are agreeing to have your wages reduced by the amount of such payments. Note also that if you do not enroll in a different medical plan option during your initial enrollment, you will be automatically enrolled in the REI Saver Medical Plan for employee only coverage, and payments for the cost of this coverage will be deducted from your wages.

SPOUSE/LIFE PARTNER MEDICAL PLAN SURCHARGE

If your spouse/life partner is offered medical coverage through their employer but is not enrolled in such coverage and you enroll them in an REI medical plan, you will pay a surcharge of approximately $100 per month ($46.15 per pay period) on a pre-tax basis. If your spouse/life partner is an REI employee, you do not have to pay this surcharge if you enroll them in an REI medical plan.

THE PRE-TAX ADVANTAGE

Your paycheck contributions for many benefits are withheld from your paycheck before federal income and Social Security taxes are calculated, helping to reduce your taxable income. You must pay for other benefits on an after-tax basis.

Keep in mind that paying for benefits pre-tax reduces the amount you pay in Social Security taxes. Because the amount you pay for benefits is not subject to Social Security taxes, your Social Security covered compensation will be reduced if you are not over the Social Security wage base ($160,200 for calendar year 2023). This may reduce your future Social Security benefits.

PAYING FOR LIFE PARTNER BENEFITS

If you cover your life partner and/or your life partner's children, you pay for their coverage on a pre-tax basis. The IRS considers both REI's contribution towards the cost of coverage and the amount you paid on a pre-tax basis (including, if applicable, the life partner surcharge discussed above) as taxable income to you if your life partner and your life partner's children are not your tax dependents. REI will impute taxable income to you on the total amount (the REI contribution and the amount you paid on a pre-tax basis) on your W-2. Additional information on this issue is found later in the SPD.

WHO IS ELIGIBLE?

YOURSELF

When you join REI, your benefits eligibility for most benefits depends on if you are a regular or seasonal full-time employee or a regular or seasonal part-time employee. You are considered to be a regular full-time employee if you are regularly scheduled to work for 32 or more hours per week. You are considered to be a regular part-time employee if you are regularly scheduled to work less than 32 hours per week.

If you are a regular full-time employee, you will be eligible for REI's benefits on:

- Your date of hire, if hired on the first of the month; otherwise,
- The first of the month following your date of hire.

If you are a regular or seasonal part-time employee, you will be eligible for benefits if you average 20 or more hours per week (called **average weekly hours**) over the course of a 12-month evaluation period. This first 12-month evaluation period is called your **initial evaluation period** and it begins the first of the month that falls on or next follows your date of hire. For example (see illustration on the following page), if you were hired on April 14, your initial evaluation period will be May 1 through April 30 of the following year. REI will review your hours the following month (**administrative month**). If your average hours are 20 per week during the 12-month initial evaluation period, you will be eligible for the Plan for at least 12 months (guaranteed coverage period) as long as you remain an active employee and continue to pay for your portion of coverage. You will lose your eligibility for coverage after your initial guaranteed coverage period if you do not qualify for continuing coverage during an ongoing evaluation period as described below.

If you are a part-time employee and do not become benefits-eligible after your initial evaluation period, we will review your hours during the next **ongoing evaluation period**, which occurs every year from October 4 through October 3 of the following year to determine your eligibility for the following January 1 plan year (see *Staying Eligible for the Plan* for more details). If you work an average of 20 or more hours per week during an entire ongoing evaluation period, you are benefits eligible for the following plan year.

You can also keep track of your hours during the evaluation period by reviewing the Status and Key Dates page in Employee Self-Service. To learn more detail about the evaluation period and when you will be covered review the Benefits Eligibility page on **www.foryourbenefit-rei.com**.

Following is an example of what the benefits eligibility process looks like for a part-time employee hired on April 14, 2022:

<table>
<tr><td rowspan="12">2022</td><td>APR</td><td colspan="2">HIRED ON: April 14, 2022</td></tr>
<tr><td>MAY</td><td rowspan="12">Average 20+ hours per week
INITIAL EVALUATION PERIOD:
May 1, 2022 – April 30, 2023</td><td rowspan="4"></td></tr>
<tr><td>JUN</td></tr>
<tr><td>JUL</td></tr>
<tr><td>AUG</td></tr>
<tr><td>SEP</td></tr>
<tr><td>OCT</td><td rowspan="11">Average 20+ hours per week
ONGOING EVALUATION PERIOD:
October 4, 2022 – October 3, 2023</td></tr>
<tr><td>NOV</td></tr>
<tr><td>DEC</td></tr>
<tr><td rowspan="12">2023</td><td>JAN</td></tr>
<tr><td>FEB</td></tr>
<tr><td>MAR</td></tr>
<tr><td>APR</td></tr>
<tr><td>MAY</td><td>ADMINISTRATIVE MONTH:
May 1 – 31, 2023</td></tr>
<tr><td>JUN</td><td rowspan="12">Initial Guaranteed Coverage Period
COVERAGE EFFECTIVE:
June 1, 2023 – May 31, 2024</td></tr>
<tr><td>JUL</td></tr>
<tr><td>AUG</td></tr>
<tr><td>SEP</td></tr>
<tr><td>OCT</td><td rowspan="2"></td></tr>
<tr><td>NOV</td></tr>
<tr><td>DEC</td></tr>
<tr><td rowspan="12">2024</td><td>JAN</td><td rowspan="12">Ongoing Guaranteed Coverage Period
COVERAGE EFFECTIVE:
January 1 – December 31, 2024</td></tr>
<tr><td>FEB</td></tr>
<tr><td>MAR</td></tr>
<tr><td>APR</td></tr>
<tr><td>MAY</td></tr>
<tr><td>JUN</td><td rowspan="7"></td></tr>
<tr><td>JUL</td></tr>
<tr><td>AUG</td></tr>
<tr><td>SEP</td></tr>
<tr><td>OCT</td></tr>
<tr><td>NOV</td></tr>
<tr><td>DEC</td></tr>
</table>

STAYING ELIGIBLE FOR THE PLAN

If you're a full-time employee: You will remain eligible for as long as you remain a regular or seasonal full-time employee. See *Employment Status Change* under the *Life Events* section to find out what happens to your benefits when you change to part-time.

If you're a part-time employee: After you've been with REI for 12 months, your hours are reviewed every year from October 4 through the following October 3 to determine your eligibility for the following January 1 plan year. This 12-month period is called the **ongoing evaluation period**. If you average 20 hours or more per week during the ongoing evaluation period, you will be eligible for benefits for the entire following plan year (January 1 – December 31) as long as you remain an active employee and continue to pay for your portion of coverage.

If your average weekly hours during the 12-month ongoing evaluation period are less than 20, you will not be eligible for benefits for the entire following plan year and will have to find coverage elsewhere. We will review your hours again at the end of the next ongoing evaluation period.

If you were benefits-eligible and lost eligibility because you did not work enough hours during the ongoing evaluation period, you have options to obtain insurance through the Marketplace, another employer or continue coverage with REI through COBRA. See *Employment Status Changes* under the *Life Events* section for more information.

Track your hours and find out when you'll be eligible for the Plan

You can monitor your eligibility for Plan Benefits in Employee Self-Services > Myself > Personal > Status/Key Dates.

SPOUSES AND LIFE PARTNERS

Spouses

If you are eligible for Plan benefits, your spouse is also eligible for certain benefits.

Family Double Coverage Rule

If you and your spouse/life partner are both REI employees:

- Each of you may be covered only once — either as an employee or as the spouse/life partner of an employee.
- You and your spouse/life partner may enroll your eligible children only once, either as your dependents or as your spouse/life partner's dependents.

Life Partners

A life partner is eligible if you are in a committed, "spouse-like" relationship with your partner and your relationship meets the specific requirements spelled out in the REI Life Partner Affidavit. These requirements are:

1. You have been in a relationship for at least six months;
2. You are each other's sole life partner and intend to remain so indefinitely;
3. You live together and intend to do so indefinitely;
4. You are jointly responsible for each other's welfare and common financial obligations;
5. You are not legally married to anyone else;
6. You are not related by blood to a degree that would prohibit legal marriage; and
7. You are both at least the age of consent in the state where you live.

If you are eligible for Plan benefits, your life partner is eligible for certain Plan benefits.

Please note that your designation of someone as your life partner may have legal ramifications outside of the Plan. Please consult your legal advisor or call the EAP for more information.

You are responsible for notifying the Plan if your life partnership ends.

If you are enrolling a life partner for the first time

You must complete and submit the REI Life Partner Affidavit, regardless of whether or not the state you live in requires or does not require a domestic partner filing. Get a copy of the affidavit on **www.foryourbenefit-rei.com**. More information about the taxation of health coverage for life partners is provided later in the SPD.

Contact the Employee Service Center at 1-800-999-4734 or **hrhr@rei.com** if you have any questions.

Life Partner Tax Considerations

You can pay for most of your life partner's benefits (excluding Supplemental Life and Supplemental Accidental Death and Dismemberment Insurance) with pre-tax dollars. However, the actual cost of your life partner's health care coverage is considered income when calculating your federal, state (if applicable), Social Security and Medicare (FICA) taxes. You cannot submit claims for life partner expenses under your FSA or HSA unless your life partner is your tax dependent. See below for more details.

Spouse/Life Partner Medical Plan Surcharge

If your spouse/life partner is offered medical coverage through their employer but is not enrolled and you enroll them in an REI medical plan, you will pay a surcharge of approximately $100 per month ($46.15 per pay period) on a pre-tax basis. If your spouse/life partner is an REI employee, you do not have to pay this surcharge if you enroll them in an REI medical plan.

DEPENDENT CHILDREN

Your children are eligible for Plan benefits if they:

- Are your biological, step or adopted children related to you by blood or marriage/life partnership, or are children for whom the courts have given you, your spouse or your life partner rights, duties and obligations similar to those of a parent. This may include, but is not limited to, an award of legal custody or legal guardianship. Foster children are not eligible for the Plan.

- Are under age 26, or any age if they are incapable of self-support due to disability, provided the disability began before age 26.

You can enroll your life partner's child if the child meets the age limitations of the Plan.

Qualified Medical Child Support Order (QMCSO)

QMCSO is a judgment, decree or order issued by a court or through an administrative process established by state law, under which an employee or spouse must provide medical coverage for a dependent child. This might apply, for example, following a divorce.

Under such an order, REI may be authorized to make the applicable payroll deductions to pay for the coverage.

TAX CONSEQUENCES OF ENROLLING A LIFE PARTNER AND CERTAIN CHILDREN

There are tax consequences to you when you enroll your life partner and certain children in benefits offered under the Plan.

Under federal tax law, if your life partner or your life partner's child does not qualify as your tax dependent for Plan purposes (as defined in *Who Is a Tax Dependent for Plan Purposes?*), then the value of their health and accident coverage, including the spouse/life partner surcharge, will be included in your gross income, subject to federal and, in some cases, state income tax withholding and federal employment taxes, and will be reported on your Form W-2. If you live in a state (e.g., CA, CT, OR, MA, NJ) that allows you to exclude the value of your life partner benefits from your state taxable wages, notify the Employee Service Center. You must meet certain state requirements (e.g., state-registered domestic partner, civil union) to be eligible for the tax exemption.

If your life partner or your life partner's child qualifies as your tax dependent for Plan purposes (as defined in *Who Is a Tax Dependent for Plan Purposes?*), then the value of the coverage provided to them will not be included in your gross income, subject to state and federal withholding or employment taxes. Note that if your life partner or child fails to qualify as your tax dependent for Plan purposes for the entire year because of a change in tax status during the year, the value of the applicable coverage for the portion of the tax year prior to the change will be included in your gross income. As a result, related income tax and employment tax withholding will be deducted from your pay as soon as is possible.

You must notify the Employee Service Center if there are any changes to your dependent's tax status.

Note: If you elect a Health Savings Account (HSA), REI's contribution toward your HSA is not considered taxable income for your life partner coverage.

Who Is a Tax Dependent for Plan Purposes?

Your spouse and/or your spouse's children under age 26 are considered your tax dependents for purposes of federal income and employment taxation. Children with disabilities who are age 26 and older may or may not be considered your tax dependents. You should consult with a tax advisor for the information needed to make the determination of whether your child with a disability is your tax dependent for federal income and employment tax purposes.

For Plan purposes, your life partner is a tax dependent for purposes of federal income and employment taxes if you claim an exemption for your life partner on your Form 1040. Your life partner could be your federal tax dependent for Plan purposes even if you do not claim an exemption for them on your Form 1040 if the following conditions are met:

- You and your life partner have the same principal place of residence for the entire calendar year;
- Your life partner is a member of your household for the entire calendar year (the relationship must not violate local law);
- During the calendar year, you provide more than 50% of the total support for your life partner;
- Your life partner is not your (or anyone else's) "qualifying child" under Internal Revenue Code Section 152(c); and

- Your life partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico.

REI will also consider your life partner to be your federal tax dependent for Plan purposes if the life partner meets the above requirements for the first portion of the year, then you marry, and they remain your legal spouse for the remainder of the year.

To determine whether you provide more than half of the total support for your life partner, you must compare the amount of support you provide with the amount of support your life partner receives from all sources, including Social Security, welfare payments, and the support your life partner provides from the life partner's own funds. Support includes food, shelter, clothing, medical care, education and the like. If you believe you might provide more than half of the support for your life partner, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information) before you complete the *Tax Certification* described below.

The child of your life partner, who is also not your child, may qualify as your tax dependent for Plan purposes under federal tax law in certain circumstances. You should consult with a tax advisor for the information needed to make this determination.

Certification of Federal Tax Dependent Status to Avoid Taxation. To avoid the tax consequences described above, you must complete and return a *Certification of Federal Tax Dependent Status (Tax Certification),* indicating that an enrolled life partner or child of your life partner qualifies as your federal tax dependent for Plan purposes. You must contact the Employee Service Center to obtain a *Tax Certification* form. You must complete the form and return it to the Employee Service Center to avoid taxation. If there are changes to the tax status of your life partner or your life partner's tax status, it is your responsibility to notify the Employee Service Center to complete and submit any necessary forms.

HOW TO ENROLL

There are three types of enrollment periods under the Plan: (1) Initial Enrollment; (2) Open Enrollment; and (3) Midyear Enrollment due to qualified life or special enrollment events.

INITIAL ENROLLMENT

Benefit choices you make during initial enrollment will apply for the rest of the plan year, as long as you remain eligible. (This rule does not apply to contributions you make to an HSA, which can be changed at any time.) You will not be able to make changes to your choices until the next open enrollment unless you experience a qualifying life event (see page 21). The plan year runs from January 1 through December 31.

WHEN COVERAGE BEGINS

Coverage for you and your eligible dependents begins on:

- **For Full-time Employees:** The first of the month following your date of hire, or if your date of hire is the first day of the month, on your date of hire. For example, if you start work August 1, coverage is effective August 1. For a hire date of August 15, coverage begins September 1.
- **For Part-time Employees:** After your initial evaluation period is complete, REI will review your hours the month following its completion. This month is called the administrative month. If your average weekly hours during your initial evaluation period are 20 or more, you will be eligible for benefits the first of the month following the administrative month for at least 12 months as long as you remain an active employee.

  For example, Mary was hired on April 14, 2022 and her initial evaluation period is May 1, 2022 – April 30, 2023. We will review the hours Mary was paid during her initial evaluation period in May of 2023. If Mary's average weekly hours during the 12-month initial evaluation period are 20 or more, Mary will be notified in May that she is eligible for benefits from June 1, 2023 to May 31, 2024.
- **For Current Part-time Employees:** If you are employed with REI as of October 4 of any year, your hours are reviewed every year from October 4 through the following October 3 (ongoing evaluation period) to determine your eligibility for the following plan year. If you were not previously benefits-eligible and you average 20 hours or more per week during the ongoing evaluation period, you will become eligible for benefits starting on January 1 of the following year. You will be notified of your eligibility right before open enrollment period begins (see *Open Enrollment* section) in the fall.

  For example, Lloyd was hired the same day as Mary (on April 14, 2022) but he did not average 20 or more hours during his initial evaluation period. In October 2023, we reviewed Lloyd's average weekly hours during his first ongoing evaluation period (October 4, 2022 – October 3, 2023) and his average hours during the ongoing evaluation period were 20 or more. As a result, Lloyd gained benefits eligibility for January 1, 2024.

For qualified life events, coverage for family members who become eligible due to marriage or commencement of a life partnership is effective the first day of the month falling on or following the date the enrollment is completed, provided you report the qualified life event within 30 days to the Employee Service Center. For your child who becomes eligible because of birth, adoption or placement for adoption, health coverage is effective retroactive to the date of the birth, adoption, or placement for adoption, provided you report the qualified life event within 30 days.

OPEN ENROLLMENT

Open enrollment for Plan benefits is held each year in the fall, shortly after the end of the ongoing evaluation period (typically in early November). In general, this is your once-a-year chance to change current benefit choices, add or delete an eligible family member from coverage, add coverage you previously declined, confirm if the spouse/life partner surcharge may apply to you, or enroll in a Flexible Spending Account or Health Savings Account (if eligible) for the coming plan year.

The benefit elections you make during annual open enrollment are in effect for the entire benefits plan year, January 1 through December 31, unless you have a qualified life or special enrollment

event that allows you to make a midyear change. If you are already enrolled in the Plan but you don't take action during open enrollment, your current benefit elections, excluding your FSA elections, will automatically carry forward. REI will adjust your paycheck for the new rates effective January 1.

How to Enroll in Benefits

Go to **www.foryourbenefit-rei.com** > Enrollment > Enroll in Benefits.

If you have any trouble enrolling online, contact the Employee Service Center at 1-800-999-4734, or **hrhr@rei.com**.

IF YOU DON'T ENROLL DURING INITIAL ENROLLMENT

If you don't enroll on time when you first become eligible for the Plan, you'll automatically be covered through the end of the plan year in which you first became eligible for the Plan unless you have a qualifying event to update your benefit elections:

- REI Saver Medical Plan (or REI Custom Saver Medical Plan for Alaska and Montana), employee only
- Basic Life
- Basic Accidental Death and Dismemberment (AD&D)
- Short Term Disability (hourly benefits-eligible employees, except hourly HQ and hourly retail and OPO management)
- Salary Continuation (all salaried/exempt, all HQ and all hourly retail and OPO management employees)
- Core Long Term Disability

You are automatically enrolled in the following benefits as of your first day of work at REI:

- Employee Assistance Program (EAP)
- RethinkCare
- Business Travel Accident
- Quit for Life

Proof of Good Health

If you don't enroll when you first become eligible or want to increase your coverage, certain types of insurance require you or your family members to show proof of good health to enroll later. To do this, you must complete and submit an *Evidence of Insurability (EOI)* form, and the insurance company must approve your application before your new coverage begins. You also may need to complete a health questionnaire and take a physical exam in some cases.

During open enrollment or after a qualifying life event, you may have to provide EOI to enroll in Supplemental Life Insurance and Voluntary LTD for the first time. Full-time employees also have to provide EOI to increase Supplemental Life coverage if the amount exceeds $500,000 or to increase the amount by more than one level. When you are initially eligible, you will also be required to complete an EOI form if you elect a Supplemental Life amount greater than $500,000. Part-time employees have to provide EOI to increase Supplement Life coverage if the amount exceeds $120,000 or to increase the amount by more than one level.

When your spouse/life partner is initially eligible for benefits, EOI for your spouse/life partner is also required if you elect Supplemental Life coverage for them in an amount greater than $75,000. During open enrollment or after a qualifying life event, EOI is also required for your spouse/life partner if you elect or increase Supplemental Life coverage for your spouse/life partner.

Submitting EOI

When EOI is required for Supplemental Life, The Hartford will automatically notify you by email or mail. The notification includes instructions about time frames and how to complete your EOI. You have 60 days to complete your EOI online once you are notified by The Hartford.

You can check the status of your application by calling the Hartford directly. Once The Hartford has approved your EOI, they will notify the Employee Service Center and your coverage will increase and your new payroll contribution will begin.

If EOI is required for Voluntary Long Term Disability, Lincoln Financial Group will email you a link to complete the EOI application. You can check the status of your application by calling Lincoln Financial Group directly.

CHANGING YOUR ELECTIONS MIDYEAR

Since you pay for most Plan benefits on a pre-tax basis, the Internal Revenue Service (IRS) imposes strict rules on changes you may make to your medical, dental, vision or FSA benefit elections during the plan year. Under these rules you may make midyear changes only if you have a qualified life event, or qualify for a health care special enrollment period, as described below.

Qualified Life Events

You may change your benefit elections within 30 days after a qualified life event. Qualified life events may include the following:

- **Legal change in your relationship.** Changes such as marriage, commencement or termination of a life partnership, divorce, annulment, or spouse/life partner's death.
- **Number of dependents.** Changes in the number of your dependents caused by birth, adoption, placement for adoption or death.
- **Residence.** A change in residence for you, your spouse or your dependent that affects your benefits.
- **Employment status.** A change in your, your spouse's or your dependent's employment status that affects Plan eligibility. For example, these may include changes in the work site, strike, lockout, starting or ending employment, in certain situations starting or returning from a paid or an unpaid leave of absence, and a change in job status (going from full-time to part-time or vice versa).
- **Dependent child's eligibility.** A change that causes your dependent to start or stop meeting the Plan's eligibility requirements such as reaching the limiting age (26).
- **Significant change in cost or coverage.** You can change your benefit election and/or pretax contribution if there is a change in the cost or coverage (doesn't apply to Health Care or Limited Use Health Care FSAs). Includes significant midyear increases or decreases in the cost of coverage provided by your dependent's employer. For example, your dependent child starts or stops day care, your dependent care provider increases the monthly fee or your dependent care provider changes from a paid provider to a neighbor or relative that provides coverage at no cost.
- **Addition or improvement of a benefit option.** For example, if REI adds a new benefit option or significantly improves an existing benefit option in the middle of a plan year (doesn't apply to Health Care or Limited Use Health Care FSAs or Dependent Care FSA).
- **Enrollment change in another plan.** You or your dependent experiences a change in enrollment in another plan in the middle of a plan year, including, for example, joining another plan during your spouse's annual enrollment period (if the plan year of the other coverage is different from the plan year of this Plan).
- **Entitlement to Medicare or Medicaid.** You or your dependent becomes eligible or ineligible for Medicare or Medicaid.
- **Loss of governmental or educational coverage.** You or your dependent loses coverage under a group health plan sponsored by a governmental or educational institution.
- **Marketplace Enrollment.** For the medical plans only, you may drop your REI medical plan coverage to enroll in insurance coverage that is available to you during a special or open enrollment period at the Marketplace. The Marketplace is a governmental sponsored exchange where eligible individuals may purchase individual or family health insurance policies called qualified health plans.
- **Judgment, decree or order.** You receive a judgment, decree or court order from a divorce, legal separation, annulment or change in legal custody, including a QMCSO that requires you to add or remove health care coverage for a dependent child.

The Consistency Rule

Under the IRS rules for qualified life events, most benefit changes you make following a qualified change in status must be consistent with the qualified life event, that is, a result of and corresponding to the change in status. Under this consistency rule, the IRS spells out exactly what kinds of changes are and are not allowed. Here are some examples:

- Your spouse loses eligibility under the medical plan sponsored by the employer of your spouse. Electing spouse coverage under your REI Plan would be consistent. It would not be consistent to drop your coverage.
- If you participate in the Dependent Care FSA and your provider's charges go up, then it would probably be consistent to increase your contributions to the Plan — but not consistent to reduce the amount you put in.

To find out what changes would be considered consistent in your case, contact the Employee Service Center.

For qualified life events, the change in coverage is effective the first day of the month falling on or following the date the change is reported to the Plan, provided you report the qualified life event within 30 days to the Employee Service Center. For your child who becomes eligible because of birth, adoption or placement of adoption, medical coverage is effective retroactive to the date of the birth, adoption or placement for adoption, provided you report the qualified life event within 30 days.

Health Care Special Enrollment

NOTICE: The deadlines set forth in this section, if they occurred between March 1, 2020, and July 10, 2023, are delayed for up to one year due to the COVID pandemic. Please see *Appendix A* for additional details on the delay in these deadlines.

In addition to the qualified life events summarized above, you may enroll yourself and/or eligible family members for Plan medical, dental and/or vision coverage or change these coverage options in the middle of the plan year after one of the health care special enrollment events shown below. When you enroll a newly acquired family member, you may also add other eligible family members at the same time – even if you previously declined their coverage.

- **You acquire a new family member.** See the *Life Events* section starting on page 21 for information about enrolling new dependents due to a special enrollment event such as marriage, beginning a life partnership or adding a new child. You have 30 days after the event to enroll yourself and/or your dependents in the Plan.
- **You lose other coverage.** If you declined REI coverage for yourself and/or your dependents because of coverage under another group medical/dental/vision plan (such as your spouse's employer's plan), you and/or your eligible dependents may enroll in or you may change your medical/dental/vision coverage options within 30 days after loss of other coverage. This applies only if eligibility for the other coverage was lost due to:
  - Divorce/termination of a life partnership.
  - Loss of dependent status.
  - Death.
  - Termination of employment or reduction in hours.
  - Termination of employer contributions for the cost of coverage or termination or discontinuation of an employer plan.
  - You or your dependents no longer live or work in a Plan's service area.
  - You or your dependents' COBRA coverage has ended.
- **You or a family member lose eligibility for Medicaid or CHIP coverage.** If you or one of your dependents eligible for Plan medical coverage loses eligibility for Medicaid coverage or coverage under a State Children's Health Insurance Program (CHIP), you and your eligible dependents may enroll in a Plan medical option if you request enrollment within 60 days after the date of termination of the Medicare or CHIP coverage due to loss of eligibility. You do not have this special enrollment right if you lose Medicaid or CHIP coverage due to failure to pay required premiums for such coverage.
- **You or a family member become eligible for Medicaid or CHIP or if you become eligible to receive state premium assistance**

under Medicaid or CHIP. If you or one of your dependents eligible for health coverage becomes eligible for a state program under which Medicaid or a State Children's Health Insurance Program (CHIP) will provide assistance to pay a portion of the cost of your premium for health coverage, you and your eligible dependents may enroll in a health benefit option if you request enrollment within 60 days after the date you or your dependent becomes eligible for such assistance. Please note that not all states have such a program.

For changes in coverage due to special enrollment events, the change in coverage is effective the first day of the month falling on or following the date the change is reported to the Plan, provided you report the special enrollment event within the required time frame to the Employee Service Center. For your child who becomes eligible because of birth, adoption or placement of adoption, coverage is effective retroactive to the date of the birth, adoption or placement for adoption, provided you report the special enrollment event within the required time frame.

How to Make Midyear Changes

To find out more about what changes you can make if you have a qualified life or special enrollment event, see the *Life Events* section starting on page 21 for detailed information about certain events such as marriage or divorce, commencement or termination of a life partnership, and adding a new child. If you have questions, contact the Employee Service Center at 1-800-999-4734 or **hrhr@rei.com**.

WHEN PLAN COVERAGE ENDS

These are general rules for when Plan participation ends. For details about when coverage ends under a particular benefit, see the individual plan descriptions later in this SPD and/or the benefits booklet or certificate of coverage for the particular benefit.

Plan coverage for you and your family ends the last day of the month in which:

- You terminate employment for any reason other than disability.
- You reach the end of an approved medical disability leave and you are not approved for LTD.
- You reach the end of approved medical disability leave and you are approved for LTD. If you are approved for LTD by the Plan's disability insurance company and you are enrolled in the REI benefits program, then you are eligible to be covered under the medical, dental and/or vision plan in which you are enrolled under a subsidized continuation (COBRA) program for up to 24 months, for yourself and eligible family members (if they were enrolled prior to your disability). The COBRA coverage is subsidized by REI, and you will pay the same premiums as you did when you were an active employee. Please note that your cost for this coverage is subject to change each plan year on January 1. COBRA enrollment and payment information is mailed to your home from our COBRA administrator.
- You lose eligibility status, including losing eligibility due to fraud or intentional misrepresentations.
- You fail to pay your share of the cost of coverage.
- The Plan is terminated.

In most instances, if you switch from full-time to part-time status during the first 12 months of employment, benefits coverage for you and your family ends the last day of the second month following the date of your status change.

In addition, coverage for enrolled family members ends the last day of the month when they are no longer eligible or when you die.

If you or your ex-spouse or former life partner do not notify REI of your divorce or dissolution of your life partnership within 30 days of the final divorce or dissolution of life partnership, coverage will end retroactive to the last day of the month that your divorce or dissolution of life partnership occurred and you will not be refunded any premiums paid for your former spouse or life partner's coverage. REI reserves the right to recover any and all benefit payments made for services received by the ineligible dependent. Failure to notify the Plan of a divorce or dissolution of a life partnership is considered by the Plan to be fraud and an intentional

misrepresentation of material fact. In addition, if you or your ex-spouse or former life partner fails to provide notice of your dependent's ineligibility within the time frames required by COBRA, your ex-spouse or former life partner may lose rights to COBRA continuation coverage.

If you or a family member does not notify REI within 30 days of a dependent's loss of eligibility for coverage, your ineligible dependent's coverage will end retroactive to the last day of the month your dependent became ineligible for the Plan and you will not be refunded any premiums paid for the ineligible dependent(s). REI reserves the right to recover any and all benefit payments made for services received by the ineligible dependent. This may also be deemed an intentional misrepresentation of material fact by the Plan. In addition, if you or your dependent fails to provide notice of your dependent's ineligibility within 60 days of the date of ineligibility, your dependent may lose rights to COBRA continuation.

In most cases, when health care coverage for you or enrolled family members ends, you may purchase continued coverage for a period of time under a federal law known as COBRA. For more information, see page 91. Under the Affordable Care Act, individuals can access coverage through government Marketplaces, where they may qualify for tax credits that immediately lower health insurance costs, if they are not eligible for other employer coverage or not enrolled in another health plan. To learn more about the Marketplaces, visit **www.healthcare.gov**.

LIFE EVENTS

JOINING REI OR BECOMING BENEFITS-ELIGIBLE FOR THE FIRST TIME

If you're a full-time employee, you have 30 days after the date you become eligible to enroll in the Plan. If you do not decline or elect other medical coverage during this 30-day time period, you will be automatically enrolled in the REI Saver Medical Plan.

If you're a part-time employee, you have 30 days after you become eligible to enroll in the Plan. Once you become eligible for benefits, you are eligible for coverage for at least a full year (this is called your guaranteed coverage period) as long as you remain an active employee and pay your portion of the cost of coverage. If you do not decline or elect other medical coverage during this 30-day time period, you will be automatically enrolled in the REI Saver Medical Plan. You will become eligible for the Plan if you average 20 or more hours per week over the course of a 12-month evaluation period. Review the *Who Is Eligible* section on page 10 for more details on when a part-time employee becomes eligible for the Plan.

If you miss the deadline, you must wait until the annual Plan open enrollment to make changes, unless you have a qualified life or special enrollment event.

Coverage under the Plan begins on the first day of the month that falls on or follows your date of hire or benefits eligibility date. Once you are eligible for the Plan, coverage for Basic Life, Basic AD&D, Business Travel Accident, Short Term Disability, Salary Continuation and Long Term Disability begins the later of your first day of active work or the first day you are eligible for the Plan.

If you're a full-time employee, you will continue to be eligible for the Plan as long as you remain full-time.

If you're a part-time employee and meet the benefit eligibility requirements, you will be eligible for the Plan for 12 months.

What to Do:

- Go to **www.foryourbenefit-rei.com** to learn more about our benefits and access our online enrollment portal.
- Enroll in benefits and name your beneficiary for Life Insurance and Accidental Death & Dismemberment (AD&D).
- Review the chart below for an overview of your Plan benefits and the enrollment decisions you need to make or visit **www.foryourbenefit-rei.com** for more information.
- Name your retirement plan beneficiaries at **www.schwab.com/workplace**.

Plan Coverage	Enrollment decisions and clarifications
Health Care – Medical, Dental and Vision	• Choose to enroll or decline coverage for yourself and your eligible family members; if you take no action, you will be automatically defaulted to the REI Saver Medical Plan for employee only coverage for the remainder of the plan year.

Plan Coverage	Enrollment decisions and clarifications
Tax Based Accounts	• Unless you are enrolled in the REI Saver or Custom Saver Medical Plan, you can enroll in the Health Care FSA. As required by federal tax law, REI must limit the amount you can contribute to the Health Care Flexible Spending Account (FSA). For the 2023 plan year, the dollar limit is set at $2,850. The limit will potentially increase for cost-of-living adjustments in the future. Available to all benefits-eligible part-time and full-time employees who are not enrolled in the REI Saver or Custom Saver Medical Plan. Employees enrolled in the REI Saver or Custom Saver Medical Plan may enroll in the Limited Use Health Care FSA and contribute up to the same dollar limit. • If you are a full-time employee, enroll in the Dependent Care FSA and contribute up to $5,000 or $2,500 (married and filing separately) per plan year. Available to eligible full-time employees only. • If you elect the REI Saver or Custom Saver Medical Plan, you may be eligible to enroll in a Health Savings Account. For 2023, the maximum contribution to your HSA (counting both what you contribute and what REI contributes) is $3,850 for individual coverage and $7,750 for family coverage. Your contributions are made through pre-tax payroll deductions. REI will contribute up to $500 for employee only coverage and up to $1,000 for family coverage. These maximum amounts may be reduced based on the number of months in the plan year in which you were enrolled in the REI Saver or Custom Saver Medical Plan. • Note: If you enroll in the HSA, you can also enroll in a Limited-Use FSA.
Life Insurance	• Basic Life coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Supplemental Life – start coverage for yourself, your spouse or life partner or your eligible children. Evidence of Insurability (EOI) may be required for certain coverage levels. You pay for the cost of Supplemental Life insurance.
Accidental Death and Dismemberment (AD&D)	• Basic AD&D coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Supplemental AD&D – start coverage for yourself, your spouse or life partner and any eligible children. You pay for the cost of Supplemental AD&D.
Business Travel Accident (BTA)	• Coverage starts on your first day of active work. REI pays the full cost of coverage.
Short Term Disability (hourly benefits-eligible employees, except hourly HQ and hourly retail and OPO management)	• Coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage.
Salary Continuation (all salaried/exempt, all HQ and all hourly retail and OPO management employees)	• Coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage.

Plan Coverage	Enrollment decisions and clarifications
Long Term Disability (LTD)	• Core LTD coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Voluntary LTD – Start coverage for yourself. You pay for the cost of Voluntary LTD.
Employee Assistance Program (EAP)	• Program is available to you and your household members on your first day of active work. REI pays the full cost of coverage.
Quit for Life®	• Program is available on your first day of active work. You and your dependents over age 18 are eligible to participate in the program. REI pays the full cost of coverage. REI will pay your out-of-pocket cost for nicotine cessation medications prescribed by a doctor if you are enrolled in this program and an REI medical plan.
RethinkCare	• Program is available to you and your eligible dependents on your first day of active work. REI pays the full cost of coverage.
Commuter Benefits	• You can enroll at any time. REI pays for the full cost of public transit passes up to the monthly IRS limit. Employees may pay for parking through pre-tax payroll deductions, up to the monthly IRS limit.

PART-TIME HOURLY EMPLOYEES BECOMING RE-ELIGIBLE FOR BENEFITS

If you were previously enrolled in benefits but lost coverage because of a reduction in hours (i.e., worked less than 20 hours per week during the 12-month ongoing evaluation period), you must wait 12 months before your average weekly hours will be reviewed again to determine benefits re-eligibility.

If you are a part-time employee, we will review your hours during the ongoing evaluation period every year from October 4 through October 3 of the next year. If you average 20 or more hours a week, you will become eligible for benefits starting the following January 1.

If you become re-eligible for benefits, you will be notified in October and can make your benefit elections for the following January 1 plan year during open enrollment (typically occurs November 1 – November 15).

If you do not enroll during open enrollment, you must wait until the next annual Plan open enrollment to make changes, unless you have a qualified life or special enrollment event. If you do not waive or elect other medical coverage during open enrollment, you will be automatically enrolled in the REI Saver Medical Plan for employee only coverage.

What to Do:

- Go to **www.foryourbenefit-rei.com** to learn more about our benefits and access our online enrollment portal.
- Enroll in benefits and name your beneficiary for Life Insurance and Accidental Death & Dismemberment (AD&D).
- Review the chart below for an overview of your Plan benefits and the enrollment decisions you need to make or visit **www.foryourbenefit-rei.com** for more information.

Plan Coverage	Enrollment decisions and clarifications
Health Care – Medical, Dental and Vision	• Choose to enroll or decline coverage for yourself and your eligible family members; if you take no action, you will be automatically defaulted to the REI Saver Medical Plan for employee only coverage.

Plan Coverage	Enrollment decisions and clarifications
Tax Based Accounts	• Unless you are enrolled in the REI Saver or Custom Saver Medical Plan, you can enroll in the Health Care FSA for the upcoming plan year. As required by federal tax law, REI must limit the amount you can contribute to the Health Care Flexible Spending Account (FSA). For 2023, the dollar limit is set at $2,850. The limit will potentially increase for cost-of-living adjustments in the future. Available to all benefits-eligible part-time and full-time employees who are not enrolled in the REI Saver or Custom Saver Medical Plan. Employees enrolled in the REI Saver or Custom Saver Medical Plan may enroll in the Limited Use Health Care FSA and contribute up to the same dollar limit. • If you elect the REI Saver or Custom Saver Medical Plan, you can enroll in a Health Savings Account for the upcoming plan year. For 2023, your maximum contribution to the HSA (counting both what you contribute and what REI contributes) is $3,850 for individual coverage and $7,750 for family coverage. Your contributions are made through pre-tax payroll deductions. REI will contribute up to $500 for employee only coverage and up to $1,000 for family coverage. These maximum amounts may be reduced based on the number of months in the plan year in which you were enrolled in the REI Saver or Custom Saver Medical Plan. Note: If you enroll in the HSA, you can also enroll in a Limited-Use FSA.
Life Insurance	• Basic Life coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Supplemental Life – start coverage for yourself, your spouse or life partner or your eligible children. Evidence of Insurability (EOI) may be required for certain coverage levels. You pay the cost of supplemental Life.
Accidental Death and Dismemberment (AD&D)	• Basic AD&D coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Supplemental AD&D – start coverage for yourself, your spouse or life partner and any eligible children. You pay the cost of Supplemental AD&D.
Business Travel Accident (BTA)	• Coverage starts on your first day of active work. REI pays the full cost of coverage.
Short Term Disability (hourly benefits-eligible employees, except hourly HQ and hourly retail and OPO management)	• Coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage.
Long Term Disability (LTD)	• Coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Voluntary LTD – start coverage for yourself. Evidence of Insurability (EOI) may be required. You pay for the cost of Voluntary LTD.
Employee Assistance Program (EAP)	• Program is available to you and your household members on your first day of active work. REI pays the full cost of coverage.

Plan Coverage	Enrollment decisions and clarifications
Quit for Life®	• Program is available on your first day of active work. You and your dependents over age 18 are eligible to participate in the program. REI pays the full cost of coverage. REI will pay your out-of-pocket cost for nicotine cessation medications prescribed by a doctor if you are enrolled in this program and an REI medical plan.
RethinkCare	• Program is available to you and your eligible dependents on your first day of active work. REI pays the full cost of coverage.
Commuter Benefits	• You can enroll at any time. REI pays for the full cost of public transit passes up to the monthly IRS limit. Employees may pay for parking through pre-tax payroll deductions, up to the monthly IRS limit.

LEAVE OF ABSENCE

During an approved leave (whether paid or unpaid) of up to 26 weeks, you may continue the same health care, life, and AD&D insurance benefits you had as an active employee for the duration of your approved leave. While you are on leave and covered by this Plan, REI will continue to subsidize your coverage as if you were at work. In the case of military (USERRA) leave, including voluntary or involuntary duty with the U.S. Armed Services, National Guard or as a commissioned member of the Public Health Service, you may continue health, dental and vision benefits for up to 24 months on an unsubsidized basis. See the *USERRA Continuation Coverage* for more details.

If you stop receiving a paycheck from REI while on leave and your benefits continue, you will be responsible for paying back your share of the cost of benefits coverage through payroll deductions when you return to work.

If you would like to request a payment plan, please contact the Employee Service Center at 1-800-999-4734 or **hrhr@rei.com**.

When you return to REI immediately after the end of your approved leave, your coverage will resume the same as before, for example, with no new benefit waiting periods required.

If you do not return to work upon the end of your approved leave, REI has the right to request reimbursement for your share of the cost of the benefits coverage received and/or the cost of the benefits received from the Plan while you were on leave.

If you are not a full-time employee of REI and you go on an approved leave of absence, we add unpaid hours to your timesheet for the time you are away from work, so it does not negatively affect your average weekly hours used to determine future benefits eligibility.

You may change your benefits the same as an employee not on leave during open enrollment and special enrollment periods that occur while you are on leave.

What to Do:

- Let your direct leader know that you have requested a leave and maintain contact throughout the duration of your leave.
- Contact REI Health Guide at 1-800-451-2967 to request a leave of absence. REI Health Guide will walk you through the process of arranging the leave and will stay in touch with you during your leave.
- REI Health Guide will keep your direct leader apprised of your leave status and planned return to work date.
- Call the EAP at 1-800-451-2967 if you would like help with any personal concerns.

Plan Coverage	What happens to your benefits while you are on an approved leave
Health Care – Medical, Dental and Vision	• You may continue the same medical, dental and vision coverage you had as an active employee for up to 26 weeks of your approved leave.
Tax Based Accounts	• If you are receiving a paycheck, your contributions to the Health Care FSA, Limited Use Health Care FSA, Dependent Care FSA and/or HSA continue as usual.
Life Insurance	• REI continues to pay for Basic Life coverage for up to 26 weeks of your approved leave. • You may continue the same Supplemental Life coverage you had as an active employee for up to 26 weeks of your approved leave.

Plan Coverage	What happens to your benefits while you are on an approved leave
Accidental Death and Dismemberment (AD&D)	• REI continues to pay for Basic AD&D coverage for up to 26 weeks of your approved leave. • You may continue the same Supplemental AD&D coverage you had as an active employee for up to 26 weeks of your approved leave.
Business Travel Accident (BTA)	• Your coverage ends on the first day of your approved leave. It is reinstated when you return to work.
Short Term Disability (hourly benefits-eligible employees, except hourly HQ and hourly retail and OPO management)	• REI continues to pay for STD coverage for up to 26 weeks of your approved disability leave. However, your Short Term Disability Benefits will terminate immediately if you voluntarily resign from REI.
Salary Continuation (all salaried/exempt, all HQ and all hourly retail and OPO management employees)	• REI continues to pay for Salary Continuation coverage for up to 26 weeks of your approved disability leave (reduced from 100% to 80% for weeks 13 – 26) or up to 12 weeks of your approved care of ill/injured family member leave at 100%. However, your Salary Continuation Benefits will terminate immediately if you voluntarily resign from REI.
Long Term Disability (LTD)	• REI continues to pay for Core LTD coverage for up to 26 weeks of your approved leave. • You may continue Voluntary LTD coverage for up to 26 weeks of your approved leave.
Employee Assistance Program (EAP)	• REI continues to pay for EAP coverage for up to 26 weeks of your approved leave.
Quit for Life®	• REI continues to pay for Quit for Life for up to 26 weeks of your approved leave.
RethinkCare	• REI continues to pay for RethinkCare for up to 26 weeks of your approved leave.

LONG TERM DISABILITY

Monthly long term disability (LTD) benefits are generally payable until you recover or you reach your full Social Security retirement age (which is age 67 for persons born in 1960 or after), subject to Plan limitations. This section describes the effects on your other benefits when you have a long term disability.

What to Do:

- Call REI Health Guide at 1-800-451-2967 (Leave & Disability) for information about how and when to file a claim. The deadline for filing an LTD claim is 90 days after the end of the 26-week qualifying period. If you are unable to meet this deadline, your claim may be accepted if you file no later than one year after the deadline.
- You or your family members may want to call the Work/Life and Employee Assistance Program at 1-800-451-2967 for free confidential assistance during this time.
- Review the following chart to see the Plan benefits available to you and your family members during your disability.

Plan Coverage	What happens to your benefits
Health Care – Medical, Dental and Vision	• Coverage ends for you and your family members after the end of your elimination or waiting period under LTD insurance, which is 180 days of disability (hourly benefits-eligible employees, except hourly HQ and retail management) or 26 weeks of salary continuation (all salaried/exempt, all HQ and all hourly management employees), unless you return to work at REI in a benefits-eligible position before the end of the elimination periods. • In most cases, you and your eligible family members can buy continued health care coverage under COBRA after the elimination periods. If you have been approved for LTD benefits, REI will subsidize most of the cost of your COBRA premiums for you and your eligible family members (enrolled prior to being disabled) for up to 24 months. • Under the Affordable Care Act, you can also purchase coverage through a government Marketplace. To learn more about Marketplaces, visit **www.healthcare.gov**.
Tax Based Accounts	• You may continue making after-tax contributions to the Health Care FSA or Limited Use Health Care FSA. You may be able to elect COBRA from these FSAs through the end of the plan year under COBRA if you have an underspent account. See *COBRA Continuation Coverage* for more details. Claims must be submitted within 90 days following the end of the plan year. You may continue to submit claims to the Dependent Care FSA. Claims for expenses incurred prior to termination of coverage must be submitted within 90 days following the end of the plan year. • You may continue to submit claims to the Dependent Care FSA for eligible expenses incurred prior to the date of termination of employment, but you cannot make any further contributions. Claims must be submitted within 90 days following the end of the plan year. – REI will stop making contributions to your Health Savings Account (HSA). You may continue making after-tax contributions to the HSA. The HSA is owned by you, and you may keep your HSA account through HealthEquity or roll your funds into another HSA. – Your commuter benefits end on your last day of employment with REI.

Plan Coverage	What happens to your benefits
Life Insurance	• REI-provided coverage ends on your last day of employment, which in most instances is the day your elimination period ends. • Supplemental coverage for you and your family members ends at the end of the month following your last day of employment. However, if you are approved for disability, you may be able to receive a premium waiver and continue supplemental coverage if you meet the following criteria: You may remain eligible for Life Insurance coverage (but not Accidental Death and Personal Loss Coverage)* if The Hartford determines that, prior to reaching age 60, you have become permanently and totally disabled. The total disability must start: – While you are insured; and – On or after the date this subsection applies to you; and – Before you retire. This eligibility ceases at the first to occur of: – The date your employer determines that you are no longer permanently and totally disabled; and – The date you reach age 65. *Subject to change or termination as provided elsewhere in the group contract. • You and your family may be eligible to transfer your REI term life insurance policy to an individual term life insurance without providing Evidence of Insurability. • You may also convert it to an individual whole life policy. To be eligible, you must call The Hartford at 1-877-320-0484 within 31 days after REI group coverage ends.
Accidental Death and Dismemberment (AD&D)	• Coverage ends for you and your family members when your employer notifies Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work.
Business Travel Accident	• Your coverage ends on your last day of employment with REI, which in most cases is the day your elimination period ends.
Short Term Disability (hourly benefits-eligible employees, except hourly HQ and hourly retail and OPO management)	• Your coverage ends on your last day of employment with REI, which in most cases is the day your elimination period ends.
Salary Continuation (all salaried/exempt, all HQ and all hourly retail and OPO management employees)	• Your coverage ends on your last day of employment with REI, which in most cases is the day your elimination period ends.

Plan Coverage	What happens to your benefits
Employee Assistance Program	• Coverage ends on your last day of employment with REI, which in most cases is the day your elimination period ends. Coverage for you and your family members will continue if you elect continued health care coverage under COBRA.
Quit for Life®	• Coverage ends at the end of the month of your last day of employment with REI. In most cases, you and your eligible family members will have continued tobacco cessation coverage under COBRA if you elect to continue your medical benefits under COBRA.
RethinkCare	• Coverage ends at the end of the month of your last day of employment with REI. You and your eligible family members have an additional 90 days to complete or transition support with RethinkCare.

LEAVING REI

What to Do:

If you were enrolled in an REI health plan benefit prior to leaving REI, you may be eligible to continue health care coverage through COBRA. Carefully review *COBRA Continuation Coverage* if you wish to continue health coverage. You also may be eligible to purchase coverage through a government Marketplace. To learn more about public Marketplaces, visit **www.healthcare.gov**.

- If you want to transfer your REI term life insurance policy or convert it to an individual whole life policy, you must call Aetna at 1-800-826-7448 within 31 days after REI group coverage ends.

Plan Coverage	What happens to your benefits
Health Care – Medical, Dental and Vision	• Coverage ends for you and your family at the end of the month in which your employment terminates. In most cases, you and your eligible family members may continue health care coverage under COBRA.
Tax Based Accounts	• You may be able to continue making after-tax contributions to the Health Care FSA or Limited Use Health Care FSA through the end of the plan year under COBRA if your account is underspent. See *COBRA Continuation Coverage* for more details. Claims must be submitted within 90 days following the end of the plan year. • You may continue to submit claims to the Dependent Care FSA for eligible expenses incurred prior to the date of termination of employment, but you cannot make any further contributions. Claims must be submitted within 90 days following the end of the plan year. • You may be able to continue making contributions to the Health Savings Account (HSA) during your COBRA continuation coverage period if you are enrolled in the REI Saver or Custom Saver Plan. Any such contributions are made directly by you to HealthEquity. REI does not make any contributions to your HSA after your termination of employment. The HSA is owned by you, and you can take your funds with you. You may keep your HSA account through HealthEquity or roll your funds into another HSA.

Plan Coverage	What happens to your benefits
Life Insurance	• REI-provided coverage ends for you and your family members when REI notifies The Hartford of the date your employment ceases. Coverage under this Plan will end either on the date you cease active work or on the day before the next premium due date following the date you cease active work. • Supplemental coverage for you and your family members ends at the end of the month following your last day of employment. • You and your family may be eligible to transfer your REI term life insurance policy to an individual term life insurance policy without providing Evidence of Insurability (EOI). • You may also convert your coverage to an individual whole life policy. To be eligible, you must call The Hartford at 1-877-320-0484 and complete paperwork within 31 days after REI group coverage ends.
Accidental Death and Dismemberment (AD&D)	• Coverage ends for you and your family members when REI notifies The Hartford of the date your employment ceases. Coverage under this Plan will end either on the date you cease active work or on the day before the next premium due date following the date you cease active work.
Business Travel Accident	• Your coverage ends on your last day of employment with REI.
Short Term Disability (hourly benefits-eligible employees, except hourly HQ and hourly retail and OPO management)	• Your coverage ends on your last day of employment with REI. However, if REI terminates your employment while you are receiving STD benefits, your benefits will continue until your benefits have been exhausted or you are no longer disabled. If you voluntarily resign while you are receiving STD benefits, your STD benefits will immediately end.
Salary Continuation (all salaried/exempt, all HQ and all retail and OPO hourly management employees)	• Your coverage ends on your last day of employment with REI. However, if REI terminates your employment while you are receiving salary continuation benefits, your benefits will continue until your benefits have been exhausted or you are no longer disabled. If you voluntarily resign while you are receiving salary continuation benefits, your salary continuation benefits will immediately end.
Long Term Disability (LTD)	• REI-provided coverage ends on your last day of employment with REI. • Voluntary coverage ends at the end of the month following your last day of employment.
Employee Assistance Program (EAP)	• Coverage ends at the end of the month of your last day of employment with REI. Coverage for you and your household members will continue provided you purchase continued health care coverage under COBRA.
Quit for Life®	• Coverage ends at the end of the month of your last day of employment with REI. In most cases, you and your eligible family members will have continued tobacco cessation coverage under COBRA if you elect to continue your medical benefits under COBRA.

Plan Coverage	What happens to your benefits
RethinkCare	• Coverage ends at the end of the month of your last day of employment with REI. You and your eligible family members have an additional 90 days to complete or transition support with RethinkCare.
Commuter Benefits	• Your commuter benefits end on your last day of employment with REI.

REHIRED

If you're rehired as a regular or seasonal full-time employee, you will be eligible for Plan benefits on:

- Your date of hire if hired on the first of the month; otherwise,
- The first of the month following your date of hire.

Unless you are rehired within 30 days of your termination date, you must re-elect Plan benefits.

If you're a part-time employee, your eligibility for benefits upon rehire depends on how long you were separated from REI and if you were eligible for benefits prior to leaving REI.

- If you've been away from REI for less than 30 days, you will be treated as if you never left REI for benefit eligibility purposes. You do not have to wait a full 12 months (i.e., initial evaluation period) before we review your hours to determine Plan eligibility. If you are rehired within the same month that you left, your prior benefit elections will be automatically reinstated, unless a new plan year began while you were away from REI, in which case you will need to re-elect the benefits for which you are eligible. You'll also need to re-elect if you were rehired in a new month.
- If you've been away from REI for more than 30 days but less than 13 weeks, you will be treated as if you never left REI for benefit eligibility purposes. You do not have to wait a full 12 months (i.e., initial evaluation period) before we review your hours to determine benefits eligibility.
  - If you were not previously benefits-eligible (i.e., not in a guaranteed coverage period) prior to leaving, your evaluation period to determine future eligibility for benefits will be reinstated. The weeks you were away will affect your 12-month average weekly hours calculation (i.e., you will be credited zero hours during the times you weren't working).

    For example, Jim left REI on July 10, 2022. Before he left, he was not eligible for benefits. Jim was then rehired on September 15, 2022. Because Jim returned to REI within 2 months, he doesn't have to wait another 12-month period to be considered for benefits. His prior ongoing evaluation period from October 4, 2021 through October 3, 2022 will continue and the hours he was paid prior to leaving REI, while he was away and after he returns apply to this evaluation period. If in October Jim's average weekly hours are 20 or more, he will be eligible for benefits on January 1, 2023. If it is less than 20, he will not be reconsidered for benefits until October 2023 for the 2024 plan year.
  - If you were previously benefits-eligible (i.e., in a guaranteed coverage period) prior to leaving, you will become re-eligible the first of the month that falls on or next follows your rehire date. You will have to re-elect your benefits (i.e., your prior benefit elections will not be reinstated).

    For example, Sally left REI on July 10, 2022. Before she left, she was eligible for benefits from January 1, 2022 through December 31, 2022. Sally was then rehired on September 15, 2022. Because Sally returned to REI within 2 months, she doesn't have to wait 12 months to be considered for benefits. She is guaranteed eligibility from October 1, 2022 through December 31, 2022. Similar to Jim, Sally's prior ongoing evaluation period of October 4, 2021 – October 3, 2022 will continue and the hours she was paid prior to leaving REI, while she was away and after she returns apply to this evaluation period. If in October Sally's average weekly hours are 20 or more, she will continue to be eligible for benefits on January 1, 2023.
- If you've been away from REI for more than 13 weeks, you will be treated like a new hire for benefits eligibility purposes and you will start a new initial evaluation period, which will begin the first of the month that falls on or next follows your date of hire. See the *Who Is Eligible?* section on page 10 for more details.

If you are a part-time employee who has been away from REI for less than 13 weeks and was previously benefits-eligible (in a guaranteed coverage period) or if you are a full-time employee, you have 30 days after you are rehired to enroll in Plan benefits. If you don't enroll, you will be automatically enrolled in our default plan. See the

If You Don't Enroll During Initial Enrollment on page 16 for more details.

Coverage under the Plan begins on the first day of the month that falls on or follows your date of hire or benefits eligibility date. Once you are eligible, coverage for Basic Life, Basic AD&D, Business Travel Accident, Short Term Disability, Salary Continuation and Long Term Disability begins on the later of your first day of active work or your benefits eligibility date.

What to Do:

- Review the chart below for an overview of your Plan benefits and the enrollment decisions you need to make.
- Go to **www.foryourbenefit-rei.com** to enroll in benefits and name your beneficiary for Life Insurance and Accidental Death & Dismemberment (AD&D).

Plan Coverage	Enrollment decisions and clarifications
Health Care – Medical, Dental and Vision	• Choose to enroll or decline coverage for yourself and your eligible family members. If you take no action, you will be automatically defaulted to the REI Saver or Custom Saver Medical Plan for employee only coverage for the remainder of the plan year.
Tax Based Accounts	• You can enroll in the Health Care FSA. – Available to all benefits-eligible part-time and full-time employees who are not enrolled in the REI Saver or Custom Saver Plan. • If you are a full-time employee, you can enroll in the Dependent Care FSA and contribute up to $5,000 or $2,500 (married and filing separately) per plan year. • Your maximum contribution to the Health Care FSA or the Limited Use Health Care FSA for the plan year in which you are rehired may be reduced based on any amount you contributed earlier in the same plan year and/or prorated based on the number of months remaining in the plan year. • If you elect the REI Saver or Custom Saver Medical Plan, you can enroll in a Health Savings Account. For 2023, your maximum contribution to the HSA (counting both what you contribute and what REI contributes) is $3,850 for individual coverage and $7,750 for family coverage. Your contributions are made through pre-tax payroll deductions. REI will contribute up to $500 for employee only coverage and up to $1,000 for family coverage. These maximum amounts may be reduced based on the number of months in the plan year in which you were enrolled in the REI Saver or Custom Saver Medical Plan. Note: If you enroll in the HSA, you can also enroll in a Limited-Use FSA. See page 50 for details.
Life Insurance	• Basic Life coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Supplemental Life – start coverage for yourself, your spouse or life partner or your eligible children. Evidence of Insurability (EOI) may be required for certain coverage levels. You must pay for the cost of Supplemental Life coverage.
Accidental Death and Dismemberment (AD&D)	• Basic AD&D coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Supplemental AD&D – start coverage for yourself, your spouse or life partner and any eligible children. You pay for the cost of Supplemental AD&D coverage.
Business Travel Accident (BTA)	• Coverage starts on your first day of active work. REI pays the full cost of coverage.

Plan Coverage	Enrollment decisions and clarifications
Short Term Disability (hourly benefits-eligible employees, except hourly HQ and hourly retail and OPO management)	• Coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage.
Salary Continuation (All salaried/exempt, all HQ and all hourly retail and OPO management employees)	• Coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage.
Long Term Disability (LTD)	• Core LTD coverage starts on the first day you become eligible for benefits. REI pays the full cost of coverage. • Voluntary LTD – start coverage for yourself. You pay for the cost of Voluntary LTD.
Employee Assistance Program (EAP)	• Program is available to you and your household members on your first day of active work. REI pays the full cost of coverage.
Quit for Life®	• Program is available on your first day of active work. You and your eligible dependents over age 18 are eligible to participate in the program. REI pays the full cost of coverage. REI will pay your out-of-pocket cost for nicotine cessation medications prescribed by a doctor if you are enrolled in this program and an REI medical plan.
RethinkCare	• Program is available to you and your eligible dependents on your first day of active work. REI pays the full cost of coverage.
Commuter Benefits	• You can enroll at any time. REI pays for the full cost of public transit passes up to the monthly IRS limit. Employees may pay for parking through pre-tax payroll deductions, up to the monthly IRS limit.

RELOCATION

A change in residence or work site may count as a qualified life event and allow you to make midyear changes to your Plan elections. You have 30 days following a qualified life event to make changes to your Plan coverage. If you miss this deadline, you must wait until the annual Plan open enrollment to make changes.

What to Do:

- Review the chart below to see if there are any benefit elections you want to change.
- Go to **www.foryourbenefit-rei.com** to enroll in benefits and name your beneficiary for Life Insurance and Accidental Death & Dismemberment (AD&D).

Plan Coverage	Changes you can make
Health Care – Medical, Dental and Vision	• Change your current medical plan election if you move out of your current provider's service area or become eligible for a new medical plan option.
Tax Based Accounts	• Change your Dependent Care FSA contribution if you experience a significant change in the cost or coverage from your dependent care provider. Part-time employees are not eligible to participate in the Dependent Care Flexible Spending Account.
Commuter Benefits	• You can enroll at any time. REI pays for the full cost of public transit passes up to the monthly IRS limit. Employees may pay for parking through pre-tax payroll deductions, up to the monthly IRS limit.

EMPLOYMENT STATUS CHANGES

If you have a change in employment status that affects your benefits eligibility, you will receive notification from the Employee Service Center that includes a description of your benefits options along with instructions on how to make benefit elections. A qualified change in employment status may be a change for you, your spouse or your dependent and can include changes in the work site, starting or ending employment, starting or returning from a paid or unpaid leave of absence, a change in job status (going from full-time to part-time or vice versa) or other changes that affect Plan eligibility.

You have 30 days following a qualified change in employment status to make changes to your Plan coverage. If you miss this deadline, you must wait until the annual Benefits Plan open enrollment to make changes.

Full-Time Employees Who Change to Part-Time Hourly Status (Not Part-Time Exempt Status)

If you switch from full-time to part-time status during the first 12 months of employment, benefits coverage for you and your family ends the last day of the second month following the date of your status change. For example, if you are hired as a full-time employee on May 1 but you change to part-time hourly status on August 16, your Plan coverage will end on September 30.

If you switch from full-time to part-time status after the first 12 months of employment, benefits coverage for you and your family could continue until the end of the plan year in which you had an employment status change if: (1) you work an average of 20 hours or more per week for each month of the plan year, or (2) you worked an average of 20 hours or more per week during the ongoing evaluation period that applies to that plan year (as though you had been a part-time employee). If you do not qualify for continuing eligibility under this rule, coverage for you and your eligible dependents ends of the last day of the second month following the date of your status change.

For example, Paul is hired as a full-time employee on November 3, 2022. Because he is a full-time employee, he gains benefits eligibility on December 1, 2022. On August 16, 2024, he moves to part-time status. However, Paul averaged 20 hours or more per week from October 4, 2022 through October 3, 2023 (the ongoing evaluation period that would have applied if he had been a part-time

employee at that time). Since he already worked enough hours to qualify for coverage for his guaranteed coverage period of January 1, 2024 through December 31, 2024, he will not lose coverage and he will remain covered through the end of his guaranteed coverage period (December 31, 2024).

Check the *Status/Key Dates* page in *Employee Self Service* to determine if you are in a guaranteed coverage period for the Plan. Contact the Employee Service Center 1-800-999-4734 or **hrhr@rei.com** if you have any questions.

What to Do:

- Review the chart below for an overview of your Plan benefits and the enrollment decisions you need to make or visit **www.foryourbenefit-rei.com** for more information.
- Go to **www.foryourbenefit-rei.com** to make changes to your benefits.

Plan Coverage	Changes you can make if you are still benefits-eligible
Health Care – Medical, Dental and Vision	• No changes allowed. • If you lose eligibility, see the next section, *Hourly Part-Time Employees Who Lose Eligibility for Benefits*.
Tax Based Accounts	• No changes allowed for Health Care or Limited Use Health FSA. • Part-time employees are not eligible to participate in the Dependent Care Flexible Spending Account. You will no longer be able to contribute to a Dependent Care Flexible Spending Account. You may continue to submit Dependent Care FSA claims incurred during the current plan year prior to your change to part-time status, but you cannot make any further contributions to the Dependent Care FSA. Claims must be submitted within 90 days following the end of the plan year. • Changes can be made to your HSA contribution at any time. If you lose eligibility, see the next section, *Hourly part-time employees who lose eligibility for benefits*.
Supplemental Disability and Life Insurance	• No changes allowed. • If you lose eligibility for the Plan, see the next section, *Hourly part-time employees who lose eligibility for benefits*.

Hourly Part-Time Employees Who Lose Eligibility for Benefits

Once you become eligible for benefits, you are guaranteed coverage for at least 12 months (this is called your **guaranteed coverage period**) as long as you remain an active employee and continue to pay for your portion of coverage. After you become eligible for benefits, we will review your hours every year from October 4 through October 3 of the following year to determine if you've worked enough hours (i.e., your average weekly hours are 20 or more) to remain eligible for benefits.

If your average weekly hours during the ongoing evaluation period are less than 20, you will lose benefits eligibility. The timing of when you lose benefits eligibility depends on your guaranteed coverage period. If you're losing benefits at the end of your initial guaranteed coverage, your coverage will end on the last day of your initial guaranteed coverage period. See the *Status/Key Dates* page in *Employee Self-Service* for specific details. If you're losing benefits at the end of your ongoing guaranteed coverage period, your coverage will end on December 31 of that year.

What to Do:

- You may continue coverage through COBRA. Review COBRA details on page 91.
- Review additional health insurance options through a government Marketplace on **www.healthcare.gov**.

Plan Coverage	Changes you can make
Health Care – Medical, Dental and Vision	• Coverage ends at the end of the initial or ongoing guaranteed period or at the end of the month for you and your family, as applicable. In most cases, you and your eligible family members may continue health care coverage through COBRA, as described on page 91. • You can also purchase coverage through a government Marketplace. To learn more about Marketplaces, visit **www.healthcare.gov**.
Tax Based Accounts	• If your eligibility terminates during the plan year, you may be able to continue coverage under the Health Care or Limited Use Health Care FSA if your account is underspent. See *COBRA Continuation Coverage* for more details. • Part-time employees are not eligible to participate in the Dependent Care Flexible Spending Account. You will no longer be able to contribute to a Dependent Care Flexible Spending Account, but you may continue to submit claims for qualifying expenses you incurred during the plan year prior to your loss of eligibility. Claims must be submitted within 90 days of the end of the plan year. • You may no longer contribute to an HSA if you lose eligibility for the REI Saver or Custom Saver Medical Plans, but you can continue to use HSA funds after you lose eligibility for such plans.
Commuter Benefits	• You may continue your commuter benefits.

Plan Eligible Part-Time Hourly Employees Who Change to Eligible Full-Time Status

If you were already a part-time hourly employee eligible for benefits, you'll continue the same coverage as before your change in employment status.

What to Do:

- Go to **www.foryourbenefit-rei.com**to review your benefits, confirm your beneficiary for Life Insurance and Accidental Death & Dismemberment (AD&D) and enroll in the Dependent Care FSA if applicable.
- Review the chart below for an overview of your Plan benefits at **www.foryourbenefit-rei.com**.

Plan Coverage	Changes you can make
Health Care – Medical, Dental and Vision	• No changes allowed.
Tax Based Accounts	• Enroll in the Dependent Care Flexible Spending Account and contribute up to $5,000 or $2,500 (married and filing separately) per plan year.
Disability and Life Insurance	• No changes allowed.

MARRIAGE/LIFE PARTNERSHIP

If you get married or begin a life partnership, you can enroll your new spouse or life partner and your eligible children for Plan benefits. See page 11 for a list of eligible family members. You may also enroll yourself in the Plan's medical, dental and/or vision benefits if you are not already enrolled, and you may make other changes to your Plan benefits as set forth in the chart below.

You have 30 days following a family change to make changes to your Plan coverage. If you miss this deadline, you must wait until the annual Plan open enrollment to make changes and/or add your dependents.

Coverage for family members who become eligible due to marriage or commencement of a life partnership is effective the first day of the month falling on or following the date the enrollment is completed.

What to Do:

- Complete the Qualified Status Change form, available at **www.foryourbenefit-rei.com**, within 30 days of your marriage or commencement of your life partnership.
- If you are enrolling a life partner, complete and send in the REI Life Partner Affidavit and, if applicable, the *Tax Certification* form to the Employee Service Center.
- Update your W-4 withholding form with payroll.
- If your name changed due to your marriage, send a copy of your updated driver's license or other government issued ID to the Employee Service Center.
- Update your retirement plan beneficiaries at **www.schwab.com/workplace**.
- Review the chart below for an overview of your Plan benefits and the enrollment decisions you need to make or visit **www.foryourbenefit-rei.com** for more information.
- Visit **www.foryourbenefit-rei.com** to enroll in benefits and name your beneficiary for Life Insurance and Accidental Death & Dismemberment (AD&D).

If you do not notify REI within 30 days of your marriage that your life partner has become your spouse, you will not be able to make any midyear changes to your benefits. REI can only remove imputed income incorrectly calculated for your spouse's coverage retroactively to the first of the month following the date of your marriage if the date is still within the same calendar (tax) year in which you notified us. If it isn't, we can only retroactively remove imputed income for pay periods that fall within the same calendar tax year. For example, if your life partner became your spouse on November 15, 2022 and you notified us in March of 2023, we can only remove the imputed income for the pay periods that fall within the 2023 tax year. If you wish to make adjustments to the additional taxes you paid in 2022, please consult with a tax advisor.

The 30-day deadline described in this section, if it occurred between March 1, 2020 and July 10, 2023, is delayed due to the COVID pandemic. For additional details, see *Appendix A*.

Plan Coverage	Changes you can make
Health Care – Medical, Dental and Vision	• Add coverage for yourself, your new spouse or life partner, and eligible children. • Change or stop your current medical, dental or vision elections.

Plan Coverage	Changes you can make
Tax Based Accounts	• Start, stop, increase or decrease contributions to the Health Care FSA or Dependent Care FSA. • Changes can be made to your Health Savings Account (HSA) contribution at any time. If you switch from individual to family coverage in the REI Saver or Custom Saver Plan, REI's contribution to your HSA will increase and the maximum contributions (both REI's and yours) to your HSA will increase. Update your beneficiary designation for your HSA.
Life Insurance	• Update your beneficiary for Basic and Supplemental Life. • Start, stop, increase or decrease Supplemental Life coverage for yourself, your spouse or life partner or your eligible children. Evidence of Insurability (EOI) may be required for starting or increasing supplemental life.
Accidental Death and Dismemberment (AD&D)	• Update your beneficiary for Basic and Supplemental AD&D. • Start, stop, increase or decrease Supplemental AD&D coverage for yourself, your spouse or life partner or your eligible children.
Long Term Disability (LTD)	• Start or stop Voluntary LTD coverage for yourself. Evidence of Insurability (EOI) is required to start LTD coverage.

DIVORCE/DISSOLVE A LIFE PARTNERSHIP

If you get divorced, your marriage is annulled, or you dissolve a life partnership, your spouse or life partner (and your life partner's children, if applicable) will no longer be eligible for the Plan. Benefits for these ineligible former family members will end on the last day of the month in which the divorce, annulment, or dissolution of the life partnership is final.

What to Do:

- Notify REI of your finalized divorce, annulment, or dissolution of your life partnership within 30 days of the final divorce, annulment, or dissolution of the life partnership. If you do not notify REI within 30 days, your spouse/life partner will lose benefits coverage retroactive to the last day of the month in which your divorce, annulment, or dissolution of life partnership occurred.
- Complete the *Qualified Status Change* form found on **www.foryourbenefit-rei.com** within 30 days of the event.
- Update your W-4 withholding form with Payroll as desired.
- Update your retirement plan beneficiaries at **www.schwab.com/workplace**.
- Review the chart below to see if there are any benefits you want to change.
- Go to **www.foryourbenefit-rei.com** to enroll in benefits and name your beneficiary for Life Insurance and Accidental Death & Dismemberment (AD&D).
- Consider calling the EAP at 1-800-451-2967 for free confidential assistance with all types of personal issues including financial planning and legal assistance.

Benefits Plan Coverage	Changes you can make
Health Care – Medical, Dental and Vision	• Stop coverage for your ex-spouse or life partner and any stepchildren or your ex-life partner's children who are no longer eligible. • Start coverage for yourself. • Add your eligible children to your coverage. • Change your current medical, dental or vision election. • Your ex-spouse/life partner and any children who lose eligibility are eligible to continue benefits through COBRA.
Tax Based Accounts	• Start, stop, increase or decrease contributions to the Health Care FSA, Limited Use Health Care FSA or Dependent Care FSA. • Changes can be made to your HSA contribution at any time. If you switch from family to individual coverage, REI's contribution to your HSA will decrease or stop and the maximum contributions (both REI's and yours) you can make to your HSA will decrease. Update your HSA beneficiary designation.
Life Insurance	• Stop coverage for your ex-spouse or ex-life partner and any stepchildren or your ex-life partner's children who are no longer eligible for Supplemental Life coverage. Your former family members may be eligible to buy individual term life insurance without providing Evidence of Insurability (EOI) within 31 days after REI group coverage ends. They may also have the option to convert to a whole life policy within 31 days after REI group coverage ends. • Update your beneficiary for Basic and Supplemental Life. • Start, stop, increase or decrease Supplemental Life coverage for yourself or your eligible children. Evidence of Insurability (EOI) may be required for starting or increasing coverage.
Accidental Death and Dismemberment (AD&D)	• Stop coverage for your ex-spouse or life partner and any stepchildren or your ex-life partner's children who are no longer eligible for Supplemental AD&D family coverage. • Update your beneficiary for Basic and Supplemental AD&D. • Start, stop, increase or decrease Supplemental AD&D coverage for yourself or your eligible children.
Long Term Disability (LTD)	• Start or stop Voluntary LTD coverage for yourself. Evidence of Insurability (EOI) is required to start LTD coverage.

NEW CHILD

If you have a new child through birth, adoption or placement for adoption, you have 30 days to enroll new children, yourself, your spouse/life partner and your other eligible dependents in medical, dental and vision plans. If you miss this deadline, you must wait until Benefits Plan annual open enrollment to make changes.

Health care coverage changes made due to birth, adoption or placement for adoption are effective retroactive to the date the children became part of your family.

The 30-day deadlines described in this section, if they occurred between March 1, 2020 and July 10, 2023, have been delayed due to the COVID pandemic. For additional details, see *Appendix A*.

What to Do:

- Complete the *Qualified Status Change* form found on **www.foryourbenefit-rei.com** within 30 days of the event.
- Update your W-4 withholding form with Payroll, as desired.
- Update your retirement plan beneficiaries at **www.schwab.com/workplace**.
- Consider calling the EAP at 1-800-451-2967 for child care referrals and resources in your area and financial planning assistance.
- Review the chart below to see if there are any benefit elections you want to change.
- Go to **www.foryourbenefit-rei.com** to enroll in benefits and name your beneficiary for Life Insurance and Accidental Death & Dismemberment (AD&D).

Benefits Plan Coverage	Changes you can make
Health Care – Medical, Dental and Vision	• Add yourself, your spouse/life partner, your new child and/or other eligible children. • Change your current medical, dental or vision elections. • Stop your current medical, dental or vision elections.
Tax Based Accounts	• Start, stop, increase or decrease contributions to the Health Care FSA, Limited Use Health Care FSA or Dependent Care FSA. • Changes can be made to your Health Savings Account (HSA) contribution at any time. If you switch from individual to family coverage in the REI Saver or Custom Saver Plan, REI's contribution to your HSA will increase and the maximum contributions (both REI's and yours) to your HSA will increase.
Life Insurance	• Update your beneficiary for Basic and Supplemental Life. • Start, stop, increase or decrease Supplemental Life coverage for yourself, your spouse or life partner or your eligible children. Evidence of Insurability (EOI) may be required to start or increase Supplemental Life.
Accidental Death and Dismemberment (AD&D)	• Update your beneficiary for Basic and Supplemental AD&D. • Start, stop, increase or decrease Supplemental AD&D coverage for yourself, your spouse or life partner or your eligible children.
Long Term Disability (LTD)	• Start Voluntary LTD coverage for yourself. Evidence of Insurability (EOI) is required.

DEATH OF AN EMPLOYEE

What to Do:

- A family member should contact the Employee Service Center at 1-800-999-4734 for help with filing claims and making benefit changes, including help with any retirement plan benefits that may be available.
- Your family members may want to call the EAP at 1-800-451-2967 for free confidential assistance during this time.
- The chart below outlines the Plan benefits available to your surviving family members.

Plan Coverage	What happens to your benefits
Health Care – Medical, Dental and Vision	• Coverage ends for your enrolled family members at the end of the month in which your death occurs. In most cases, your eligible family members can buy continued health care coverage under COBRA.
Tax Based Accounts	• Any funds remaining in your HSA pass to the named beneficiary of the account when you die. If there is no beneficiary, the funds will go to your estate. • Your eligible dependents may be able to continue coverage under the Health Care or Limited Use Health Care FSA if your account is underspent. See *COBRA Continuation Coverage* for more details. Claims must be submitted within 90 days following the end of the plan year. • Your family or a representative of your estate may continue to submit claims to the Dependent Care FSA for expenses incurred prior to your death. Claims must be submitted within 90 days following the end of the plan year.
Life Insurance	• Your Basic and Supplemental Life benefits are paid to your beneficiary. • If enrolled, your family members may be eligible to buy individual term life insurance without providing Evidence of Insurability (EOI) within 31 days after REI group coverage ends. They may also have the option to convert to a whole life policy within 31 days after REI group coverage ends.
Accidental Death and Dismemberment (AD&D)	• Your Basic and Supplemental AD&D benefits are paid to your beneficiary if your death is the result of an accident. • Your family members may be eligible for special education, training or child care benefits. • Coverage ends for your family members.
Business Travel Accident	• If your death was the result of an accident while on a covered trip, benefits are paid to your beneficiary. • Coverage ends for your family members.
Short Term Disability (hourly benefits-eligible employees, except hourly HQ and hourly retail and OPO management)	• If you die while disabled, your coverage ends.
Salary Continuation (all salaried/exempt, all HQ and all hourly retail and OPO management employees)	• If you die while disabled, your coverage ends.

Plan Coverage	What happens to your benefits
Long Term Disability (LTD)	• If you die while disabled, a benefit may be paid to your survivors.
Employee Assistance Program	• Coverage for your family members will continue provided they purchase continued health care coverage under COBRA.
Quit for Life®	• In most cases, tobacco cessation coverage for your eligible family members will continue provided they purchase continued health care coverage under COBRA.

DEATH OF A SPOUSE, LIFE PARTNER OR DEPENDENT CHILD

What to Do:

- Contact the Employee Service Center at 1-800-999-4734 to report the death and for help completing the *Life Status Change* form, filing claims and making benefit changes.
- You or your family members may want to call the Work/Life and Employee Assistance Program at 1-800-451-2967 for free confidential assistance during this time.
- Review the chart below to see if there are any benefit elections you want to change.
- Update your retirement plan beneficiaries as necessary or desired at **www.schwab.com/workplace**.
- Go to **www.foryourbenefit-rei.com** to make changes to your benefits or update your beneficiary for Life Insurance and Accidental Death and Dismemberment (AD&D).

Plan Coverage	Changes you can make
Health Care – Medical, Dental and Vision	• Remove your deceased family member from coverage.
Tax Based Accounts	• You may decrease or stop your Health Care FSA or Limited Use Health Care FSA or start or increase your Health Care FSA or Limited Use Health Care FSA if you lose coverage from another employer due to the death. • You may start, increase, drop or decrease your Dependent Care FSA contributions. • Changes can be made to your Health Savings Account (HSA) contribution at any time. • Update your HSA beneficiary designation as necessary or desired.
Life Insurance	• After the death of a dependent, Supplemental Life benefits are paid to you. • Review your beneficiary designation for Basic or Supplemental Life Insurance and your retirement plan beneficiary designations.
Accidental Death and Dismemberment (AD&D)	• Supplemental AD&D benefits are paid to you if your dependent's death is a result of an accident. • Review your beneficiary designation for Basic or Supplemental AD&D Insurance.

HEALTH

Your well-being depends on making the right choices for your health care benefits so you and your family have access to the care you need. The Plan offers comprehensive medical, dental and vision coverage as well as additional resources to support you on your path to wellness.

MEDICAL PLANS

Every REI medical plan covers the same kinds of core services, including preventive services, but some plans may offer enhanced benefits for certain conditions or medical needs.

For details about the REI medical plans, refer to the appropriate Plan documents:

- **REI Saver Medical Plan**
- **REI Custom Saver Medical Plan**
- **REI Choice Medical Plan**
- **REI Custom Choice Medical Plan**

Health Maintenance Organizations (HMOs) are available at certain locations. You can get information about that plan in your **HMO's certificate of coverage**.

YOUR MEDICAL ID CARD

You can get your Aetna medical ID card anytime by visiting **www.aetna.com.**

TRAVEL AND LODGING REIMBURSEMENT

As of January 1, 2022, the Plan provides reimbursement benefits of up to $3,000 in certain medical situations for travel and lodging expenses that you or your eligible dependents incur for (1) infertility and gender affirming care; and (2) abortions. These benefits are administered by HealthEquity and are taxable benefits, which will be reported on your W-2 as income.

INFERTILITY AND GENDER AFFIRMING CARE

Employees and enrolled eligible dependents in an REI medical plan who have pre-certified medical and prescription services from an in-network provider and must travel more than 100 miles for services may be reimbursed for certain travel and lodging expenses.

ABORTION

Employees and enrolled eligible dependents in an REI medical plan who live in states where abortions are prohibited by law and who must travel more than 100 miles for services may be reimbursed for certain travel and lodging expenses.

Find additional information at **www.myhealthequity.com** on (1) what expenses are eligible for reimbursement and (2) how to file a claim.

PRESCRIPTION DRUG PLAN

For details about the prescription drug plan, administered by Express Scripts (ESI), refer to the **Plan document**.

DENTAL PLAN

You may elect core dental and additional orthodontia coverage, whether or not you enroll in medical coverage. The dental plan is administered by Delta Dental.

For more information, refer to the **Plan document**.

VISION CARE PLAN

You may elect this optional plan administered by VSP, whether or not you enroll in medical and dental coverage.

For more information, refer to the **Plan document**.

TAX BASED ACCOUNTS

FLEXIBLE SPENDING ACCOUNT PLANS

The Flexible Spending Accounts (FSAs) let you pay eligible expenses with pre-tax money. HealthEquity, Inc. administers these optional plans:

- **Health Care FSA** can help you pay for out-of-pocket health costs not covered by another plan for you, your spouse, your children (and your life partner and the children of your life partner, if they are your tax dependents). Not available if you elect an HSA.
- **Limited-Use Health Care FSA** can help you pay for out-of-pocket dental and vision expenses not covered by another plan for you, your spouse, your children (and your life partner and children of your life partner if they are your tax dependents) if you elect the REI Saver or Custom Saver Medical Plan.
- **Dependent Care FSA** can help you pay someone to care of your children and other dependents while you're at work.

Questions About the FSAs?
HealthEquity: 1-877-924-3967 or
Employee Service Center: 1-800-999-4734

How the FSAs Work

- Your contributions are deducted on a pre-tax basis from your paychecks throughout the year and go straight into your FSA account. By contributing to the plan, you reduce your taxable income, which can result in a lower tax bill for you. You cannot change your contributions during the plan year unless you have a qualified change event.
- After you incur an eligible expense, you submit a claim for reimbursement to HealthEquity, the FSA administrator.
- You'll be reimbursed for your claim from the money in your account.
- You have until March 31 (90 days after the end of the plan year) to request reimbursement for expenses incurred during the year.
- Under IRS regulations, you must forfeit any money over $500 left in your account after all the year's expenses have been paid. If you have $500 or less left in your account after all claims for the plan year have been paid, that amount will carry over into the next plan year.
- If you are no longer eligible to participate in the Health Care FSA because you have enrolled in the REI Saver or Custom Saver Medical Plan, your balance in the Health Care FSA will automatically be rolled over to the Limited Use Health Care FSA as of the date you enroll in the REI Saver or Custom Saver Medical Plan.

Enrolling In an FSA

Part-time benefits-eligible employees may participate in the Health Care FSA and Limited-Use Health Care FSA. Full-time benefits-eligible employees may participate in the Health Care FSA, Limited-Use Health Care FSA and Dependent Care FSA. Or you can decline participation altogether.

The Dependent Care FSA Plan is available only to full-time employees. If you're a full-time employee who switches to part-time during the plan year, you will no longer be able to contribute the Dependent Care FSA; however, if you still have money in your account, you can continue to submit claims for dependent care expenses incurred in the plan year prior to the date you switched to part-time status.

Employees enrolled in the REI Saver or Custom Saver Medical Plan cannot participate in the Health Care FSA but can participate in the Limited-Use Health Care FSA.

Contribution Limits

You can contribute up to:

- Health Care FSA: $2,850 for the 2023 plan year.
- Limited-Use Health Care FSA: $2,850 for the 2023 plan year.
- Dependent Care FSA: $5,000 (if you're married filing jointly) and $2,500 (if you're single or married filing separately).

You must contribute a minimum of $50 per plan year if you elect an FSA.

Getting Reimbursed

You have several options for getting your eligible health care and dependent care expenses reimbursed:

- **HealthEquity Health Care Card** – available for the Health Care FSA only, it is a prepaid card that you can use at select pharmacies, health care providers and drug and other eligible stores.
- **Pay My Provider** – an online bill pay system that requires no receipts or claim forms.
- **Pay Me Back** – paper or online claim forms that you submit to HealthEquity.

No matter which of these methods you choose to have your expenses reimbursed, **you must always keep your receipts for documentation and you must present them when they are requested by HealthEquity**, the FSA Administrator.

HealthEquity Health Care Card – Health care expenses only

You can use your HealthEquity Health Care Card at health care providers, pharmacies and general merchandise stores that have an IRS-approved system that can identify FSA eligible items at the register. In most cases, your card transaction will automatically be verified at checkout, which means you may not have to submit a receipt to HealthEquity after the transaction. You should keep all receipts in case verification is required from HealthEquity and for tax purposes.

If you use your card at a health care provider or pharmacy that does not have an IRS-approved inventory system, then you may be required to submit a receipt or health insurance explanation of benefits (EOB) to verify that the transaction was for an eligible health care expense. HealthEquity will notify you about any card transactions that require verification on your monthly account statement.

By using the HealthEquity Health Care Card, you are certifying that the card will only be used for eligible expenses and that you have not been reimbursed and will not seek reimbursement for the expense from another source, such as any other plan or insurance covering health benefits.

If you do not provide the requested documentation (itemized receipts or EOBs) to HealthEquity within 30 days of the date requested, then the following will occur:

- Your card will be suspended, and you will be required to submit paper claim forms.
- You must repay the amount of the transaction to your Health Care FSA or Limited-Use Health Care FSA. This payment is due upon receipt of a request for repayment.
- If you do not repay the amount of the transaction as requested, the amount may be:
  - Deducted from your wages and repaid to your account. By using the HealthEquity Health Care Card, you are giving your consent to REI to withhold this amount from your paycheck. You also may be required to give this consent in writing.
  - Offset or deducted from valid paper claims that you submit to the Health Care FSA or Limited-Use Health Care FSA later in the plan year.

If you terminate employment and continue your participation in the Health Care FSA or Limited-Use Health Care FSA though COBRA, your HealthEquity Health Care Card will be deactivated and you must submit paper claims, as described below.

Pay My Provider – Health care and dependent care expenses

You can pay many of your eligible health care and dependent care expenses directly from your FSA account. Log onto your FSA account at **www.HealthEquity.com**, select *Health Care* or *Dependent Care*, then *Pay My Provider* from the menu and follow the instructions. HealthEquity will send a check directly from your account. If you pay for eligible recurring expenses, you can also set up automatic monthly payments.

Pay Me Back Claim Form – Health care and dependent care expenses

After you pay an eligible expense yourself, you can submit a paper or online *Pay Me Back Claim Form* and get reimbursed by check or direct deposit. Claim forms are available at **www.HealthEquity.com**.

You can request reimbursement any time after you incur an expense. The deadline for submitting claims for all expenses incurred during the plan

year (January 1 through December 31) is March 31 (90 days after the end of the year). The plan won't pay claims submitted after this 90-day deadline.

Along with each claim, you must provide complete documentation of your expenses from your provider. This may include, for example, an itemized receipt or an Explanation of Benefits (EOB) from a health plan. Be sure these documents contain:

- Provider name.
- Date of service.
- Service description.
- Amount.
- Patient name (health care claims) or dependent name (dependent care claims).

Also, if you're making a claim to the Dependent Care FSA, you must include your dependent's name as well as the Social Security or Tax ID number of your dependent care provider. For more information on how to file a Dependent Care FSA Claim, see *Eligible Providers* on page 51.

The way your claims may be reimbursed depends on the plan:

- **For the Health Care FSA or Limited-Use Health Care FSA,** you'll be reimbursed up to the amount of your claim. If the claim amount is greater than the balance in your account, the plan will pay up to the total annual amount you've elected to contribute for the plan year minus any previous reimbursements.

  For example, say you've elected to contribute an annual total of $1,200, or $100 per month. If you make a claim for $500 in May (the first month of plan year), you'll be reimbursed for that amount. But the most you can be reimbursed for the rest of the year is $700 ($1,200 minus $500).
- **For the Dependent Care FSA,** you'll be reimbursed up to the amount of your claim or the balance in your account, whichever is less. If there's not enough money in your account at the time of the claim, you'll receive a partial payment. Then, after you've made additional contributions to your account, HealthEquity will send you the balance.

If Your Claim Is Denied

If your claim is denied, in whole or in part, please follow the claims procedures described in the *Claims and Appeals* section, beginning on page 101.

FSA vs. Federal Tax Breaks

Instead of paying eligible expenses through an FSA, you should be aware that the IRS offers alternative federal tax breaks.

For instance:

- A deduction is available for health care expenses that exceed a certain percentage (7.5% for 2022) of adjusted gross income; and
- A dependent care tax credit may be available for eligible dependent care expenses.

In most cases, you can take advantage of either the applicable tax break or an FSA, but not both. According to many financial experts, for most employees, the FSAs may provide better tax-savings compared to the federal tax breaks. Of course, the final outcome will depend on your personal situation. To find out more, you might want to talk to a professional tax advisor.

When FSA Coverage Ends

For a description of when your REI Plan benefits will end, see *When Plan Coverage Ends* on page 19. In addition, your FSA participation will stop at the end of the plan year if you don't re-enroll during annual open enrollment. After your participation ends, you may request reimbursement for any eligible expenses incurred while you were an active employee. You have until March 31 (90 days after the end of the year) to file the claim.

If your FSA participation ends because you are no longer employed with REI or eligible for REI's Benefits Plan, you can:

- **For the Health Care FSA:** Submit reimbursements for eligible expenses received prior to your benefits ending. You have until March 31 (90 days after the end of the year) to file the claim.
- **For the Limited-Use Health Care FSA:** Submit reimbursements for eligible expenses received prior to your benefits ending. You have until March 31 (90 days after the end of the year) to file the claim.

- **For the Dependent Care FSA:** Once you lose eligibility for the Dependent Care FSA, you may no longer contribute to your Dependent Care FSA; however, if you lost eligibility for the Dependent Care FSA during a plan year, you may submit reimbursements for eligible expenses incurred anytime during the plan year prior to the date you lost eligibility if you still have money in your FSA. You have until March 31 (90 days after the end of the year) to file the claim.

If your participation in the Health Care FSA ends due to a COBRA qualifying event, you and eligible family members may be able to continue participation through the end of the plan year. In this case, you'd have to make contributions on an after-tax basis. You may continue to contribute to the Health Care FSA through the remainder of the plan year only if you have an unused balance in the Health Care FSA at the time of your qualifying event. By continuing coverage through COBRA, you can continue participation through the end of the plan year — rather than through the last day of eligibility or termination of employment. Continued participation due to a COBRA qualifying event is not available for the Dependent Care FSA.

For more information about COBRA, see page 91.

Health Care FSA

You can use the Health Care FSA to pay for most health care expenses incurred by you, your spouse, your eligible children (as defined on page 49) and any other dependents you can claim on your tax return (even if not otherwise enrolled in REI benefits) – just as long as the expense is not covered by another plan. Health care expenses for dependent children will be reimbursed through the last day of the month in which the child attains age 26.

In addition:

- If you're divorced or separated, you can claim expenses you pay for your children provided you or the other parent claim them as dependents or you claim them under a multiple support agreement.
- You cannot claim expenses incurred by your life partner or your partner's children unless they qualify as your dependents for federal income tax purposes.

Your Contributions

Your Health Care contributions come out of your bi-weekly paychecks in equal amounts throughout the year before federal income, Social Security or, in most states, state income taxes are withheld. The money is deposited directly into an account under your name.

When you enroll in an FSA, you decide how much you want to contribute annually. Keep in mind, if you participate in more than one FSA, you can't use the money designated for one FSA to pay expenses for another FSA. For example, you cannot use the Health Care FSA to pay for dependent care expenses. Also, no contributions may be made by anyone to your or your spouse's Health Savings Account (HSA) while you are participating in a Health Care FSA. However, you may participate in the Limited-Use Health Care FSA described at the end of this section if contributions are being made to your or your spouse's HSA.

The most you can contribute to the Health Care FSA for the 2023 plan year is $2,850. The annual contribution limit is prorated if you begin participating in an FSA in the middle of the plan year, for instance, because you're newly eligible or you have a change in status. For more information, contact the Employee Service Center at 1-800-999-4734 or **hrhr@rei.com**.

Eligible Expenses

With some exceptions, a wide range of health care expenses may be reimbursed through the Health Care FSA. This may include, for instance, your out-of-pocket health care costs, such as copays and annual deductibles, as well as many items and services usually not covered or covered only partially by most health plans. However, you cannot be reimbursed for any expense for which you are reimbursed or paid by another plan or insurance, such as an REI Medical, Dental and/or Vision plans.

The IRS specifies what health care costs may or may not be eligible for reimbursement. Keep in mind, the list of eligible expenses can change from year to year. If you have any questions about your

particular situation, feel free to contact the Employee Service Center or HealthEquity.

Examples of eligible expenses include:

- Birth control pills or other prescription contraceptives.
- Health, dental and vision plan out-of-pocket costs, such as annual deductibles, coinsurance, copays, and other amounts not paid by the plans.
- Hearing aids and batteries.
- Medical aids and equipment such as braces, orthopedic shoes, crutches, and wheelchairs.
- Nursing help – if you pay someone for both nursing and housework, you can be reimbursed only for the cost of the nursing help.
- Medically necessary obesity treatment, including physician prescribed behavioral counseling, nutritional counseling, prescription drugs and surgery.
- Orthodontia.
- Over-the-counter medication.
- Services of chiropractors, Christian Science practitioners, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts.
- Tobacco cessation classes and related prescription drugs.
- Vision care, including extra eyeglasses, special lens treatments and coatings, contact lenses, and procedures to correct vision such as radial keratotomy and laser surgery.
- Personal protective equipment, such as masks, hand sanitizer and sanitizing wipes.
- Menstrual care products, such as tampons, pads and similar products.

Examples of costs that are not eligible:

- Cosmetic surgery or treatment, unless medically necessary due to injury, disease or birth defect.
- Expenses reimbursed by any other health, dental or vision care plan.
- Health club dues.
- Health care premiums of any kind, including Medicare Part B premiums.
- Illegal operations or drugs.
- Medical or recreational marijuana.
- Nursing care for a healthy baby unless medically necessary.
- Nutritional supplements.
- Travel, even if prescribed by your doctor for rest or change.
- Vitamins or food supplements.
- Weight-control products or services unless medically necessary for the health of the participant.

Eligible Expenses

For more information, refer to Internal Revenue Service Publication 502 *Medical and Dental Expenses.* You can get a copy:

- At your local IRS office;
- By calling call IRS Forms Hotline, 1-800-829-3676; or
- Online at **www.irs.ustreas.gov/cover.html**.

You can also call Tele-Tax at 1-800-829-4477 for taped information. You may also learn more through HealthEquity at 1-877-924-3967 or at **www.HealthEquity.com**.

Limited Use Health Care Flexible Spending Account (FSA)

If you enroll in the REI Saver or Custom Saver Medical Plan, you are NOT eligible to participate in the Health Care FSA, but you can participate in the Limited Use Health Care FSA. However, note that if you submit an expense for payment to the Limited Health Care FSA, you cannot also pay for the same expense with funds from your HSA on a tax-free basis.

A Limited-Use Health Care FSA is available only to those full-time and part-time employees who are or who become covered under the REI Saver or Custom Saver Medical Plan. The Limited-Use Health Care FSA has a maximum contribution limit of $2,850 for the 2023 plan year and is limited to the reimbursement of the following expenses:

- Dental expenses not covered by the Dental Plan, your spouse's or life partner's health care plan, or any other health care plan or insurance; and
- Vision expenses not covered by the Vision Care Plan, your spouse's or life partner's health

care plan, or any other health care plan or insurance.

Many of the rules for the Health Care FSA also apply to the Limited Use Health Care FSA, such as the rule requiring you to forfeit unused funds in excess of $500 that you have contributed to the FSA at the end of each plan year.

Dependent Care FSA

If you have eligible dependents, you can use the Dependent Care FSA to reimburse most of the costs of their care, as long as the purpose is to allow you (and, if you're married, your spouse) to work, look for work or attend school full-time. The care must be provided by an eligible dependent care provider.

These expenses are not eligible: educational expenses (for kindergarten and above); medical expenses; overnight camp; cost of food or clothing; transportation between your home and the dependent care facility; babysitting during non-work hours.

Please note that the Dependent Care FSA is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA).

Eligible Dependents

Eligible dependents include:

- Your children under age 13 who you or your spouse may claim as dependents for federal income tax purposes. In the case of a divorce, you or your spouse must be the custodial parent (have physical custody of the child for more than half of the year).
- A relative or member of your household whom you can claim as a dependent on your tax return (such as a parent or child over age 13), who is physically or mentally incapable of self-care and who regularly spends at least eight hours per day in your household.
- Your spouse who is physically or mentally incapable of self-care and who regularly spends at least eight hours per day in your household.

Unless your life partner or your partner's children qualify as your dependents for federal income tax purposes, their care is not eligible for reimbursement.

Eligible Providers

Eligible dependent care providers include:

- Licensed dependent care centers (see text box).
- Babysitters inside or outside your home.
- Non-spouse relatives as long as you don't claim them as dependents on your federal income tax return, including your children age 19 or older.
- Preschools.
- Day camps.

Providers have to report any payments received from you through the FSA as taxable income. Consequently, when you file a claim for reimbursement, you must supply your provider's name, address and taxpayer ID number. For self-employed providers such as babysitters, this usually means their Social Security numbers. Tax ID numbers for church groups and other tax exempt organizations are not required, but you must provide their names and addresses.

Individuals who are not eligible dependent care providers include: anyone you claim as a dependent on your income tax return or any child of yours under age 19 on December 31 of the year in which expenses are incurred — even if you don't claim that child as a dependent.

Dependent Care Center

A facility that provides care for more than six non-resident individuals and receives a fee, payment or grant for providing services for any other individuals is a dependent care center. Whether or not the center is operated for profit, it must comply with applicable state and local government laws and regulations.

Your Contributions

Your Dependent Care FSA contributions come out of your bi-weekly paychecks in equal amounts throughout the year before federal income, Social Security or, in most states, state income taxes are withheld. The money is deposited directly into an account under your name.

When you enroll in an FSA, you decide how much you want to contribute annually. Keep in mind, if

you participate in more than one FSA, you can't use the money designated for one FSA to pay expenses for another FSA. For example, you cannot use the Dependent Care FSA to pay for health care expenses. When you enroll, you'll indicate your annual contribution amount for each FSA on your personalized election form.

The most you can contribute per plan year to the Dependent Care FSA is $5,000 ($2,500 per year for married filing separately) — see *Special IRS Limits on Contributions* below for further limits.

Special IRS Limits on Contributions
The IRS has strict rules for how much employees may be reimbursed from a Dependent Care Flexible Spending Account each plan year. Consequently, while most employees can be reimbursed up to $5,000 ($2,500 if married filing separately) per plan year, special limits may apply under certain circumstances.

When deciding how much to contribute to the plan, it's important to keep the following special reimbursement limits in mind. That's because, if your reimbursement exceeds the limit, you must report the excess amount as taxable income on your annual tax return.

Participation in more than one plan. If you're married and your spouse participates in a similar plan through your spouse's employer, the most you may be reimbursed from this and your spouse's plan combined is $5,000 per plan year ($2,500 if married filing separately).

Limits on earned income. Your annual reimbursement cannot exceed your own or, if you're married, your spouse's income for the plan year. For instance, if your spouse earns only $3,000 per year at a part-time job, that's the most you may be reimbursed from the FSA in a calendar year.

Unemployed spouse. The purpose of a Dependent Care FSA is to give you a tax break if you must pay for care of family members while you or, if you're married, both you and your spouse are at work. That's why, if you're married, you may participate only if your spouse is employed.

The exception is if your spouse is incapable of self-care or is a full-time student. In that case, your spouse is considered to have a monthly earned income of:

- $250 if you have one child, so you may be reimbursed up to $3,000 per calendar year, or
- $500 for two or more children, so you may be reimbursed up to $5,000 per calendar year.

A spouse is treated as a full-time student if they are enrolled at an educational institution for at least five months of the year.

Highly paid employees. The IRS limits the benefits that certain highly paid employees may receive from the plan in proportion to those received by lower paid employees. If you fall into the highly paid group, in certain plan years you may be limited in how much you may contribute or you may not even be allowed to participate. Your contributions may also lose their tax-free status. You'll be notified if this restriction ever applies to you.

Filing Your Federal Income Taxes
When you file your federal income tax return at the end of the year, you must attach special form #2441 *Child and Dependent Care Expenses* to show costs reimbursed through the FSA. Each year, by January 31, REI will furnish you with a statement that shows all reimbursements made to you during the preceding calendar year.

Earned Income

Earned income is the amount of compensation you earn as an employee or from self-employment. It doesn't include any pension or annuity benefits or amounts you're reimbursed by the Dependent Care FSA.

HEALTH SAVINGS ACCOUNT (HSA)

If you are covered under the REI Saver or Custom Saver Medical Plan and you are an "eligible individual," REI will make a contribution to a Health Savings Account (HSA) on your behalf. An HSA is a separate special bank account you use to pay for certain health care expenses not covered by the REI Saver or Custom Saver Medical Plan, or any other health care plan, that are incurred after your HSA is established. Please note: Neither REI's arrangement for making contributions to HSAs of eligible employees nor the HSAs themselves are

ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).

General Information About HSAs

An HSA is a special type of personal bank account that an individual must establish with a qualified trustee (e.g., bank). Funds in an HSA can be used to pay for certain out-of-pocket medical, dental and vision expenses on a tax-free basis if they are not otherwise paid by the REI Saver or Custom Saver Medical Plan (such as the deductible amounts). HSA contributions can be made by an "eligible individual" (see definition below), an eligible individual's employer, or third parties. Under federal law, employer contributions to a HSA are nontaxable and pre-tax contributions can be made by an eligible employee to a HSA via payroll deductions. Eligible individuals may also make after-tax contributions to a HSA that qualify for an "above-the-line" tax deduction (up to the maximum annual contribution allowed under federal law). However, please note that some states, including California, do not allow you to deduct HSA contributions made in any way, including through payroll deduction, on your state income tax return. Please consult your personal tax advisor for more information on state law taxation of HSA contributions.

HSA account balances are nonforfeitable and automatically carry forward from year to year for future health care or other expenses. Earnings on HSA account balances are generally not taxed while held in the HSA, which means the accounts grow on a tax-free basis. In addition, you are responsible for reporting to the IRS the contributions made to your HSA and the distributions from your HSA. To learn more about HSAs, see Publication #969 *Health Savings Accounts and other Tax-Favored Health Plans* at the IRS website **www.irs.gov/pub/irs-pdf/p969.pdf**.

HSA Eligibility Requirements

To be an "eligible individual" and qualify to make contributions to an HSA, you must meet the following requirements:

- Be covered under a qualifying high deductible health plan. The REI Saver or Custom Saver Medical Plan is a qualifying plan.
- Have no other health coverage except certain types of permitted insurance.
- Not be enrolled in Medicare or TRICARE.
- Not be claimed as a dependent on someone else's tax return.

If you meet these requirements, you are an "eligible individual" even if your spouse or life partner has non-qualifying coverage, provided their plan does not cover you. Your eligibility for an HSA is determined each month, as of the first day of the month. It is your responsibility to track your own eligibility for the HSA.

Establishing Your HSA

For administrative convenience, REI has chosen to make HSA contributions for employees enrolled in the REI Saver or Custom Saver Medical Plan by direct deposit to HSAs established through HealthEquity into a bank account held by a custodial bank (HealthEquity). You will be provided with the information and forms necessary to establish the HSA. Please note that due to the timing of the initial account setup, it may take up to three weeks before your account is open and money is available for reimbursement.

HSA Contributions

HSA contributions may be made by an HSA account holder or on the holder's behalf by another person, including an employer or family member. REI is making it possible for contributions to be made to your HSA in the following ways: (1) by REI as a result of your election to become covered under the REI Saver or Custom Saver Medical Plan and (2) by you, in the form of pre-tax contributions.

If you enroll in the REI Saver or Custom Saver Medical Plan and elect the HSA, REI will contribute $500 to your HSA if you enroll in individual coverage or $1,000 if you choose family coverage (e.g., employee + spouse, child(ren) or family). REI will contribute to your HSA each pay period. If you enroll in the plan midyear because you are newly eligible or because of a qualifying life event, REI's contribution will be prorated based on the remaining number of pay periods in the plan year. Please note that the REI contribution is available only to employees who are in active pay status on the date the REI contribution is made to your HSA. In order to receive an REI contribution in any calendar year, you must be enrolled in the REI Saver Medical Plan or REI Custom Saver Medical Plan by December 1, and

your account must be open by December 31 to receive a contribution from REI for that calendar year.

You can also make pre-tax contributions to your HSA through payroll deductions. As long as you are covered by the REI Saver or Custom Saver Medical Plan, you can start, stop or change your contribution to your HSA at any time during the year by logging in to **www.foryourbenefit-rei.com**. If you continue enrollment in the REI Saver or Custom Saver Medical Plan, the amount of your HSA pre-tax election will automatically carry over to future years. The maximum contributions that can be made to an HSA are set on a calendar year. During calendar year 2023, the maximum contribution that can be made to your HSA (including amounts contributed by REI) is $3,850 for individual coverage and $7,750 for family coverage. If you are 55 or older, you can also make an additional "catch-up" contribution of up to $1,000 to your HSA for 2023 on a pre-tax basis.

Please note that if you are married and your spouse is also contributing to an HSA, the combined maximum that you and your spouse may contribute to your HSAs is $7,750. Please also note that you may not be eligible to contribute these full amounts if you are not an eligible individual for the entire calendar year. If you contribute over your limit, the amount of excess contributions will be taxable to you and you must include this amount in your gross income. In addition, excess HSA contributions are subject to a 6% excise tax. However, if any excess contributions and earnings on those contributions are returned to you prior to the filing deadline for your income tax return, the 6% excise tax will not apply — you will only have to pay ordinary income tax on the excess amount and the earnings on the excess amount. You may request a return of excess contributions by contacting HealthEquity.

HSA Distributions

You can receive a distribution from your HSA in one of two ways: (1) writing a check or using a debit card for your HSA account; or (2) paying out-of-pocket, and then requesting a payment from HealthEquity. Distributions from your HSA will be tax-free if they are for expenses incurred after your HSA has been established for your medical care as defined in Internal Revenue Code Section 231(d) or the medical care of your spouse or tax dependents. (Unless your life partner is your tax dependent under Internal Revenue Code Section 152, distributions from the HSA for your life partner's medical expenses cannot be made on a tax-free basis.) Please note that federal health care reform's expanded definition of "children" for which health plan coverage is tax-free (children through the end of the year in which they turn 26) DOES NOT apply to HSA distributions. Distributions from an HSA for medical expenses of children are only tax-free if the child is a tax dependent of the employee.

Example: Employee Bob covers his 25-year-old married daughter Mary under the REI Saver Medical Plan. Bob does not pay federal income tax on the cost of coverage for Mary under the REI Saver Medical Plan. However, Mary is not Bob's tax dependent. Bob cannot pay for Mary's medical expenses with HSA funds on a tax-free basis.

Qualified health expenses include:

- Standard medical services (office visits, laboratory tests, etc. not covered by insurance);
- Copayments, coinsurance and deductibles;
- Prescription drugs;
- Over-the-counter medications;
- Dental and vision care expenses, including eyeglasses and laser eye surgery;
- COBRA premiums;
- Health insurance premiums paid while receiving unemployment insurance;
- Premiums for qualified long term care insurance contracts, up to certain limits;
- Menstrual care products; and
- Personal protective equipment.

For a complete list of eligible health care expenses, see IRS Publication 502, available at **www.irs.gov**. You may use your HSA funds for other purposes, but distributions for other purposes are taxable to you and you may be required to pay a 20% penalty tax. If you are disabled or age 65 or older, you may take non-qualified distributions without paying the 20% penalty tax. You are not required to submit receipts to HealthEquity, but it is a good idea to save receipts and records of your expenses in case of an IRS inquiry. HealthEquity will not make determinations on whether your expenses are qualified medical expenses.

To be tax-free, distributions must cover qualified medical expenses that you incur after you have established your HSA. Otherwise, there is no time limit on when you can request a distribution to pay a qualifying expense. Please note, however, that there may be some delay between when REI withholds amounts from your paycheck for deposit into your HSA and when the amounts are available for withdrawal, but usually this delay will not exceed one week.

HSA Investments

You may be offered different investment options from HealthEquity for your HSA account balance. REI has not reviewed these options, if any, and does not endorse or recommend any options. You should consult a tax advisor or financial consultant to determine what, if any, investments are appropriate for you. Neither REI nor any official or employee of REI is a Plan fiduciary with respect to the investment designation or direction you make. You are solely responsible for your actions concerning HSA investment decisions.

When HSA Participation Ends

If you switch to a non-high deductible medical plan or otherwise become ineligible to fund an HSA (such as by enrolling in Medicare), no further contributions can be made to the HSA, either by you or by REI. However, the account balance always belongs to you, and you may continue to take distributions from your HSA. If you die when you still have a balance in your HSA, your beneficiary will receive a payout of the funds. You may make beneficiary designations by contacting HealthEquity.

WELL-BEING

REI offers tools and resources to help you and your family members improve their overall well-being. Here are four programs you might find useful.

- **Employee Assistance Program (EAP):** This benefit is described later in this SPD.
- **Quit for Life:** This is a phone-based tobacco cessation counseling program that includes unlimited toll-free access to quit coaches and medications to help you quit tobacco for good. This program is available at no charge to you and your covered family members over age 18.
- **RethinkCare:** This program provides parents and other caregivers raising children with learning and behavior challenges with valuable support and research-based resources. Parents and caregivers have access to live tele-consultation with behavioral health experts to answer questions and provide guidance, hundreds of easy-to-follow videos, printable materials, and training to best support children in reaching their top potential.

QUIT FOR LIFE®

The Quit for Life tobacco cessation program is available at no cost to you and your covered family members over age 18. Once you call 1-866-QUIT-4-LIFE (784-8454) or visit **www.quitnow.net/REI** to enroll, you will work with a Quit Coach® to create a personal quitting plan, which may include nicotine replacement patches, gum or covered nicotine cessation drugs. Your Quit Coach can help you decide if one of these products will work for you.

Participants receive:

- Up to five coaching calls and unlimited toll-free access to a Quit Coach for the duration of the program.
- Unlimited access to Web Coach™, an interactive online community that offers e-learning tools, social support and information about quitting.
- Recommended nicotine replacement patches or gum delivered to your home at no cost to you.
- Printed, stage-appropriate Quit Guides.
- Emails to keep you motivated throughout the quitting process.

In addition, REI will pay your out-of-pocket cost for nicotine cessation medications prescribed by a doctor if you are enrolled in Quit for Life and an REI medical plan.

Quitting is about more than just not smoking. When you join the Quit for Life program, a Quit Coach will help you become an expert in living without tobacco using *The 4 Essential Practices to Quit for Life*, principles based on 25 years of research and experience helping people quit tobacco. The Quit for Life program has helped over 500,000 tobacco users.

RETHINKCARE

The RethinkCare solutions are provided at no cost and provide support for you at home and at work.

- **Parental Success:** Gives working parents behavioral health support for themselves and their children, including those with learning and developmental challenges.
- **Personal Well-being**: Learn lifelong skills including mindfulness techniques, managing stress, anxiety and sleep issues, plus how to maintain a positive mindset.
- **Professional Resilience**: Build emotional intelligence, learn how to manage coworker stress and grow professionally.

Call a RethinkCare expert at 1-800-714-9285, email **info@rethinkbenefits.com**, or visit **rei.rethinkbenefits.com** for more information on this program.

FINANCIAL PEACE OF MIND

REI offers benefits to help protect you and your family from life's uncertainties. And REI pays the cost for most of your basic insurance coverage. You can choose to pay for supplemental coverage.

- **Life Insurance:**
  - Basic Life.
  - Supplemental Life – optional additional life insurance for you and optional life insurance for eligible family members.
- **Accidental Death and Dismemberment (AD&D):** Pays benefits for certain serious losses due to an accident.
  - Basic AD&D.
  - Supplemental AD&D – optional additional AD&D for you and optional AD&D for eligible family members.
- **Short Term Disability:** For all hourly benefits-eligible employees (except HQ and retail and OPO management employees).
- **Salary Continuation:** For all salaried/exempt, all HQ and all retail and OPO management employees.
- **Long Term Disability (LTD):** For all benefits-eligible hourly and full-time employees:
  - Core LTD.
  - Voluntary LTD – optional additional LTD benefits for you.
- **Business Travel Accident (BTA):** You and accompanying family members.

SALARY CONTINUATION BENEFIT AND SHORT TERM DISABILITY PLAN

Questions About Disability?
Call REI Health Guide
1-800-451-2967 (Leave & Disability)

If you're unable to work for a short term period of time due to a non-occupational illness or injury, REI's salary continuation benefits or short term disability plan can help protect you from loss of income.

- **Salary Continuation.** If you're an eligible salaried/exempt, HQ or hourly retail or OPO management employee, you are covered by the Salary Continuation benefit if you have an approved disability claim for up to 12 weeks to care for yourself or an eligible family member. If approved, you may also receive an additional 14 weeks of salary continuation at a reduced rate of 80% of your basic weekly earnings for your own medical condition. To find out more about this benefit, visit **www.foryourbenefit-rei.com**.
- **Short Term Disability (STD).** If you are an hourly benefits-eligible employee, (excluding hourly HQ and retail and OPO management employees), you are covered by STD, after a five-calendar-day waiting period, for approved disability claims.

REI pays the entire cost for both Salary Continuation and Short Term Disability coverage.

Although the Salary Continuation benefit is described in this SPD, the Salary Continuation benefit is not part of the Plan and thus is not subject to the provisions in the Plan document or this SPD (including the ERISA rights and claims procedures described in this SPD). Below is a high-level description of these benefits. For more information, visit **www.foryourbenefit-rei.com**.

FEATURES	SALARY CONTINUATION	SHORT TERM DISABILITY (STD)
Weekly Benefit Amount	Pays bi-weekly benefits at 100% of your basic weekly earnings at the time your disability claim is approved for up to the first 12 weeks for your or your family member's illness or injury and 80% of your basic weekly earnings for up to an additional 14 weeks in the case of your own non-work-related illness or injury.	Pays bi-weekly benefits at 100% of basic weekly earnings at time your disability claim is approved for up to six weeks and 60% of lost weekly earnings up to an additional 20 weeks for non-work-related disabilities.
When Benefits May Begin	With an approved disability claim, benefits may begin on the first day of illness or injury.	With an approved disability claim, after five calendar days for illness/pregnancy and injury.
How Long Benefits May Continue	Up to 12 weeks to care for an eligible family member; 26 weeks for your own illness.	Up to 26 weeks for your own illness.
Preexisting Conditions	None.	None.

FEATURES	SALARY CONTINUATION	SHORT TERM DISABILITY (STD)
Disability Income Offsets	Your weekly benefit may be offset by certain income you receive from other sources such as state disability payments, payments from a group plan, unemployment compensation, any amount paid by a third party because of your disability, judgment or settlement, or any other source. Contact REI Health Guide at 1-800-451-2967 for more information.	Your weekly benefit may be offset by certain income you receive from other source, such as state disability payments, payments from another group plan, unemployment compensation, any amount paid by a third party because of your disability, judgment or settlement, or any other source. Contact REI Health Guide at 1-800-451-2967 for more information.

HOW THE STD PLAN WORKS

The STD Plan pays benefits, with an approved disability claim, if you become disabled due to a non-work-related illness or injury.

To qualify for STD benefits, you must be disabled as defined by the plan and under the continuous care of a physician in the appropriate specialty as determined by the insurance company.

Benefits are provided under an insurance policy purchased by REI. For details about our salary continuation program, review **www.foryourbenefit-rei.com**.

When Coverage Begins

Plan coverage begins the first of the month following your date of hire or on your benefits eligibility date. If you're not actively at work due to physical disease, injury, pregnancy or mental disorder on the day before your Plan coverage is scheduled to begin, coverage will be delayed until the day after you've completed one full day of active work.

Actively at work means you're performing in the usual way all the essential functions of your regular occupation on your normal full-time or part-time basis at your usual place of employment or a location to which REI requires you to travel or your home, if that is the business location REI has agreed to and you are physically able to work at another location if REI required it. You are considered actively at work if you meet the conditions stated above but are absent from work on a day that is a holiday, vacation day or regularly scheduled day off for you as long as you were actively at work on your preceding regularly scheduled workday.

Regular Occupation

Regular occupation is the activity you regularly performed that was your source of income from REI, immediately prior to the non-work-related injury or illness for which you are receiving benefits.

For a detailed definition, see the *Glossary*, starting on page 113.

How the Plan Pays Benefits

You are eligible to receive STD benefits if you have an approved disability and have been disabled for five calendar days. STD weekly benefits equal 100% of lost weekly earnings for up to the first six weeks and 60% of lost weekly earnings for up to an additional 20 weeks.

Your STD benefit is equal to your net weekly benefit, as determined below:

- Multiply your hourly rate by your average weekly hours (AWH) before you go out on leave by the applicable STD benefit percentage (e.g., 100% or 60%).
- Compare the amount from above with the maximum weekly benefit. The lesser of these two amounts is your **gross weekly benefit**.
- Subtract the weekly amount of other income benefits or offsets from your gross weekly benefit. This is your **net weekly benefit**.

If the sum of your weekly work earnings during your recovery period (i.e., income from another employer) and your gross weekly benefit as calculated above is more than your predisability weekly income, your gross weekly benefit will be reduced by the excess amount.

Except where necessary to recover an overpayment, your net weekly benefit will not be less than the minimum weekly benefit.

Predisability Earnings

Definition of Disability

Disabled means that during the STD qualifying and benefit period you:

- Cannot perform the essential functions of your regular occupation or a reasonable employment option offered to you by REI, and as a result,
- Are unable to earn more than 80% of your predisability weekly income.

The STD plan does not cover any disabilities arising out of or in the course of any employment for wage or profit.

To determine your benefits under STD, the plan uses your lost monthly and weekly income, including pre-tax contributions you make to any REI benefits program, including this Plan, the Commuter Plan, and/or the REI retirement plan. Predisability earnings do not include shift differential pay, employer contributions on your behalf to the retirement plan, contributions you make to a non-qualified deferred compensation plan (SERP) or any other form of extra compensation or fringe benefit.

Your predisability earnings for STD are determined by multiplying your hourly rate by your average weekly hours (AWH) before you go out on leave.

How Long Benefits May Continue

STD benefits may continue for up to 26 weeks of benefits or until the date of any of the following events — whichever comes first:

- You begin to receive benefits from Long Term Disability.
- You are no longer disabled.
- The date you are earning more than 80% of your predisability weekly income.
- You die.
- You reach the maximum benefit period.
- You voluntarily resign from employment at REI.
- You fail to provide the insurance company with proof of your disability.
- The date you cease to be under the regular and appropriate care of a physician or refuse to undergo an examination or testing by a physician, or vocational or rehabilitation testing when the insurance company requires such examination and testing.
- The date you refuse to receive medical treatment that is generally acknowledged by physicians to cure or improve the medical condition for which you are claiming benefits under the plan, so as to reduce the disabling effect, and that the insurance company has recommended.
- The date you refuse to try or attempt to work with the assistance of modifications made to your work environment, functional job elements or work schedule, or adaptive equipment or devices that were recommended by a qualified physician as accommodating the limiting factors of the disabling condition and that enable you to perform the essential functions of your regular occupation or a reasonable employment option offered to you by REI.

Essential Functions of Your Job

Functions that are normally required for the performance of an occupation and that cannot be reasonably omitted or modified are the essential functions of your job.

For a detailed definition, see *Glossary*, starting on page 113.

Using Your Sick or Vacation Pay

For disabled hourly employees, your available sick or vacation pay will be processed during your five-calendar-day waiting period. If your STD extends beyond the initial six weeks and your benefit decreases to 60%, you may not use any remaining accrued sick or vacation pay to supplement your reduced STD benefit.

Temporary Recovery

If you become disabled under the plan, recover, then become disabled once again, here's what will happen:

- Temporary recovery during the STD benefit qualifying period — if you become disabled and are waiting to satisfy the benefit five-calendar-day waiting period before disability payments start and then recover and return to work, you may return to work for up to five calendar days without having to re-satisfy the benefit waiting period if you become disabled again. Temporary recovery of more than five calendar days will require you to re-satisfy the benefit qualifying period.
- If your benefit waiting period has been satisfied and you have returned to work for less than 15 days, your STD benefits will resume immediately with no new benefit waiting period required. Benefits may continue for the maximum 26-week benefit payment period — the time you were recovered won't count against this period. Predisability earnings used to calculate benefits will remain the same as before the temporary recovery. If your temporary recovery was 15 days or more, or your relapse is due to a different condition, you will have to complete a benefit waiting period the same as for any new disability.

The plan will not pay benefits during a period of temporary recovery. Also, if you became eligible for disability benefits under another disability insurance plan during your period of recovery, you won't qualify for benefits from this plan when your disability recurs.

STD Return to Work Incentive Benefits

Even though you remain disabled under the plan, you may be able to work, at least on a part-time basis. Subject to approval by the insurance company, if you return to work while disabled the plan may continue to pay benefits in addition to your work earnings.

Under this return to work provision, if your STD benefits (not counting other income) plus your earnings add up to:

- Less than your predisability earnings, you'll continue to receive full benefits with no reduction.
- More than your predisability earnings, your STD benefits will be reduced by the excess amount.

For example, if your predisability earnings are $500 and your STD benefits are $300 per week, and you return to work under the plan's return to work provision, here's what might happen:

- Scenario 1. You earn $100 per week. Your STD benefits plus work earnings add up to $400 per week. Since that's less than your predisability earnings of $500, STD benefits are not reduced.
- Scenario 2. You earn $250 per week. Your STD benefit plus work earnings add up to $550 — $50 more than your predisability earnings. Your STD benefits are reduced to $250 ($300 minus $50 work earnings).

Other Income

Benefits from the STD plan will be reduced by other income. Other income refers to any income you receive from any formal or informal sick leave and the amount of earnings you earn or receive from employment with REI.

If you become eligible for other income due to your disability, these are the rules:

- You must pursue any other income for which you may be eligible. If you don't provide proof that you've applied, Lincoln Financial Group will estimate the amount of the other income and reduce your plan benefits accordingly.
- Your plan benefits won't be reduced until the other income becomes payable — but if this results in an overpayment of LTD and STD benefits, you'll be required to repay the plan for any excess amount you receive.
- If you get other income as a lump sum payment, your plan payments will be reduced on a prorated basis as if the lump sum had been paid in monthly amounts.

Examples of Other Income

- 50% of any award provided under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.
- Disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are:
  - Unemployment compensation benefits.
  - Temporary or permanent, partial or total disability benefits under any state or federal Workers' Compensation law or any

other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity.
  - Automobile no-fault wage replacement benefits to the extent required by law.
  - Statutory disability benefits.
  - Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan.
  - Veterans' benefits.
- Disability or unemployment benefits under any plan or arrangement of coverage:
  - As a result of employment by or association with REI; or
  - As a result of membership in or association with any group, association, union or other organization. This includes both plans that are insured and those that are not.
- Unreduced retirement benefits for which you are or may become eligible under a group pension plan at the later of:
  - Age 62; and
  - The pension plan's Normal Retirement Age, but only to the extent that such benefits were paid for by an employer.
- Voluntarily elected retirement benefits received under any group pension plan; but only to the extent that such benefits were paid for by an employer.
- Disability payments which result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources.
- Disability benefits under any group mortgage or group credit disability plan.
- Other income benefits include those, due to your disability or retirement, that are payable to you, your spouse, your children, and your dependents.

Examples of What Is Not Other Income

- Profit sharing plans.
- Thrift plans.
- 401(k) plans.
- Keogh plans.
- Employee stock option plans.
- Tax sheltered annuity plans.
- Severance pay.
- Individual disability income policies.
- Individual retirement accounts (IRAs).
- Retirement or disability benefits you were receiving before the date you were disabled.

PAYING TAXES

If you receive STD plan benefits you may have to pay federal income taxes on payments you receive. You may also have to pay your share of FICA (Social Security/Medicare) taxes while you're receiving benefits. State taxes will depend on the state in which you live.

Call REI Health Guide to File a Claim
1-800-451-2967 (Leave & Disability)

FILING A DISABILITY CLAIM

To receive STD benefits, you must make a claim no later than 31 days from the date your disability begins. If you are or expect to be out of work more than five days due to an injury or illness, call REI Health Guide at 1-800-451-2967. A health guide will check your eligibility for benefits, ask you a few questions about your illness or injury, ask you to describe your occupation and begin the claim process. A health guide will walk you through the medical certification process, which may involve your doctor, and evaluate and certify your length of disability. As a follow-up to your phone call, you will receive a notification in the mail stating your approved length of disability, or reason for denial.

Before paying benefits, Lincoln Financial Group will require you to provide written proof of your disability (Proof of Loss), or medical certification, at your own expense. Lincoln Financial Group reserves the right to investigate your claim at any time and may require you to submit medical recertification while you are receiving disability benefits. If you fail to cooperate, your benefits could be denied or suspended. Medical certification for STD benefits must be submitted no later than 30 days after the end of the STD qualifying period (five days).

IF YOUR CLAIM IS DENIED

If your claim is denied, in whole or in part, and you disagree with the denial, please follow the procedures described in the *Claims and Appeals* section, beginning on page 101.

WHEN COVERAGE ENDS

Coverage under the Salary Continuation and Short Term Disability Plans ends on the date your employment with REI terminates. However, if your employment is terminated by REI while you are receiving STD or salary continuation benefits, your STD or salary continuation benefits will continue until your benefits have been exhausted or you are no longer disabled. For a general description of when Plan benefits end, see *When Plan Coverage Ends* on page 19.

STD EXCLUSIONS

In addition to all the other limitations and exclusions discussed throughout this section, the following are further exclusions and limitations of the STD Plan. Be sure to call REI Health Guide with any questions at 1-800-451-2967 (Leave & Disability).

No STD benefits will be paid for any period of disability as follows:

- That is due to intentionally self-inflicted injury, while sane or insane.
- That results from your commission of or attempt to commit a felony, or your engagement in an illegal occupation.
- That results from driving an automobile while intoxicated. Intoxicated means the blood alcohol of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under state law.
- That is due to war or any act of war (declared or not declared).
- That is due to insurrection, rebellion or taking part in a riot or civil commotion.
- For any day during a disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense.
- That began before your coverage effective date under the group policy.
- When you are not under the regular and appropriate care of a physician.
- That results from an illness or injury for which workers' compensation disability income benefits are payable.

LONG TERM DISABILITY PLAN

If you're unable to work beyond 26 weeks (i.e., 180 days) due to a disability, REI's Long Term Disability (LTD) Plan can help protect you from loss of income. All benefits-eligible hourly and full-time employees are automatically covered by the Core LTD Plan. For more protection, you may elect Voluntary LTD coverage. The plan is insured through Lincoln Financial Group.

REI pays the full cost for Core LTD coverage. You pay for the cost of Voluntary LTD.

Questions About Disability?
Call REI Health Guide
1-800-451-2967 (Leave & Disability)

LONG TERM DISABILITY (LTD)	
FEATURES	**DESCRIPTION**
When LTD Begins	After 26 weeks (i.e., 180 days) of Short Term Disability benefits or Salary Continuation. Disabled employees with a work-related injury/illness that goes beyond 26 weeks (180 days) may also qualify if an LTD claim is approved.
How Long Benefits May Continue	See *Maximum Benefit Period*.
Monthly Benefit Amount	Core – 40% of lost monthly income (i.e., base pay at time your disability claim was initiated) to maximum $6,667 per month if approved for LTD. Voluntary – additional 20% of lost monthly income (i.e., base pay at time your disability claim was initiated) to maximum benefit of $3,333 per month if approved for LTD.
Return to Work Benefit	If you're still disabled but can return to work on a limited basis, the plan may pay partial disability benefits.
Survivor Benefit	If you die while disabled, the plan pays your survivors three times your monthly benefit.
Preexisting Condition Limitation	Core and Voluntary LTD: No benefits are payable for any disability that occurs within the first 12 months of your coverage effective date if in the three months prior to your coverage effective date this disability was diagnosed or treated. This includes taking drugs or medicines prescribed or recommended by a physician for that condition. Other limitations may apply. Please contact REI Health Guide at 1-800-451-2967 if you have a specific situation for which you need further information on how benefits will be paid.
Disability Income Offsets	LTD benefits will be offset by certain income you receive from other sources such as sick pay and incidental salary continuation pay, including donated sick and vacation, Social Security disability and workers' compensation. See *Other Income* on page 66 for more information or contact REI Health Guide at 1-800-451-2967.

HOW THE LTD PLAN WORKS

The Long Term Disability (LTD) Plan may begin to pay monthly benefits starting after 26 weeks (specifically, 180 days) of disability. To qualify, you must meet all of the following conditions:

- Be disabled due to a disease or injury.
- Meet the plan's definition of disability.
- Be under the regular care of a physician.
- Provide Lincoln Financial Group with proof of your disability (Proof of Loss) at your own expense.

Definition of Disability

The plan's definition of disability differs depending on how long you've been disabled:

For the 180-day benefit waiting period and first 24 months of LTD, you'll be considered disabled if you are unable to perform the material duties of your own occupation because of disease or injury and your work earnings are 80% or less of your adjusted predisability earnings.

After the first 24 months of LTD benefits, you'll be considered disabled if you are unable to work at any reasonable occupation for which you may be qualified by education, training or experience because of disease or injury, and as a result, you are unable to earn more than 60% of your adjusted predisability earnings under the Core LTD Plan or combined Core and Voluntary LTD Plans.

Your Costs

REI provides your coverage under the Core LTD Plan at no cost to you. If you elect Voluntary LTD, you pay the full cost on a post-tax basis. The cost of your Voluntary LTD coverage is based on how much you earn.

When Coverage Begins

If you're not actively at work due to physical disease, injury, pregnancy or mental disorder on the day before your disability coverage is scheduled to begin, LTD coverage will be delayed until the day after you've completed one full day of active work.

Actively at work means you're performing in the usual way all the essential functions of your regular occupation on your normal full-time or part-time basis at your usual place of employment or a location to which REI requires you to travel or your home, if that is the business location REI has agreed to and you are physically able to work at another location if REI required it. You are considered actively at work if you meet the conditions stated above but are absent from work on a day that is a holiday, vacation day or regularly scheduled day off for you as long as you were actively at work on your preceding regularly scheduled workday.

Evidence of Insurability

If you decline Voluntary LTD coverage when first eligible, you will have to provide the insurance company with Evidence of Insurability (EOI) to add coverage at a later date. EOI will also be required if you drop coverage then later want to re-enroll.

To provide EOI, you must complete an EOI application and authorize the Lincoln Financial Group to obtain information about your health. Also, depending on your circumstances, Lincoln Financial Group may require you to undergo a physical exam and provide additional information about your insurability.

Eligibility for Life Insurance if Permanently and Totally Disabled

You may remain eligible for REI's Life Insurance coverage (but not Accidental Death and Personal Loss Coverage)* if REI determines that, prior to reaching age 65, you have become permanently and totally disabled. The total disability must start:

- While you are insured; and
- On or after the date this subsection applies to you; and
- Before you retire.

This eligibility ceases at the first to occur on:

- The date REI determines that you are no longer permanently and totally disabled; or
- The date you reach age 65.

Report a disease or injury to REI as soon as you can. REI will help you determine if you qualify.

If you were insured for Accidental Death and Personal Loss Coverage, that coverage ends on the date you went on disability.

**Subject to change or termination as provided elsewhere in the group contract.*

How the Plan Pays Benefits

If you become disabled and qualify for LTD, the amount of your monthly benefit will depend on whether you're covered by Core only or Core and Voluntary LTD at time of disability and whether you're eligible to receive other income due to your disability.

Here's how it works:

- Core LTD will replace the 40% of your predisability earnings minus any other income. The maximum benefit from the plan is $6,667 per month.

- Voluntary LTD pays an additional benefit, if you're enrolled when you become disabled and qualify for benefits. The voluntary benefit equals 20% of your predisability earnings minus any other income. The maximum Voluntary LTD benefit from the plan is $3,333 per month.

The combined Core and Voluntary LTD benefits may replace up to 60% of your predisability pay to a maximum of $10,000 per month. The minimum monthly benefit is $100.

Predisability Earnings

To determine your benefits under LTD, the plan uses your monthly pay on the day before a disability starts, including commissions, awards, overtime pay (averaged over the last 12 months of actual employment or a shorter period if actual employment was for fewer than 12 months) and any pre-tax contributions you make to the Plan, Commuter Plan, REI retirement plan or an executive non-qualified deferred compensation plan. Predisability earnings do not include employer contributions on your behalf to the retirement plan or a deferred compensation plan.

If you're an hourly employee, your predisability earnings are based on your hourly rate of pay times the average hours worked per month (to a maximum of 173.33 hours) over the lesser of (a) the full 12-month period immediately prior to the date disability or partial disability begins, or (b) the period of employment. However, such earnings will not include commissions, overtime pay and extra compensation other than bonuses. Bonuses will be averaged over the lesser of (a) the 12-month period prior to the date disability begins; or (b) the period of employment.

If you're a salaried employee, your predisability earnings are based on your monthly rate of earnings in effect immediately prior to the date of disability or partial disability begins. However, such earnings will not include commissions, overtime pay and extra compensation other than bonuses. Bonuses will be averaged over the lesser of (a) the 12-month period prior to the date disability begins; or (b) the period of employment.

An Example: What the Plan Pays

You become disabled and qualify for Core LTD. Your predisability earnings are $2,000. Your monthly LTD benefit is determined as follows:

40% of predisability earnings:
40% x $2,000 = **$800 monthly LTD benefit**

If you elected Voluntary LTD in addition to the Core LTD coverage provided by REI, your monthly LTD benefit would be figured like this:

Core LTD ($2,000 X 40%)	$800
Voluntary LTD ($2,000 X 20%)	+$400
Your combined total benefit	$1,200

Combined Core and Voluntary LTD monthly benefits would equal $1,200 or 60% of your predisability earnings.

If you also qualified to receive other income, that income plus LTD benefits could combine to equal up to but no more than 60% of predisability earnings.

For instance, if you also received $350 in other income, your monthly LTD benefit would be $850 ($1,200 minus $350).

Other Income

LTD benefits are reduced by disability payments you receive or are eligible to receive from other sources of income. Other income also includes benefits that are payable to you, your spouse, your children or your dependents due to your disability or retirement.

If you become eligible for other income due to your disability, these rules apply:

- You must pursue any other income for which you may be eligible. If you don't provide proof that you've applied, Lincoln Financial Group will estimate the amount of the other income and reduce your plan benefits accordingly.
- Your plan benefits won't be reduced until the other income becomes payable — but if this results in an overpayment of LTD benefits, you'll be required to repay the plan for any excess amount you receive.

- If you get other income as a lump sum payment, your plan payments will be reduced on a prorated basis as if the lump sum had been paid in monthly amounts.

Other Income Benefits That Reduce Your Monthly Benefit

- 50% of any award provided under the Jones Act or the Maritime Doctrine of Maintenance, Wages and Cure.
- Disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are:
  - Unemployment compensation benefits.
  - Temporary or permanent, partial or total disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity, lessened ability to compete in the open labor market, any degree of permanent impairment, and any degree of loss of bodily function or capacity.
  - Automobile no-fault wage replacement benefits to the extent required by law.
  - Statutory disability benefits.
  - Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan.
  - Veterans' benefits.
- Disability or unemployment benefits under any plan or arrangement of coverage:
  - As a result of employment by or association with the employer; or
  - As a result of membership in or association with any group, association, union or other organization. This includes both plans that are insured and those that are not.
- Unreduced retirement benefits for which you are or may become eligible under a group pension plan at the later of:
  - Age 62, or
  - The pension plan's normal retirement age, but only to the extent that such benefits were paid for by an employer.
- Voluntarily elected retirement benefits received under any group pension plan, but only to the extent that such benefits were paid for by an employer.
- Disability payments that result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources.
- Disability benefits under any group mortgage or group credit disability plan.

Other Income Benefits That Do Not Reduce Your Monthly Benefit

Any retirement or disability benefits you were receiving from the following sources before you become disabled under this plan will not reduce your monthly LTD benefit:

- Military and other government service pensions.
- Retirement benefits from a prior employer.
- Veterans' benefits for service related disabilities.
- Individual disability income policies.
- Social Security benefits.

Also, any income or other benefits you receive from the following sources will not reduce your monthly LTD benefit:

- Profit sharing plans.
- Thrift plans.
- 401(k) plans.
- Keogh plans.
- Employee stock option plans.
- Tax sheltered annuity plans.
- Severance pay.
- Individual retirement accounts (IRAs).
- Retirement or disability benefits you were receiving before the date you were disabled.

How Long Benefits May Continue

Your LTD benefit will end on the earliest of the following dates:

- Lincoln Financial Group finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- Lincoln Financial Group finds that you have withheld information which indicates you are

performing, or are capable of performing, the duties of a reasonable occupation.

- You refuse to be examined by, or cooperate with, an independent physician or a licensed or certified health care practitioner, as requested.
- You cease to be under the regular care of a physician.
- An independent medical exam report or functional capacity evaluation fails to confirm your disability.
- You reach the end of your maximum benefit period.
- You are not undergoing effective treatment for alcoholism or drug abuse if your disability is caused to any extent by alcoholism or drug abuse.
- You refuse to cooperate with or accept:
  - Changes made to a work site or job process to suit your identified medical limitations; or
  - Adaptive equipment or devices designed to suit your identified medical limitations that would enable you to perform your own occupation or a reasonable occupation (if you are receiving benefits for being unable to work any reasonable occupation), provided that a physician agrees that such changes or adaptive equipment suit your medical limitations.
- You refuse to receive treatment recommended by your attending physician that in Lincoln Financial Group's opinion would cure, correct or limit your disability.
- Your condition would permit you to work, or increase the number of hours you work, or the number or type of duties you perform in your own occupation, but you refuse to do so.
- Your death.
- The day after Lincoln Financial Group determines you are able to participate in an approved rehabilitation program and you refuse to do so.

Maximum Benefit Period

If your disability starts before you reach age 60, benefits will end with the calendar month in which you reach your full Social Security retirement age (age 67 for persons born in 1960 or thereafter).

If your disability starts on or after the date you reach age 60, benefits will end when your maximum benefit period expires according to the following schedule:

IF YOU BECOME DISABLED AT THIS AGE	LTD BENEFITS MAY CONTINUE
60 but less than 61	for 60 months
61 but less than 62	for 48 months
62 but less than 63	for 42 months
63 but less than 64	for 36 months
64 but less than 65	for 30 months
65 but less than 66	for 24 months
66 but less than 67	for 21 months
67 but less than 68	for 18 months
68 but less than 69	for 15 months
69 and over	for 12 months

LTD benefits are limited to a maximum of 24 months if a mental illness or substance abuse is the primary cause of your disability. After 24 months, LTD benefits may continue if you are confined as an inpatient in a hospital or treatment facility for the condition that caused the disability. If the inpatient confinement lasts:

- Less than 30 days, LTD benefits will end when you are no longer confined.
- 30 days or more, LTD benefits may continue until 90 days after the date you have not been confined due to the condition.

Temporary Recovery

If you become disabled under the plan, return to work and then become disabled again, here's how a temporary recovery may affect your LTD benefits:

- **Temporary recovery during the 26-week benefit waiting period:** If the same disability recurs within 30 consecutive workdays after you return to work, you will not have to start a new benefit waiting period – but the time you were recovered will not count toward your benefit waiting period.
- **Temporary recovery after benefits begin (during the maximum benefit period):** If the same disability recurs within six consecutive

months after your recovery, benefits will resume immediately with no benefit waiting period required.

In either case, the time you return to work will not reduce your maximum benefit period for the first 24 months benefits are payable (your own occupation period). Also, plan benefits will be based on your predisability earnings before the recurrence of your disability.

You will be considered to have a new disability and have to complete a new benefit waiting period if:

- Your relapse occurs during the benefit waiting period and your recovery lasted more than 30 consecutive days; or
- Your relapse occurs after benefits begin and your recovery lasted more than six consecutive months; or
- You become disabled due to a different condition.

Rehabilitation Program

If you become disabled under the LTD Plan, Lincoln Financial Group may require you to participate in a rehabilitation program. The rehabilitation program must be approved by Lincoln Financial Group and consist of a written plan, program or course of vocational training or education intended to enable you to return to work. The plan will pay for all services and supplies required to participate, except for those for which you can receive reimbursement from any other resource.

Return to Work Incentive Benefits

Under the return to work provision of the LTD policy, you may be able to go back to work on part-time or reduced schedule. If approved by Lincoln Financial Group, you may qualify to receive full or partial LTD benefits while you work. Together, your work earnings plus your LTD benefits will add up to more than you'd get from the plan alone.

The plan's return to work incentive benefit is figured differently depending on whether you return to work during the first 12 months LTD benefits are payable (immediately following the plan's benefit waiting period) or after LTD benefits have been payable for 12 months.

The first 12 months benefits are payable while you're working. If your regular monthly LTD benefit plus monthly work earnings add up to:

- Less than your predisability earnings, you'll continue to receive full LTD benefits.
- More than your predisability earnings, your LTD benefits will be offset by a portion of your work earnings.

For example, if your predisability earnings were $2,000 per month and you qualify for $1,200 monthly LTD benefits (Core plus Voluntary), here's how your plan benefits may be determined if you work part-time under the return to work provision:

	$1,200	Maximum LTD Benefit
	+ 1,000	Plus Work Earnings
=	$2,200	Equals Combined total
	-2,000	Minus Predisability Earnings
=	$200	Equals Work Earnings Offset

To determine the LTD benefit payable, work earnings offset would be subtracted from your maximum LTD benefit. In this case, that means your LTD benefits would equal $1,000 ($1,200 LTD minus $200 work earnings). Your LTD benefit plus your work earnings would add up to $2,000 — more than you'd get from the LTD Plan alone.

After the first 12 months benefits are payable. Provided you continue to be disabled under the plan, your return to work incentive benefit (proportionate benefit) will be figured like this:

Adjusted predisability earnings minus work earnings

Divided by

Adjusted predisability earnings

Times

The monthly benefit payable

For example, if your predisability earnings were $2,000 per month and you qualify for $1,200 monthly LTD benefits (Core plus Voluntary) and you earn $500 per month under the return to work

provision, here's how your plan benefits may be determined:

	$1,500	Adjusted predisability earnings minus work earnings ($2,000 – $500)
	÷$2,000	Adjusted predisability earnings
=	0.75	Equals
	x 1,200	LTD monthly benefit payable
=	$900	Return to work incentive benefit ("proportionate benefit")

Your $500 work earnings plus $900 LTD benefit adds up to $1,400 per month — $200 more than you would get from the LTD Plan alone.

SURVIVOR BENEFIT

The plan will pay a lump sum benefit to your survivors if you die while LTD benefits are payable, provided you've completed at least 26 weeks of disability. The benefit equals three times your monthly LTD benefit, unreduced by any other income.

First, the plan will apply this benefit toward any overpayment of your claim. Next, the insurance company will pay the benefit to your spouse or life partner if the life partner is listed on your Affidavit of Life Partnership at the time of your death. If you do not have a spouse or life partner at the time of death, the benefit will be paid in equal shares to your biological or legally adopted children who:

- Are not married; and
- Are dependent mainly on you for support; and
- Are under age 25 (this age limit will not apply if a child is not capable of self-sustaining employment because of mental or physical disability that existed prior to age 25).

The benefit may also be paid to anyone who provides care and support for your eligible spouse or dependents.

If you don't have one of the survivors listed above, the benefit will be payable to your estate.

FILING AN LTD CLAIM

To receive LTD benefits, you must file a claim by contacting REI Health Guide at 1-800-451-2967 (Leave & Disability). A health guide will check your eligibility for benefits, ask you a few questions about your illness or injury, ask you to describe your occupation and begin the claim process. Notify the health guide if you are initiating an LTD claim for a work injury/illness. A health guide will walk you through the medical certification process, which may involve your doctor, and evaluate and certify your length of disability. As a follow-up to your phone call, you will receive a notification in the mail stating your certified length of disability or reason for denial.

Before paying benefits, Lincoln Financial Group will require you to provide written proof of your disability (proof of loss) at your own expense. Lincoln Financial Group reserves the right to investigate your claim at any time and may require you to have a medical examination periodically while you're receiving benefits. If you fail to cooperate, your benefits could be denied or suspended. Proof of loss for LTD benefits must be submitted no later than 90 days after the end of the LTD 26-week qualifying period.

Your claim must give proof of the nature and extent of the loss. Lincoln Financial Group may require copies of documents to support your claim, including data about other income benefits. You must also authorize Lincoln Financial Group to investigate your claim, your eligibility for, and the amount of other income benefits. You must provide true and correct information as reasonably requested by Lincoln Financial Group.

IF YOUR CLAIM IS DENIED

If your claim is denied, in whole or in part, please follow the procedures described in the *Claims and Appeals* section, beginning on page 101.

WHEN COVERAGE ENDS

Coverage under the LTD Plan ends on the date your employment with REI terminates. For a general description of when Plan benefits end, see *When Plan Coverage Ends* on page 19.

LTD PLAN EXCLUSIONS

In addition to all the other limitations and exclusions discussed throughout this section, the following are further exclusions and limitations of

the LTD Plan. Be sure to call Lincoln Financial Group with any questions.

Long Term Disability does not cover any disability that:

- Is due to intentionally self-inflicted injury (while sane or insane).
- Results from your commission of, or attempting to commit, a criminal act.
- Results from driving an automobile while intoxicated. Intoxicated means the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under state law.
- Is due to war or any act of war (declared or not declared).
- Is due to insurrection, rebellion or taking part in a riot or civil commotion.
- On any day during a disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:
  - The person will not be deemed to be disabled; and
  - No benefits will be payable.

PREEXISTING CONDITIONS

No benefits are payable for any disability that occurs within the first 12 months of your coverage effective date if in the three months prior to your coverage effective date this disability was diagnosed or treated. This includes taking drugs or medicines prescribed or recommended by a physician for that condition.

LIFE AND AD&D PLANS

REI pays the entire cost for basic coverage listed below and you can choose to pay for additional coverage:

- **Basic Life Insurance** coverage for all eligible employees. Supplemental Life is also available for employees and their families.
- **Basic Accidental Death & Dismemberment (AD&D)** coverage for all eligible employees. For extra protection, Supplemental AD&D is also available for employees and their families.

ENROLLING IN LIFE AND AD&D COVERAGE

Basic Life and Basic AD&D coverage is automatic, which means you don't have to enroll to be covered. You must enroll to elect Supplemental Life or Supplemental AD&D coverage. You may elect either or both plans — or waive participation altogether.

If both you and your spouse or life partner work for REI, you may only be covered by Supplemental Life or Supplemental AD&D either as an employee or as the spouse or life partner of an employee. Also, if you have eligible children, they may only be enrolled once under each of these plans — by you or by your spouse or life partner but not both of you.

Evidence of Insurability (EOI, or proof of good health) is not required for Basic Life, Basic AD&D or Supplemental AD&D coverage. You may be required to submit an *Evidence of Insurability* (EOI) form to elect or increase your Supplemental Life coverage. EOI may also be required for dependent spouse or life partner coverage and for children coverage. See *Evidence of Insurability* on page 73 for details.

Delay of Coverage

If you are not in active service on the day coverage under any of the Life Insurance and AD&D plans is scheduled to begin, coverage will be delayed for you and any enrolled dependents until the day you return to active service for one full day.

Active Service

For employees, you're performing your regular job for REI or are on a scheduled holiday or vacation day. See the *Glossary* on page 113 for a detailed definition.

YOUR COST

REI pays in full for your coverage under the Basic Life Insurance and Basic AD&D and plans — there's no cost to you for these valuable benefits.

You pay the full cost of any Supplemental Life and pay on a post-tax basis.

Your cost for Supplemental Life is calculated based on age and the benefit amount:

- For you, the cost is based on the benefit amount you elect, your annual base pay and your age on December 31 prior to the beginning of a plan year. When you have a birthday that puts you in a higher age category, your cost of coverage will increase in the next plan year. When you have a change in your base pay, your cost of coverage will increase in in the pay period in which your pay increases.
- For your spouse or life partner, the cost is based on the coverage amount, and your age on December 31 prior to the beginning of a new plan year. When you have a birthday that puts your spouse or life partner into a higher age category, your cost of coverage will increase in the next plan year.
- For your children, the cost is based the coverage amount. For each coverage option, you pay the same annual cost no matter how many children you have.

For Supplemental AD&D, your annual cost depends on your elected coverage amount, your age, and whether you elect employee only or employee and family coverage. You pay on a post-tax basis.

LIFE INSURANCE

Life Insurance pays a benefit to your beneficiaries if you die while covered. REI offers two life insurance plans, both insured by The Hartford.

Annual Base Pay

For purposes of the life insurance and AD&D benefits of the Plan, your annual wage or salary as an REI employee is your annual base pay.

It doesn't include:

- Bonuses;
- Awards;
- Commissions;
- Overtime;
- Other extra pay for more than 40 hours per week; or
- Other extra compensation.

When you first become eligible for benefits, annual base pay is determined based on your projected base wage or salary for the upcoming year as of the date your coverage begins. On December 31 of each year, your annual base pay is redetermined for the upcoming plan year based on your projected base wages or salary for the upcoming plan year.

Supplemental Life for Employees

If you elect Supplemental Life insurance, the plan will pay your elected coverage amount to your beneficiary or beneficiaries in addition to any paid by Basic Life insurance. Subject to the Evidence of Insurability (EOI) requirements, your coverage options for Supplemental Life are:

- Full-time employees: 1 – 8 times your annual base pay to a maximum of $850,000 (maximum of $1.7 million combined with Basic Life).
- Part-time employees: 1 – 8 times your Basic Life benefit to a maximum of $160,000.

For full-time employees amounts exceeding $500,000 or increasing more than one increment are subject to EOI requirements. For part-time employees amounts exceeding $120,000 or increasing more than one increment are subject to EOI requirements.

Supplemental Life for Spouses and Life Partners

You may enroll your spouse or life partner in Supplemental Life Insurance — whether or not you elect Supplemental coverage for yourself. Subject to the EOI requirements, coverage options for your spouse or life partner are $20,000, $50,000, $75,000, $100,000, $200,000 or $250,000, not to exceed the employee's combined basic and supplemental life amounts.

Grandfathered Supplemental Life for Part-time and Full-Time Employees Enrolled in the Plan Prior to May 1, 2002

If you were enrolled in REI's life insurance benefits prior to May 1, 2002 and you elected to continue the amount in place for the May 1, 2002, plan year, frozen coverage amounts available to spouse/life partners are:

- $25,000
- $50,000
- $75,000
- $100,000
- $150,000
- $200,000
- $250,000
- $300,000

Grandfathered Supplemental Spouse Life for Part-Time and Full-Time Employees Enrolled in the Plan Prior to January 1, 2018

If you were enrolled in the plan prior to January 1, 2018 and had coverage that exceeded $75,000 and you elected to continue the amount in place for the January 1, 2018 plan year, your coverage amount will continue.

Supplemental Life for Eligible Children

You may enroll your children, from live birth or adoption to age 26, for $10,000 or $20,000.

When you elect coverage for your eligible children, each eligible child in your family will be covered for exactly the same amount.

Children do not need to complete evidence of insurability.

Evidence of Insurability

If you don't enroll in Supplemental Life when you're first eligible or want to increase your coverage, you or your family members may be required to show proof of good health. To do this, you must complete and submit an online Evidence of Insurability (EOI) form, and you may need to complete a health questionnaire and take a physical exam. The insurance company must approve your application before your new coverage can take effect.

During open enrollment or after a qualifying life event, you may have to provide EOI to enroll in Supplemental Life Insurance for the first time.

Part-time employees: You will need to provide EOI:

- When you are initially eligible, and elect coverage in excess of $120,000
- For any coverage amount if you did not enroll when first eligible
- Anytime you increase coverage to an amount in excess of $120,00 or increase your existing coverage by more than one increment

Full-time employees: You will need to provide EOI:

- When you are initially eligible, and elect coverage more than $500,000
- For any amount of coverage if you did not enroll when first eligible
- Anytime you increase coverage to an amount more than $500,000 or increase your existing coverage by more than one increment

Spouse and life partner will need to provide EOI:

- When you are initially eligible, and elect coverage more than $75,000
- For any coverage amount if you did not enroll when first eligible
- Anytime you increase your existing coverage to an amount more than $75,000 or increase your existing coverage by more than one increment

EOI is also required to re-enroll yourself or a family member who was previously enrolled but dropped coverage or to increase coverage by any amount if the insurance company previously denied coverage based on EOI.

During open enrollment or after a qualifying life event, EOI is also required for your spouse/life partner if you elect or increase Supplemental Life coverage for your spouse/life partner by more than one level.

For Your Benefit at **www.foryourbenefit-rei.com** can help you determine if EOI is required during open enrollment or if you are making changes. If EOI is required, The Hartford will mail you or your dependent an EOI form. You can check the status of your application by calling The Hartford at 1-877-320-0484.

Imputed Value of Life Insurance

If the Basic Life Insurance amount provided to you by REI is more than $50,000, you have imputed taxable income for the value of such excess coverage in accordance with IRS rules.

The imputed income amount is calculated based on your age at the start of the plan year and the IRS Table I rates for life insurance.

For most REI employees, chances are any increase in income taxes due to the imputed value of their basic life insurance coverage will be modest.

Since you pay the entire cost of any Supplemental Life Insurance for yourself and your eligible dependents on an after-tax basis, there is no imputed income relating to the Supplemental Life Insurance.

Reduction of Benefits Due to Age

As follows, Basic and Supplemental Life Insurance benefits are reduced for you and your spouse/life partners age 65 or older based on the following schedule. Your premiums are also reduced by the percentages shown in the chart below.

AGE	PLAN PAYS THIS % OF BENEFITS
65 – 69	65%
70 and above	50%

Accelerated Benefit

Accelerated payment of Basic Life and Supplemental Life Insurance (if applicable) benefits is available for terminally ill participants, including enrolled employees, spouses or life partners with a life expectancy of 24 months or less or who have been diagnosed with one of the following medical conditions:

- Amyotrophic lateral sclerosis (Lou Gehrig's disease);
- End state heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate;
- A medical condition requiring artificial life support without which you would die; or

- A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in lifelong confinement in a hospital or skilled nursing facility.

Subject to approval by The Hartford, the plan will pay up to 80% of the combined coverage in effect at the time of the individual's diagnosis. The minimum benefit is $5,000 and maximum benefit is $500,000, from Basic and Supplemental Life combined. Any amounts paid out as accelerated benefits will reduce the amount payable to the beneficiary. Call REI Health Guide at 1-800-451-2967 for information about how to apply for accelerated benefits.

Payment of accelerated benefits may have tax consequences for participants or beneficiaries. To find out more about your particular situation, be sure to contact a professional tax advisor.

Assignment of Benefits

If a portion of your life or AD&D benefits are to be assigned, contact The Hartford for more information.

The insurance company will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with the insurance company. The insurance company will not be responsible for the validity or sufficiency of an assignment.

An assignment of benefits will operate so long as the assignment remains in force provided insurance under the policy is in effect. The insurance may not be levied on, attached, garnished or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

AD&D pays benefits for death and certain other serious physical losses including paralysis resulting from a covered accident. REI offers two AD&D plans, both insured by The Hartford.

Have Questions About Basic or Supplemental AD&D?

Call REI Health Guide at 1-800-451-2967

Basic AD&D

If your base pay changes during the year, your coverage amount may be adjusted accordingly. If you're not in active service, any increase will go into effect the day you return to work.

To qualify for benefits, you must be covered by the plan at the time of the accident and the loss must occur within 365 days after the accident. Depending on the loss, the plan will pay a percentage of your principal sum as follows:

BASIC AND SUPPLEMENTAL AD&D BENEFITS	
IF BODILY INJURIES RESULT IN:	**PLAN PAYS THIS % OF PRINCIPAL SUM:**
Loss of life	100%
Loss of both hands, both feet or eyesight in both eyes	100%
Loss of one hand and one foot	100%
Loss of speech and hearing in both ears	100%
Loss of either hand or foot and sight of one eye	100%
Loss of movement of both upper and lower limbs (quadriplegia)	100%
Total paralysis of both lower limbs (paraplegia)	75%

BASIC AND SUPPLEMENTAL AD&D BENEFITS	
IF BODILY INJURIES RESULT IN:	**PLAN PAYS THIS % OF PRINCIPAL SUM:**
Loss of one hand or one foot Loss of sight in one eye Loss of speech Loss of hearing in both ears Loss of movement of the upper and lower limbs of one side (hemiplegia)	50%
Loss of thumb and index finger of either hand	25%
Loss of movement of one limb (uniplegia)	25%
"Loss" means, with regard to: 1) Hands and feet, actual severance through or above wrist or ankle joints 2) Sight, speech and hearing, entire and irrecoverable loss thereof 3) Thumb and index finger, actual severance through or above the metacarpophalangeal joints 4) Movement, complete and irreversible paralysis or such limbs.	

A covered person may be considered to have loss of life if not found within one year after the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant.

Special Plan Benefits for Basic and Supplemental AD&D

As follows, Basic and Supplemental AD&D feature special provisions that may pay additional benefits under special circumstances if you are injured in a covered accident.

Coma benefit. The plan will pay 1% of the principal sum through monthly benefits for participants who become comatose due to a covered accident within 31 days of the accident. Benefits continue until the remainder of the principal sum is paid or the injured person recovers from the coma.

Seat belt benefit. Supplemental AD&D pays a special benefit for a participant who dies due to a covered car accident in which they were wearing a seat belt. Benefits may equal:

- $10,000 if the participant was wearing a seat belt at the time of the accident.
- $5,000 sum if the person was in a seat protected by a properly functioning, factory-installed airbag.

The benefit applies if, at the time of the accident:

- The participant was driving or riding as a passenger in a private vehicle equipped with seat belts, including any four-wheel car, pickup, van or other vehicle not being used for commercial purposes;
- The seat belt was in use and properly fastened – for children, this means a child restraint as required by state law and approved by the National Highway Traffic Safety Administration was properly secured and being used as recommended by the manufacturer; and
- Either the official report or the investigating officer certifies the seat belt was being used properly at the time of the accident.

Family care benefits. If anything happens to you in a covered accident, there are several special benefits designed to provide financial assistance to your surviving family members.

- **Education benefit for your dependent child.** If you die in a covered accident, the education benefit for your dependent child can help pay for your children's education. With this benefit, each qualifying child may receive an amount equal to 5% of the accidental death benefit, to a maximum of $5,000 per year. As long as the child remains a full-time student, the plan will pay these benefits for up to four consecutive years.

To qualify, on the date of the accident that qualifies for a benefit, the child must:

- Be attending school, up to and including the 12th grade;
- Be under the age of 23 and attending college or trade school on a regular basis at the time of your death; or
- Enroll in college or trade school within 365 days after the claim has been approved.

For Supplemental AD&D, the seat belt and airbag benefit and repatriation of remains benefit are only payable once even if you are covered under both Basic and Supplemental AD&D at the time of the loss. In addition, the amount of the coma benefit, education benefit for dependent children, spouse/life partner training benefit and child care benefit will be based on the combined principal sum of your Basic and Supplemental AD&D benefits.

- **Spouse or life partner training benefit.** Your spouse or life partner can gain or refresh employment skills if you die in a covered accident. Under this provision, the plan pays the actual cost of a training or education program at an accredited school, in an amount equal to 5% of your accidental death benefit up to a total of $5,000. To qualify, your spouse or life partner must be enrolled in the school within 365 days after the claim has been approved. The plan will pay these benefits for up to four consecutive years as long as your spouse or life partner is enrolled in an employment training program.
- **Child care benefit.** If you die due to a covered accident, the child care benefit can help pay the costs of care for surviving children. The annual benefit per child equals 5% of your accidental death benefits, to a maximum of $5,000 per year. Child care benefits may be paid for up to four years, until the child is no longer in a licensed child care center or the child reaches age 13, whichever comes first.
- To qualify for the annual benefits, surviving children must be:
  - Under age 7 at the time of employee's death; and
  - Enrolled in a legally licensed child care center at the time of the accident or within 365 calendar days after the claim has been approved.

Repatriation of remains. If you die in a covered accident while outside a 200-mile radius of your principal place of residence, a benefit of $5,000 is available for the preparation and transportation of your body back home.

Common carrier. If accidental death or dismemberment occurs on a common carrier (for example, travel while on a plane, bus or train), the plan will pay two times the principal sum.

Supplemental AD&D

The Supplemental AD&D plan offers the following coverage options. The coverage amount you elect is called the principal sum. You may elect any principal sum listed in the table below for yourself. The cost of Supplemental AD&D insurance is paid entirely by you on an after-tax basis.

$25,000	$50,000	$100,000
$150,000	$200,000	$300,000

Family coverage. If you elect family coverage, all eligible members of your family will automatically be covered for this percentage of your principal sum:

- Your spouse or life partner – benefit equals 50% of your Supplemental AD&D coverage.
- Your eligible children – benefit per child equals 15% of your Supplemental AD&D coverage.

What the Plan pays. The Plan pays a percentage of the principal sum depending on the loss. Refer to the table on page 75 for the percentage of the principal sum the Plan will pay for each loss.

If the same accident causes more than one covered loss, the maximum benefit payable will be 100% of the principal sum. If an enrolled child dies within 90 days after the accident, the most the Plan will pay is the benefit for loss of life.

Reduction of Benefits Due to Age

As follows, Basic and Supplemental AD&D benefits for employees age 70 or older are reduced. Spouses and life partners age 65 or above are not eligible for coverage.

IF THE PARTICIPANT IS THIS AGE	PLAN PAYS THIS % OF BENEFITS
65 – 69	65%
70 – 74	50%

CHOOSING YOUR BENEFICIARY

Your beneficiary is the person or trust you name to receive plan benefits. If you die, the plans will pay benefits to your beneficiary in the form of a single lump sum.

If you're new to the Plan, you'll be required to designate a beneficiary for all your life and AD&D coverage. You can do this through **www.foryourbenefit-rei.com**. After that, you can change your beneficiary designation at any time for any reason through **www.foryourbenefit-rei.com**.

You may name:

- Anyone you want as your primary beneficiary.
- More than one primary beneficiary.
- A contingent (secondary) beneficiary if your primary beneficiary dies before you.

You're the automatic beneficiary for family members enrolled in the Supplemental Life or Supplemental AD&D plans.

If you die without a beneficiary, plan benefits will be paid to the first of these survivors — your spouse, your children in equal shares, your parents in equal shares, or your siblings in equal shares. If you have no survivors, benefits will be paid to your estate.

FILING A CLAIM

To receive benefits from any of the Life and AD&D plans, the claim forms must be completed and submitted as soon as possible to the Employee Service Center at 1-800-999-4734 or **hrhr@rei.com**. An Employee Service Center representative will send the completed claim forms to the insurance company.

IF YOUR CLAIM IS DENIED

If your claim is denied, in whole or in part, please follow the procedures described in the *Claims and Appeals* section, beginning on page 101.

WHEN LIFE AND AD&D COVERAGE ENDS

Life Insurance and AD&D coverage under the Plan ends for plan participants, including employees and enrolled family members, as described in *When Plan Coverage Ends*, starting on page 19. In addition, if earlier, your coverage will end on the date:

- You're eligible for coverage under a plan intended to replace this coverage;
- The insurance company terminates the policy; or
- REI cancels participation under the policy.

Portable Life Insurance

Basic Life Insurance and Supplemental Life Insurance benefits are portable for all enrolled participants, including you, your spouse/life partner and eligible children. That means after your group coverage ends, you may buy an individual term life insurance policy at cost-effective rates, with no EOI requirement.

You may elect to continue 50%, 75% or 100% of the life insurance amount that is ending for you or your dependent. This amount will be rounded to the next high multiple of $1,000, if not already a multiple of $1,000. However, the life insurance amount that may be continued will not exceed:

- $250,000 for you
- $50,000 for your spouse
- $10,000 for your dependent child(ren)

If you elect to continue 50% or 75% now, you may not continue any portion of the remaining amount under this portability provision at a later date. In no event will you or your dependents be able to continue a life insurance amount that is less than $5,000.

Basic AD&D and Supplemental AD&D benefits are not portable.

Conversion Policies

As an alternative to a portable term life insurance policy, you may apply to The Hartford to convert your Basic and Supplemental Life Insurance to an individual whole life insurance policy. Costs and provisions of conversion policies differ substantially from those offered by the REI group plans:

- To qualify for a conversion policy, you must apply in writing and pay the first premium within 31 days after the group coverage ends.
- Coverage begins the first day following the 31-day conversion period.
- If you happen to die within the 31-day conversion period, the plan will pay the maximum conversion benefit — whether or not you applied for the conversion policy.

SUPPLEMENTAL LIFE INSURANCE AND AD&D EXCLUSIONS

Supplemental Life Insurance

In addition to the other limitations discussed throughout this section, if a covered person dies by suicide, while sane or insane, or from an intentionally self-inflicted injury, within two years of the effective date of coverage, no Supplemental Life benefit will be payable. If a covered person dies after two years of the effective date of coverage, while insured, but within two years of the date of an increase in coverage becomes effective, the benefit increase will not be payable.

Accidental Death & Dismemberment (AD&D)

In addition to the other limitations discussed throughout this section, here are some further limitations of the Basic and Supplemental AD&D plans. Contact REI Health Guide at 1-800-451-2967 if you have any questions.

AD&D coverage is only for losses caused by accidents. Benefits are not payable for a loss caused or contributed to by any of the following:

- Intentionally self-inflicted Injury;
- Suicide or attempted suicide, while sane or insane;
- War or act of war, whether declared or not;
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
- Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a physician;
- Injury sustained while committing or attempting to commit a felony; or
- Injury sustained while intoxicated.

BUSINESS TRAVEL ACCIDENT PLAN (BTA)

Have Questions About BTA?

REI Health Guide
1-800-451-2967

Employee Service Center
1-800-999-4734
hrhr@rei.com

The Business Travel Accident (BTA) plan protects you 24 hours a day while you're traveling on Company business. The plan, which is insured through American International Group, Inc. (AIG), pays benefits in addition to any other benefits paid by REI's Life and AD&D plans.

Coverage under the plan is automatic, for you and accompanying family members, with no enrollment or Evidence of Insurability (EOI) required, effective the first day of employment. REI pays the entire cost for BTA coverage.

Business Trip

A business trip begins when you leave your residence or place of regular employment to go on the business trip, whichever happens last, and ends when you return from the trip to your residence or place of regular work, whichever happens first.

A business trip may include side trips you make for personal reasons while on the trip. It doesn't include any time you're at your regular workplace, everyday commuting to or from work, or traveling while on leave of absence or vacation.

HOW THE PLAN WORKS

If you or eligible family members are in an accident while on a covered trip, the plan will pay benefits for certain serious physical losses that result within 365 days after the accident. This includes losses due to exposure to the elements.

Covered trips include:

- **Business trips.** Coverage applies to you, as well as to eligible family members traveling with — including spouses or life partners and eligible dependent children.
- **Family relocation trips.** Coverage applies to eligible family members who are traveling in connection with your transfer or proposed transfer by REI to a new work site. To qualify, the relocation trip must be paid for, authorized by, and taken at the direction of REI.

WHAT THE PLAN PAYS

Under the plan, REI employees and family members are covered for these principal sums:

- Employees: $250,000.
- Spouses and life partners: $100,000.
- Eligible dependent children: $10,000 per child.

Depending on the loss, the plan will pay a percentage of the principal sum as noted in the following table:

IF BODILY INJURIES RESULT IN:	PLAN PAYS THIS % OF PRINCIPAL SUM:
Loss of life	100%
Loss of any two: hand, foot or eyesight Loss of speech and hearing in both ears	100%
Quadriplegia: complete and irreversible paralysis of both upper and lower limbs	100%
Hemiplegia: complete and irreversible paralysis of the upper and lower limbs of the same side of the body	50%
Loss of one hand or one foot Loss of sight in one eye Loss of speech Loss of hearing in both ears	50%
Uniplegia: complete and irreversible paralysis of one limb	25%
Loss of thumb and index finger on same hand	25%
"Loss" means for hand or foot, complete severance through or above the wrist or ankle joint; sight of an eye, total and irrecoverable loss of the entire sight of the eye; thumb and index finger, complete severance through or above the metacarpophalangeal joints of both digits; speech, total and irrecoverable loss of the entire ability to speak; hearing, total and irrevocable loss of the entire ability to hear in that ear.	

A covered person may be considered to have loss of life if not found within one year after the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant.

Only one amount, the largest to which you are entitled, is payable for all injuries resulting from a single accident.

SPECIAL PLAN BENEFITS

If you have a covered loss, under special circumstances as follows BTA may pay special benefits in addition to the usual plan benefits for the loss.

Coma benefit. If you're in a covered accident and, as a result, become comatose within 365 days, the plan may pay monthly benefits starting as of the 31st day of the coma. Coma benefits equal 1% of your principal sum per month.

Benefits may continue until you are no longer in a coma, you die, or the plan has paid your full principal sum.

Home alteration and vehicle modification. Up to 10% of the principal sum to a maximum of $10,000 to modify a residence or vehicle to accommodate you if, as a result of a covered accident, you must use a wheelchair to be ambulatory. Subject to review by the insurance company, to be covered these modifications must be:

- Made within one year after the accident;
- On behalf of the participant due to an injury for which benefits have been paid under the plan;
- Recommended by a nationally recognized organization that provides support and assistance to wheelchair users;
- Carried out by individuals experienced in such alterations and modifications; and
- In compliance with any applicable laws or requirements for approval by the appropriate government authorities.

Rehabilitation benefit. Up to 10% of the principal sum to a maximum of $10,000 for physical or rehabilitative treatment if you have suffered a

covered loss. Subject to review by the insurance company, expenses must be:

- Incurred within two years after the accident;
- Essential for physical rehabilitative training due to the injury for which it is prescribed or performed; and
- Performed under the care, supervision or order of a physician.

Rehabilitation benefits are not payable for treatments covered by workers' compensation or similar law.

LOSSES 100 MILES FROM HOME

As follows, special plan provisions may apply if you or accompanying family members have certain covered losses while traveling 100 miles or more away from home on a business trip.

For these special provisions, AIG must authorize all arrangements and expenses in advance. If it's not reasonably possible to obtain pre-authorization, the insurance company has the right to determine what if any costs qualify for payment.

Medical emergency evacuation. If medically necessary as certified by a physician, and warranted by the severity of the injury or emergency sickness, the plan will pay for the following:

- The cost of an emergency evacuation.
- Reasonable costs of returning any accompanying children home, including transportation and associated expenses.
- Reasonable costs for bringing one person to and from the hospital when the individual is confined more than 100 miles from home.

Repatriation of remains. If a covered person dies, the plan will pay reasonable costs for returning the body home. This includes embalming or cremation and the most economical receptacle for transportation of the remains.

REDUCTION OF BENEFITS DUE TO AGE

As follows, BTA pays reduced benefits for you and your spouse/life partner age 70 or older:

IF THE PARTICIPANT IS THIS AGE	PLAN PAYS THIS % OF BENEFITS
70 – 74	65%
75 – 79	45%
80 – 84	30%
85 and older	15%

AIG TRAVEL ASSIST℠ SERVICES

Whenever you travel more than 100 miles away from home on business, AIG Travel Assist℠ Services can help with practically any aspect of your trip.

- Before you depart, you can call for information about where you're going, including recommended or required immunizations, availability of special health services, exchange rates, and even where to locate ATMs.
- During your trip, you can contact AIG Travel Assist, 24 hours a day, 365 days a year for:
  - Traveler's Assistance – help with losses and delays, replacing lost documents, filing claims, emergency message services.
  - Medical Emergency Services – referrals to local providers and hospitals, medical case monitoring, help arranging medical transportation, emergency message service.
  - Legal Assistance Services – contacts for non-criminal legal emergencies, referrals to local English speaking attorneys, help locating a U.S. consulate.

AIG Travel Assist℠

US and Canada: 1-877-244-6871 (toll free)

Outside US and Canada: 0+1-715-346-0859 (collect)

FILING A CLAIM

To receive benefits from the BTA Plan, the claim form must be completed and submitted as soon as possible to the Employee Service Center. An Employee Service Center representative will send the completed claim form to the insurance company.

IF YOUR CLAIM IS DENIED

If your claim is denied, in whole or in part, please follow the claims procedures described in the *Claims and Appeals* section, beginning on page 101.

WHEN BTA COVERAGE ENDS

BTA coverage under the Benefits Plan ends for plan participants, including employees and enrolled family members, as described in *When Plan Coverage Ends*, starting on page 19. In addition, if earlier, your coverage will end on the following dates:

- You're eligible for coverage under a plan intended to replace this coverage;
- The insurance company terminates the policy; or
- REI cancels participation under the policy.

BTA benefits are not portable which means after your group coverage ends, you cannot buy an individual policy.

BTA EXCLUSIONS

In addition to all the other limitations discussed throughout this section of the SPD, here are some further limitations of the BTA Plan. Be sure to call the Employee Service Center if you have any questions.

The plan does not pay benefits on losses due to any of the following:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury or auto-eroticism.
- Sickness or disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.
- Declared or undeclared war or any act of declared or undeclared war.
- Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Loss caused while on short term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)
- Committing or attempting to commit a felony.
- Injury resulting from riding as a passenger or otherwise in any of the following:
  - Aerial navigation used in connection with acrobatic or stunt flying, racing, speed or endurance tests, crop dusting, seeding or spraying, firefighting, exploration, pipe or power line inspections, any form of hunting, aerial photography, banner towing, tests or experimental purposes;
  - Rocket propelled aircraft;
  - Aircraft requiring special permit or waiver from the authority having jurisdiction over civil aviation;
  - Aircraft owned or operated by REI or a fellow employee, employee's family or member of an employee's household; or
  - As a pilot or member of the crew of any aircraft.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Need Help?

Call the EAP 24 hours a day, 7 days a week. Call REI Health Guide at 1-800-451-2967.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

If you're like most people, chances are you face important personal issues from time to time. When you do, the Employee Assistance Program (EAP) is there to help.

The EAP is available to you and any eligible member of your household. REI provides this valuable benefit in full, at no cost to you for unlimited telephone consultation and up to eight face-to-face or video visits. You do not need to enroll to use the EAP.

How the EAP Works

The EAP is ready to provide solution-focused, confidential consultations and counseling for all types of personal issues including: childbirth, child care, parenting, balancing work and life, diversity issues, relationship concerns, illness/disability and issues related to sick or aging parents.

When you call, a professional staff member determines your primary issue and transfers you to the counselor with expertise to meet your need. The counselor will provide you with consultation, educational materials and, if appropriate, referrals to community resources specific to your request.

Confidentiality Policy

Protecting your privacy is our top priority — that's why all records including personal information, referrals and evaluations are kept confidential in accordance with federal and state laws.

Covered Services

This is a summary of services available from the EAP at no cost to you. To get started or for more information, call REI Health Guide at 1-800-451-2967.

- Telephone consultations with EAP specialists to connect you with resources for issues regarding family, marriage, stress, finances and bereavement.
- Up to eight face-to-face or video consultations per issue per year for you and each family member.
- Referrals for assistance with chronic medical conditions.
- Child care and eldercare referrals.
- Child/parenting support services.
- Educational resources for all ages and abilities, including help with locating and evaluating schools, finding classes for special needs children, and arranging tutoring services.
- Life learning services for your children, such as resources for alternative education, tutors, early intervention programs, college search and adult education.
- Convenience Services – need a plumber? Looking for someone to service your car? Maybe you need a pet-sitter or help relocating? Want to find a rental for that ocean or mountain family getaway? Save time by letting the EAP find the information for you.
- Financial services – consultations with certified financial planners on debt management, taxes, investing and other related topics.
- Legal assistance – advice for landlord/tenant issues, personal injury, bankruptcy and other concerns. Family mediation services are also available.

If you need additional assistance, the EAP will coordinate your EAP and mental health and chemical dependency benefits. This means that if you're using the EAP and need ongoing behavioral health services, the EAP will take care of the transition to make it easy for you. This way, you won't need to find an EAP provider that is also covered under your medical plan.

COMMUTER PLAN

Although the Commuter Plan is described in this SPD, the Commuter Plan is not part of the Plan and is not subject to the Employee Retirement Income Security Act (ERISA). REI encourages the use of public transportation to reduce our carbon footprint. You can use the Commuter Plan, Pre-tax Transit Benefit to pay for work-related transit or parking expenses. REI covers 100% of the pre-tax cost for your public transit expenses (bus, train, vanpool, vanshare, ferry and trolley) when you enroll in the program. REI does not subsidize the cost of parking expenses.

How the Commuter Plan Works

The Commuter Plan is available to all REI employees. You can enroll at any time; however, there are monthly cutoff dates for placing an order. You can have either a transit or a parking account, or both. Transit covers public transportation including bus, train, vanpool, vanshare, ferry and trolley.

Parking benefits are not subsidized, but election can be made on a pre-tax basis up to the IRS limit. Parking elections must be used for parking at or near your REI work location. Visit **www.healthequity.com** to set up your account.

- Your transit pass or parking fees are deducted on a pre-tax basis from your paycheck once each month before federal income, Social Security or, in most states, state income taxes are withheld. The money is deposited directly into an account under your name with HealthEquity. By contributing to the plan, you reduce your taxable income, which can result in a lower tax bill for you.
- REI covers 100% of the pre-tax cost for your public transit expenses (bus, train, vanpool, vanshare and ferry) when you enroll in the plan.
- Once you place your order, a transit pass will be mailed to your home before the month in which it is valid.
- You can choose to have your parking expenses paid directly to the parking facility or be reimbursed for your parking expenses.
- There are monthly cutoff dates for placing an order, making a change or cancelling your account.
- There are no claim forms to submit and you do not have to report anything on your taxes.

Your Contributions

There is a limit to how much you can save through this program. IRS rules that govern the program allow a tax-free maximum per month for transit expenses and for parking expenses. Visit **www.irs.gov** for annual pre-tax limits. You can sign up, make changes, or stop participating in the program whenever you choose. For more information, contact a HealthEquity Commuter Benefits expert at 1-877-924-3967.

Eligible Expenses

The IRS specifies what transportation costs may or may not be eligible through the Commuter Plan. If you have any questions about what's eligible, please visit **www.healthequity.com** or contact a HealthEquity Commuter Benefits expert at 1-877-924-3967.

Examples of eligible work-related expenses include:

- Mass transit fares, including tickets, passes, tokens, vouchers or other fares for riding buses, trains, light rail, regional rail, streetcars, trolleys, subways or ferries.
- Vanpool (carrying six or more adult passengers excluding the driver).
- Parking fees at or near your work.
- Parking at or near public transportation to get to work.

Examples of expenses that are not eligible:

- Tolls.
- Traffic tickets.
- Fuel, mileage or other costs you incur to operate a vehicle.
- Taxis and limousines.
- Payments to fellow participants in a carpool or a friend who drives you to work.
- Parking at your residence, your spouse's work place or a mall or other location where you stop on your drive to or from work.

- Parking at an airport when travelling on business.
- Costs that have been or will be paid by REI, such as for a business trip.

To Enroll or If You Have Questions

Visit **www.healthequity.com** or call a Commuter Benefits expert at 1-877-924-3967.

MORE INFORMATION ABOUT HEALTH CARE PLANS

COORDINATION OF BENEFITS

If you or enrolled family members are covered by another group medical or dental or vision plan, your REI plan has a Coordination of Benefits (COB) provision that determines which plan pays benefits first and which pays second. Medical benefits are coordinated by Aetna, dental benefits are coordinated by Delta Dental and vision benefits are coordinated by VSP. COB does not apply to the Prescription Drug benefits. To the extent that any of these benefits has separate COB provisions in the applicable benefit booklet or certificate of insurance, the COB provisions of the applicable benefit booklet or certificate of insurance will govern.

With COB, if your provider or hospital group submits the claims on your behalf, the claims will be submitted to your plans at the same time. If you are responsible for submitting the claims, first you file a claim with your primary plan, which will pay usual benefits as if no other plans were involved. After the primary plan has paid benefits, you submit the claim to your secondary plan. That plan will pay its usual benefits, but only to the extent that the total combined payment from both plans does not exceed 100% of the covered charge.

These are some of the general Coordination of Benefits rules for determining the order of payment:

- Plans that do not have a COB provision pay before plans that have a COB provision.
- Plans that cover an individual as an employee pay before plans that cover that person as a dependent.
- If the other plan, which covers the person, is provided under COBRA or a right of continuation specified by federal or state law, the plan covering the person as an employee (or an employee's dependent) is primary and the continuation coverage is secondary.
- If the other plan is Medicare, the REI plan is primary except as permitted under federal law.
- For eligible children whose parents are not separated or divorced: The plan that covers the parent whose birthday is earlier in the year pays first. For example, if your birthday were May 15 and your spouse's October 8, your plan would be primary. If you and your spouse have the same birthday, then the plan that covered either of the parents longer will pay benefits first.
- For eligible children when parents are separated or divorced.
  - If a court decrees (i.e., Qualified Medical Child Support Order (QMCSO)) one parent must pay for the child's health expenses or provide health care coverage, that parent's plan will pay first.
  - If there's no court decree, then the primary plan will be determined in this order: The plan of the custodial parent, the plan of the spouse of the custodial parent, the plan of the non-custodial parent, and finally, the plan of the spouse of the non-custodial parent.

When none of the other COB rules apply, the plan that has covered the person for the longest will pay benefits first.

This plan always pays secondary to:

- Any medical payment, PIP or no-fault coverage under any automobile policy available to you.
- Any plan or program that is required by law.

All covered persons should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

Depending on your personal situation, coordination of benefit issues can sometimes get complicated. If you have any questions about how COB may work in your case, feel free to contact Aetna member services for assistance for medical claims, Delta Dental for dental claims or VSP for vision claims.

When You Have Medicare Coverage

This section explains how your medical benefits interact with benefits available under Medicare.

Medicare, when used in this Booklet, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare if you are covered under it by reason of age or disability, or if you have end stage renal disease.

If you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, the plan is the primary payer, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payer and pays benefits after Medicare.

Which Plan Pays First

The REI plan is the primary payer when your coverage for the plan's benefits is based on current employment with REI as an eligible employee or a dependent of an eligible employee. Coverage for most Plan participants is based on current employment. The REI plan will act as the primary payer for the REI Plan participant who is a Medicare beneficiary if:

- The participant is eligible for Medicare solely due to age.
- The participant is eligible for Medicare due to a diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the plan's benefits were payable on a secondary basis.
- The participant is eligible for Medicare solely due to any disability other than end stage renal disease.

The REI plan is the secondary payer in all other circumstances.

How Coordination with Medicare Works

When the REI plan is primary, it pays benefits first. You may then submit your claim to Medicare for consideration. When Medicare is primary, your health care expense must be considered for payment by Medicare first. You may then submit the expense to the REI health plan for consideration. The REI health plan will calculate the benefits the plan would pay in the absence of Medicare. The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total allowable expense. This review is done on a claim-by-claim basis. Charges used to satisfy your Part B deductible under Medicare will be applied under the plan in the order received by this Plan. This Plan will apply the largest charge first when two or more charges are received at the same time. This Plan will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under this plan and other plans. The Plan and its Claims Administrators have the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Plan participants and the parents, guardians, or other representatives of a dependent child who incurs claims and is or has been covered by one of the REI Medical Plans, other than the available HMOs (which have their own subrogation provisions). The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult covered person may assign any rights that such person may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extends to all insurance coverage and to any other source available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Definitions

As used throughout this *Subrogation and Right of Recovery* provision of the SPD, the following terms have the following meanings:

Responsible party means any party actually, possibly, or potentially responsible for making any payment to or on behalf of a Plan participant or beneficiary due to a Plan participant's or beneficiary's injury, illness or condition. The term "responsible party" includes the liability insurer of such party or any insurance coverage.

Insurance coverage refers to any coverage providing health or disability coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, health and disability payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

Covered person includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the employee, spouse, life partner, minor child or dependent of any Plan participant or person entitled to receive any benefits from the Plan.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, whether or not such payment is designated to reimburse or pay medical costs, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting Plan benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds and hold these funds in trust for the Plan's benefit until the Plan's subrogation rights have been fully satisfied. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery, whether by settlement, judgment or otherwise, related to the illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your

representative or agent, and/or any other source that possessed or will possess the funds.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have, including those under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first-priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery that is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorneys fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits for which the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within five days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Plan's Claims Administrator or its representative, including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You should do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act (HIPAA), 42 U.S.C. Section 1301 et seq., to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator and/or the Claims Administrator for the Plan shall have the sole authority and

discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

ASSIGNMENT OF BENEFITS

Benefits payable by the REI medical, dental and vision plans are not subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by a person.

Notwithstanding the foregoing, the Plan recognizes an assignment of benefits by an employee or dependent to a physician, hospital or other person or institution that has treated or cared for or provided services or goods to the employee or dependent and also recognizes a Qualified Medical Child Support Order (QMCSO) under ERISA.

COBRA CONTINUATION OF COVERAGE

Many of the deadlines set forth in this section, if they occurred between March 1, 2020 and July 10, 2023, are delayed for up to one year due to the COVID pandemic. Please see *Appendix A* for additional details on the delay in these deadlines.

Introduction

This section of the SPD has important information about your right to COBRA continuation coverage, which is a temporary extension of health coverage under the Benefit Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your rights to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

COBRA continuation coverage is available under the following Benefit Plan components in which you are enrolled on the day you would otherwise lose this coverage due to a qualified life event: the REI Saver and Custom Saver Medical plan, the REI Choice and Custom Choice Medical plan, the Kaiser medical plan options (for Colorado, Washington and California residents), the Health Care Flexible Spending Account plan and the Limited-Use Health Care Flexible Spending Account plan, the Dental Plan, and the Vision Care Plan. If you elect COBRA continuation under any of these benefits, your coverage under the Employee Assistance Program, and the Quit for Life program will also continue automatically. COBRA continuation coverage is not available for the Dependent Care Flexible Spending Account Plan, Life Insurance coverage, Disability Insurance coverage, commuter benefits, or any other benefits not specifically listed above.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end due to certain qualified life events.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of group health plan coverage when it would otherwise end because of a life event. This is also called a "qualified life event." Specific qualified life events are listed later in this section. After a qualified life event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse/life partner and your dependent children could become qualified beneficiaries if health plan coverage is lost because of the qualified life event. Most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your health coverage under the because of the following qualified life events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct. If you decide not to return to employment at REI during FMLA leave, you will be offered COBRA continuation coverage at the earlier of the date your FMLA leave ends or the date you tell REI that you will not return to work after the FMLA leave.

If you're the spouse/life partner of an employee, you'll become a qualified beneficiary if you lose your health coverage under the Plan because of the following qualified life events:

- Your spouse/life partner dies;
- Your spouse/life partner's hours of employment are reduced;
- Your spouse/life partner's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse or your relationship with your life partner terminates.

Your dependent children will become qualified beneficiaries if they lose health coverage under the Plan because of the following qualified life events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Benefit Plan as a "dependent child."

COBRA continuation coverage may be elected for the remainder of the employee's own continuation coverage for any dependent child born to, placed for adoption with or adopted by an employee or former employee during the period of COBRA continuation coverage.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualified life event has occurred. REI will notify the Plan Administrator of the following qualified life events:

- The end of employment or reduction of hours of employment; or
- Death of the employee.

For all other qualified life events (divorce of the employee and spouse; dissolution of a life partnership or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualified life event occurs. You must provide this notice to one of the following:

- In writing: Employee Service Center, 1700 45th Street East, Suite 101, Sumner, WA 98352
- Telephone: 1-800-999-4734
- Email: hrhr@rei.com
- Online: wexinc.com/login

If you fail to provide this notice, you will lose the rights you would otherwise have had to COBRA continuation coverage.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED AND HOW LONG DOES IT LAST?

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

When the qualified life event is the death of the employee, divorce, termination of a life partnership, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. COBRA continuation coverage generally lasts for 18 months due to employment termination or reduction of hours of work. This 18-month period of COBRA continuation coverage can be extended in a number of ways, as summarized below.

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under COBRA continuation coverage is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your other family members on COBRA continuation coverage may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability must start at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

To be eligible for the extension, the Plan Administrator must be provided with a copy of the Social Security Administration (SSA) disability determination within 60 days of the date of the SSA determination and within the initial 18-month COBRA continuation period. If you fail to provide this notice, you will lose the rights you would otherwise have had to the 11-month extension of COBRA continuation coverage.

Second qualified life event extension of 18-month period of continuation coverage
If your family experiences another qualified life event during the 18 months of COBRA continuation coverage, the spouse/life partner and dependent children in your family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second qualified life event. This extension may be available to the spouse/life partner and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Benefit Plan as a dependent child. This extension is only available if the second qualified life event would have caused the spouse/life partner or dependent child to lose coverage under the Benefit Plan had the first qualified life event not occurred.

As described above, to be eligible for this extension, you or your family members must notify the Employee Service Center at 1-800-999-4734 or at **hrhr@rei.com** within 60 days of the date of the death, divorce, termination of life partnership or loss of dependent eligibility. If you fail to provide this notice, you will lose the rights you would otherwise have had to the additional 18 months of COBRA continuation coverage.

COBRA and Medicare

When coverage is lost due to termination of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare less than 18 months before the termination or reduction of hours, COBRA continuation coverage for the qualified beneficiaries (other than the employee) who lose coverage as a result of the employee's qualified life event can last up to 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the COBRA qualified life event (36 months minus 8 months).

COBRA and Long Term Disability (LTD)

If you are approved for LTD, you may continue coverage for you and your covered dependents for a maximum of 24 months or until you are no longer considered disabled, whichever is earlier. Coverage will continue even if you become entitled to Medicare after your COBRA qualified life event date. Your coverage will continue on an REI-subsidized basis and your monthly premium will be equivalent to an active employee's premium. The REI-subsidized coverage runs concurrently with your COBRA continuation coverage period. After 24 months, you may no longer have COBRA continuation coverage rights, but if you do retain COBRA rights you will be notified of them. In no event will your entire continuation coverage period extend beyond a total of 29 months.

COBRA and the Health Care Flexible Spending Account Plans

There are special COBRA rules for the Health Care Flexible Spending Account Plan and the Limited-Use Health Care Flexible Spending Account Plan. You are only eligible for COBRA continuation coverage from these plans if your account is "underspent" at the time of the qualified life event: in other words, you have contributed more to the

plan than you have received in benefits from the plan. You are also only eligible for COBRA continuation coverage until the end of the Plan Year in which your qualified life event occurred, except you will be allowed to spend down any carryover amount remaining at the end of the Plan Year until the normal COBRA continuation period (for example, 18 or 36 months) has expired.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Benefit Plan ends because of one of the qualified life events listed above. You will also have the same special enrollment right at the end of the COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

You and your family members should consider health coverage alternatives that may be available through the Health Insurance Marketplace. Some of these alternatives may cost less than COBRA continuation coverage. In the Marketplace, individuals may be eligible, depending upon household income and other factors, for a tax credit that lowers monthly premiums right away. At the Marketplace, premiums, deductibles and out-of-pocket costs can be seen before a decision is made to enroll in any available insurance. Being eligible for COBRA generally does not limit eligibility for a tax credit through the Marketplace; however, if you elect COBRA continuation coverage, you may not qualify for the tax credit until you have exhausted your COBRA continuation coverage. For more information about health insurance options available through the Health Insurance Marketplace, visit healthcare.gov.

You have a special enrollment period to purchase individual health insurance on the Marketplace if you enroll within 60 days after your group health coverage under the Benefit Plan ends, or if you elect COBRA, within 60 days after your COBRA coverage ends. If you enroll during this special enrollment period, you do not have to wait until the next open enrollment period at the Marketplace. However, you do not have special enrollment rights at the Marketplace if your loss of coverage under the Benefit Plan or under COBRA is due to your failure to pay the required premiums for the coverage. Please note that if you enroll in another group health plan (such as a plan sponsored by your spouse's employer) or in an individual policy at the Marketplace during the special enrollment periods described above, there may be a gap in coverage between the date your coverage ends under the Benefit Plan and the date your new coverage begins.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

If you are eligible for Medicare when you lose group health plan coverage under the Benefit Plans, you should consider enrolling in Medicare rather than electing COBRA continuation coverage. Medicare coverage may be less expensive than COBRA continuation coverage. If you didn't enroll in Medicare Part A or B when you first became eligible (for example, when you turned age 65) because you were still employed and participating in the Benefit Plan, when you lose coverage under these Benefit Plans you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of:

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

- The month after your employment ends; or
- The month after your health coverage under the Benefit Plans ends.

If you enroll during this 8-month special enrollment period, you will not have to pay a Medicare Part B late enrollment penalty. If you don't enroll in Medicare during this 8-month special enrollment period and elect COBRA continuation coverage instead, once you enroll in Medicare Part B you will have to pay a Medicare Part B late enrollment penalty for as long as you continue to be enrolled in Medicare Part B and you may have a gap in coverage between when COBRA coverage ends and Medicare coverage begins. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, this Plan may terminate your COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date you elect COBRA, COBRA continuation coverage may not be discontinued on account of Medicare coverage, even if you enroll in another part of Medicare after the date of the election of COBRA coverage.

Most persons will not want to have both COBRA continuation coverage and Medicare at the same time because of the coordination rules that apply to Medicare coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. You may find that purchasing Medicare supplements is a better value than paying for COBRA continuation coverage that pays second to Medicare. For more information, visit medicare.gov/medicare-and-you.

HOW DO I APPLY AND PAY FOR COBRA CONTINUATION COVERAGE?

You must follow the steps below to apply and pay for COBRA continuation coverage.

- A COBRA Enrollment Form will be mailed to the address listed on your employment record.
- Complete the form and return it to the address on the form within 60 days of the later of (a) the date you are notified of the right to choose COBRA coverage; or (b) the date coverage would otherwise end. IF YOU DO NOT SUBMIT A COMPLETE FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA CONTINUATION COVERAGE.
- Send a check or money order for the required premium for the appropriate month to the address on the enrollment form. The envelope must be postmarked within 45 days from the date COBRA is elected.
- You will receive premium coupons, which will state the date on which each premium payment is due. Mail subsequent premium payments by the due date on each premium coupon to the address listed on the premium coupon.

WHEN WILL COBRA CONTINUATION COVERAGE END?

Your continuation coverage will end upon the first occurrence of any of the following events:

- The end of the 18, 29 or 36-month maximum coverage period;
- The required premium payment is not paid on time;
- REI terminates all group health plans for all employees;
- If continuation coverage is extended to 29 months due to disability, and the SSA makes a final determination that the individual is no longer disabled, coverage for all qualified beneficiaries will terminate the first of the month beginning more than 30 days after the SSA determination, or, if later at the end of the original 18-month continuation period;
- The individual receiving continuation coverage becomes covered, after the date of the COBRA election, by Medicare or under another group health plan not maintained by REI.

If you have elected COBRA, you must notify the Plan Administrator in writing at the address below if you become entitled to Medicare or become covered under another group health plan within 30 days of such entitlement or coverage.

Once continuation coverage is terminated or cancelled, it cannot be reinstated.

HOW MUCH DOES COBRA COVERAGE COST?

You pay the full premium cost of COBRA coverage, plus a 2% administrative fee, as permitted by law.

If You Have Questions

Questions concerning your Benefit Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act 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 dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit healthcare.gov.

Keep REI Informed of Address Changes

To protect your family's rights, let REI know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to REI.

You can contact REI for this purpose in the following manner:

- In writing: Employee Service Center, 1700 45th Street East, Suite 101, Sumner, WA 98352
- Telephone: 1-800-999-4734
- Email: hrhr@rei.com
- Online: wexinc.com/login

USERRA CONTINUATION COVERAGE: EMPLOYEES ON MILITARY LEAVE

This section sets forth the Plan's provisions concerning continuation of coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Employees going into qualifying military service may elect to continue group health plan coverage under the Plan as mandated by USERRA under the following circumstances. These rights apply only to an you and your family members covered under the group health plan benefits of the Plan immediately before you leave for military service.

The maximum period of USERRA coverage under such an election shall be the lesser of:

- The 24-month period beginning on the date on which your absence from work begins; or
- The day after the date on you were required to apply for or return to a position of employment and failed to do so.

USERRA coverage during these time periods will cease for the remainder of the coverage period if you fail to make the required contributions as discussed below.

USERRA also grants certain rights to you and your eligible dependents upon the Employee's return to employment after military leave. A waiting period will not be imposed in connection with the restatement of coverage upon reemployment.

Employees going on military leave desiring USERRA continuation coverage of group health plan coverage must elect USERRA continuation coverage. This election must be in writing on a form provided by the Plan and must be completed and returned to the REI within 60 days of the beginning of the leave, except as provided below concerning leaves in which an Employee is excused from giving advance notice of the leave.

The election form must be sent to:
Employee Service Center
1700 45th Street East, Suite 101
Sumner, WA 98352

If such an election is not received within such time period, you will lose any rights you and your family members have to USERRA continuation coverage.

Your covered family members do not have the right to USERRA continuation coverage unless you elect USERRA continuation for yourself.

Payments for USERRA coverage are due on a monthly basis and must be received by the end of the month. For example, coverage for the month of March must be received by the Plan by March 31.

You pay the full premium cost of USERRA coverage, plus a 2% administrative fee, except that the contribution for the first 31 days will be you're your regular contribution. The first payment is due no later than the last day of the month in which REI received the written election to obtain USERRA continuation coverage and must cover the month or months since your absence from work began through the month in which the election was received by REI. If full payment is not received by the due date, the USERRA continuation coverage will cease retroactively effective as of the last day of the month for which a payment was received on a timely basis.

In most instances, employees are required by USERRA to give advance notice to REI of the impending military leave. However, in certain situations under USERRA, you are excused from giving advance notice to REI of the military service because the giving of advance notice is impossible, unreasonable or precluded by military necessity. In these cases, you may elect USERRA continuation coverage by notifying REI of such election in writing within 30 days of the date that giving notice is possible, reasonable or no longer precluded by military necessity. This election must be accompanied by the following: (1) a statement of the reason(s) why you were unable to give advance notice; and (2) payment in full for the unpaid contribution amounts due for each month of coverage beginning as of the date you were first absent from work due to the USERRA leave up to the contribution amount due for the month of such election. However, if you make such election after the maximum time period for USERRA coverage has elapsed, coverage shall be only for such maximum time period and the payment must be for the entire time period. If a timely election form is filed in accordance with this paragraph, your coverage will be retroactively reinstated to the date you were first absent from work and shall continue for a period of time up to the maximum time period described above.

All notices, election forms, payments and other documents required to be provided to the Plan must be in writing and sent to the following address:
Employee Service Center
1700 45th Street East, Suite 101
Sumner, WA 98352

In many instances, employees eligible for continuation coverage under USERRA will also be eligible for continuation coverage under COBRA. To the extent allowed by law, the continuation periods under COBRA and USERRA will run concurrently (at the same time).

USERRA continuation coverage rights apply only to employees covered under group health plan benefits of the Plan, who may elect USERRA coverage for themselves and their family members. The following persons do not have USERRA continuation coverage rights:

- Your family members if you do not elect USERRA continuation coverage for yourself.
- Your family members who go into military service.

However, family members may have independent rights to elect COBRA continuation coverage and rights under other federal laws. Please see *COBRA Continuation Coverage* for more information on COBRA continuation coverage.

FINE PRINT AND ADDITIONAL RESOURCES

FEDERAL NOTICES

Federal law requires that REI provide certain notices to Plan participants regarding the benefits provided by this Plan. The following Notices, which can be found at **foryourbenefit-rei.com**, are incorporated by reference into this SPD.

1. REI Initial COBRA Notice
2. REI HIPAA Special Enrollment Rights Notice
3. REI Medicare Part D Notice of Creditable Coverage
4. REI Newborns' and Mothers' Health Protection Act Notice
5. REI Patient Protection Notice
6. REI Women's Health and Cancer Rights Act Notice
7. REI No Surprises Act Notice
8. REI Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Notice
9. REI ACA Marketplace Notice

BENEFITS COMMITTEE

Responsibility for the general administration of the REI Benefit Plan ("Plan") and for carrying out the provisions of the Plan has been placed with the Benefits Committee, which is a committee of three or more members, each of whom is an employee of REI and each of whom has been appointed by the Chief Executive Officer of REI (or the Chief Executive Officer's delegate). The Plan provides that the Benefits Committee has all powers necessary for the administration of the Plan and is the "Plan Administrator." The Benefits Committee may designate any person, partnership or corporation to carry out any of its responsibilities under the Plan. The Benefits Committee has delegated day-to-day ministerial administration of the Plan under administrative services contracts and insurance contracts and has delegated to the Appeals Committee the right and authority to hear certain types of appeals. For more information on the Appeals Committee, please see *Voluntary Appeal to the Appeals Committee* on page 108.

PLAN DOCUMENTS CONTROL

This summary is known as a Summary *Plan Description (SPD),* as explained in ***About This Summary Plan Description.*** This SPD together with the Plan and/or a Component Plan form the official Plan document. All of the Plan documents are available from the Employee Service Center or **www.foryourbenefit-rei.com**. The statements in this SPD are intended to be read as a whole. You should not rely on a statement or explanations taken out of context. Subsequent changes to the Plan, Component Plan(s) and the SPD may be communicated in written materials such as newsletters, postings or flyers.

In the event of any inconsistency between this SPD or any other communication regarding the Plan and the Plan documents, the Plan section entitled Plan Interpretation shall control in all cases. The Benefits Committee has the sole and exclusive authority to interpret the Plan documents, except to the extent it has delegated that authority.

FUTURE OF THE PLAN

REI has established the Plan for the exclusive benefit of plan participants, including eligible employees and their eligible family members. No Plan amendment or termination will be made which would cause or permit benefits to be provided other than the exclusive benefit for these individuals, unless required to comply with federal or local law.

Although REI intends to continue the Plan indefinitely, the Company reserves the right to alter, amend, delete, cancel or otherwise change these plans, any provisions of the plans or any Component Plans at any time. Any amendment to the Plan and the Cafeteria Plan will be made in writing by a duly authorized officer of REI. Also, the Plan may automatically end if REI were to go out of business.

If the Plan or a plan benefit is terminated, coverage for enrolled employees and family members will end — but eligible benefits would be paid for any covered expenses incurred before the termination.

PROTECTION OF BENEFITS

Unless specifically stated, benefits under the REI Plan cannot be assigned, sold, transferred, encumbered or used to secure debts. Benefits cannot be subject to attachment, garnishment, or any other legal process.

The plans, however, do allow for the enforcement of a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO). See the *Glossary* for a definition of these terms. Contact the Employee Service Center for a detailed explanation of REI's QDRO and QMCSO procedures. These procedures are available at no charge to you.

Information to Be Furnished

You are required to sign documents and to provide REI, the Plan Administrator, and the Claims Administrators with information and evidence as may reasonably be requested from time to time for the purpose of administration of the Plan.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor REI makes any representation, commitment, or guarantee that any amounts paid to or for the benefit of you will be excludable from your gross income for federal or state tax purposes, or that any other federal or state tax treatment will apply to or be available to any person participating in the Plan. It is your obligation to determine whether payments from the Plan are excludable from your gross income for federal and state tax purposes and to notify REI if you have reason to believe that any such payment is not excludable.

Refunds

If it is determined that a payment or overpayment of benefits to which you were not entitled has been paid by the Plan, the Plan may deduct the amount of such payment or overpayment from future payments of claims otherwise payable under the Plan to you. If the Plan for any reason is not able to make such a deduction, you agree, upon demand, to repay such payment or overpayment to the Plan. Participants not complying with this section may, in the discretion of REI, lose eligibility to participate in the Plan.

Non-Discrimination Rules

The Plan and benefits provided under the Plan comply with all applicable nondiscrimination rules under the Internal Revenue Code and other applicable law. The Plan Administrator has the power and discretion to take whatever corrective action is necessary to ensure compliance with such rules, such as making unilateral reduction or elimination of benefits and contributions by highly-compensated, key, or any other employees of REI.

Facility of Payment

In the event any benefit under the Plan is payable to a person who is incapacitated or under other legal disability so as to be unable to manage the person's financial affairs, the Plan Administrator may direct payment of the benefit to a duly appointed guardian or other legal representative of such person. In the absence of a guardian or legal representative, the Plan Administrator may direct payment to a custodian for such person under the Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. Any payment made in good faith pursuant to this provision shall fully discharge REI, the Plan, the Plan Administrator, the Claims Administrators, and any Benefit of any liability for such payment in the amount of such payment.

Severability

If any provision of this document is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of the Plan, which shall be construed as if the illegal or invalid provision had never been included.

Legal Actions

Unless otherwise specifically provided by law, no action at law or in equity may be brought to recover under this Plan unless brought within three years after the date of the claim for benefits is made.

Conclusiveness of Records

The records of REI with respect to age, continuous service, employment history, compensation, absences, illnesses, and all other relevant matters shall be conclusive for purposes of the administration of, and the resolution of claims arising under, the Plan to the extent permitted by law.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, when requested.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you 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.

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator,

you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PRIVACY

The Plan is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing privacy rules to maintain the privacy of your "protected health information." These privacy requirements apply to all group health benefits, referred to as "HIPAA Benefits."

"Protected health information" is information that identifies you and that relates to your physical or mental health. The Plan has provided you with a Notice of Privacy Practices ("Notice") summarizing the Plan's responsibilities and your rights concerning your protected health information. Although this Notice is not part of the Plan or this SPD, it is available at **www.foryourbenefit-REI.com** or by contacting the Employee Service Center at **hrhr@rei.com** or 1-800-999-4734.

CLAIMS AND APPEALS

NOTICE: Some of the deadlines described below in the Claims and Appeals sections of this SPD, if they occurred between March 1, 2020 and July 10, 2023, are delayed for up to one year due to the COVID pandemic. Please see *Appendix A* for additional details on the delay in these deadlines.

The Benefits Committee or its delegate has the authority to interpret Plan provisions and render claim decisions based on their interpretation, unless the interpretation relates to an insured benefit offered under the Plan. For insured benefits offered under the Plan, the Benefits Committee has delegated to HMOs or insurance carriers ("Insurers") the sole authority to interpret the terms of the insured benefit. For non-insured benefits offered under the Plan, the Benefits Committee has delegated to the third-party administrators the right and duty to make final claims determinations in most instances and in certain instances, delegated authority to the Appeals Committee. For more information on the authority of the Appeals Committee, please see *Voluntary Appeal to the Appeals Committee* on page 108.

Interpretation of all other Plan provisions includes but is not limited to determining factual and legal questions under the Plan, interpreting and administering the terms and conditions of the Plan, deciding all questions concerning the eligibility of any person to participate in the Plan, granting or denying benefits, construing any ambiguous provision of the Plan, correcting any defect, supplying any omission, or reconciling any inconsistency, as the Benefits Committee or its delegate, in its discretion, may determine.

Any person who believes that they are entitled to any non-insured benefit or right provided under the Plan has the right to file a written claim with a "claims administrator." A claims administrator is any person or entity who is authorized by the Benefits Committee to determine claims for benefits under the Plan, including someone on REI's Human Resources staff, the Appeals Committee, or other appropriate staff to decide claims.

Claims and Appeals Procedures for Non-Insured Benefits

The claims and appeals procedures for non-insured benefits, other than the HMOs, are provided, beginning with the *Health Care Claims Procedures* section below. These are claims for medical, dental, vision, prescription drug, behavioral health, short term disability, salary continuation, and Flexible Spending Accounts.

Claims and Appeals for Insured Benefits and the HMOs

For each insured benefit offered under the Plan, the insurer has the sole authority, discretion and responsibility to interpret the terms of the benefit. Interpretation of the insured benefit includes but is not limited to determining factual and legal questions, interpreting and administering the terms and conditions of the insured benefit and granting or denying the insured benefit, correcting any defect, supplying any omission, or reconciling

any inconsistency as the insurer, in its discretion, may determine.

If you are enrolled in an HMO, or have life, accidental death & dismemberment, business travel accident or long term disability coverage, you must follow the claims and appeals procedures outlined in the certificates of coverage that you receive from the Insurer or Kaiser (for the HMOs). The claims procedures for these benefits, are, however, provided below for your convenience. Any person who believes they are entitled payment of an insured benefit should look solely to the applicable insurance policy or contract, and not to the Company or the Trust for payment of such insured benefits.

The names and addresses of Insurers can be found in the *Plan Contacts* section.

If your claim for a benefit under the REI Benefits Plan is denied, you will receive a written notice of the claim decision within the time limits described in this section. The time limits are based on Federal laws, the type of claim, and whether or not the claims administrator has all of the information needed to process the claim. You must follow the Plan's mandatory claims procedures below. If your claim denial is upheld on appeal, you may be able to submit a final voluntary appeal to the Appeals Committee in certain limited situations. For more information, please see *Voluntary Appeal to the Appeals Committee* on page 108.

HEALTH CARE CLAIM PROCEDURES

Your claim for medical, dental, vision, prescription drug, behavioral health, short term disability, salary continuation and Health Care FSA will fall into one of these four categories:

1. Preservice claim: a request for coverage of health care benefits for which the terms of this Plan require you to obtain prior approval before receiving treatment or services, such as benefits requiring pre-certification.
2. Concurrent care claim: a request to continue coverage of services that the claims administrator approved previously as an ongoing course of treatment or to be provided for a certain time. Concurrent care claims are either urgent care claims or fall into one of the other claim categories: preservice or postservice.
3. Postservice claim: a request for coverage of health care benefits after services have been received.
4. Urgent care claim: a request for a claim determination for medical care where treatment delay could seriously jeopardize the life, health, or ability of a patient to regain maximum function, or which – in the opinion of the attending physician – would subject the patient to severe pain that could not be managed adequately without the care or treatment that is the subject of the claim.

How Do I Expedite an Urgent Care Claim?

Because urgent care claims are time-sensitive and important, you should call the claims administrator as soon as possible when you learn that you will need immediate care. If you (or your physician) provide all of the information needed to review your claim, the claims administrator will give you an answer within 72 hours.

TIME LIMITS FOR RECEIVING BENEFIT CLAIM DECISIONS		
TYPE OF CLAIM	**YOU WILL RECEIVE NOTIFICATION OF THE DECISION WITHIN ...**	**BUT IT MAY BE EXTENDED FOR AN ADDITIONAL ...**
Postservice care claim	30 days after your claim is received	15 days because of matters beyond the control of the claims administrator**
Preservice care claim*	15 days after your claim is received	15 days because of matters beyond the control of the claims administrator**
Concurrent urgent care claim	24 hours after your claim is received, provided that a request to extend an ongoing course of treatment is made at least 24 hours before the previous approval expires	Not applicable if you provide enough information†
Concurrent preservice or postservice care claim	Same as preservice or postservice claims, depending on medical circumstances	15 days because of matters beyond the control of the claims administrator**
Urgent care claim*	72 hours after your claim is received	Not applicable if you provide enough information†

* If you or your authorized representative fails to follow the Plan's procedures for filing a preservice or urgent care claim, within five days (24 hours for an urgent care claim) the claims administrator will notify you or your authorized representative of the failure and explain the proper procedures.

** If more information is required to review your claim, the claims administrator will notify you before the end of the initial review period (or within five days for a preservice claim) of the specific information needed and will allow you at least 45 days to provide that information. The review time periods for preservice and postservice claims will be suspended until the date that you respond to the request for more information.

† If more information is required to review your claim, the claims administrator will notify you within 24 hours of the specific information needed and will allow you at least 48 hours to provide that information. The review time periods for concurrent care and urgent care claims may be extended for as long as 48 hours from the earlier of (1) the date that the claims administrator receives the additional information or (2) the end of the time period that you were given to provide the additional information.

If Your Claim Is Denied

If your health care benefit claim is denied, in whole or in part, the claims administrator will send you a notice that will include the following information:

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.
- Description and explanation of any additional information that is needed to process your claim.
- Description of the Plan's appeal procedures and the applicable time limits, as well as your right to bring legal action if your claim is denied on appeal.
- Statement that you can request, free of charge, copies of documentation related to the decision.
- Description of any rule, protocol, or other criterion that was relied on in determining your claim, and your right to obtain a copy, free of charge, upon request.
- Statement that you can request, free of charge, an explanation of the scientific or clinical judgment that was used if your claim was denied based on a medical necessity, an experimental treatment, or another similar exclusion or limitation.

- For an urgent care claim, a description of the expedited review process applicable to such claims.

How to Appeal if Your Benefit Claim Is Denied

If your benefit claim is denied, in whole or in part, you may be able to resolve the denied claim through an informal review process. Simply call the claims administrator and discuss the situation.

If the claim is not resolved with a telephone call, you have the right to file a formal (written) appeal with the claims administrator. You must file your appeal within 180 days of the date that you are notified of the denial. To file your appeal, you must:

- State, in writing, why you believe the claim should have been approved.
- Submit any information and documents you think are appropriate, including any additional information not submitted with your initial claim.
- Send the appeal and any supporting documentation to the claims administrator at the appropriate claim-filing address.

You may request, free of charge, copies of all documents, records, and other information relevant to your claim for benefits.

How Can I Expedite an Appeal for Urgent Care?

You can make an appeal for urgent care by calling the claims administrator. (All other appeals must be made to the claims administrator in writing.)

The claims administrator will review your appeal and make a decision. The review will be conducted by a person who did not make the decision on your initial claim and is not the subordinate of that person. The review will include all information you submit and will not give deference to the initial claim decision. If deciding the appeal involves medical judgment, such as determining medical necessity or if treatment was experimental, a qualified health care professional will be consulted. That health care professional will not be one who was consulted in determining your initial claim and will not be a subordinate of such person. In reviewing your appeal, the claims administrator will use its discretion in interpreting the terms of the Plan and will apply them accordingly.

Time Limits for Decisions on Benefit Appeals

If the claims administrator denies your appeal, in whole or in part, you will be notified as follows:

TIME LIMITS FOR RECEIVING BENEFIT APPEAL DECISIONS	
YOU WILL RECEIVE NOTIFICATION OF THE DECISION...	
ON YOUR...	WITHIN...
Postservice care appeal	30 days for each of two levels of appeal if there are two levels of appeal; 60 days if there is one level of appeal
Preservice care appeal	15 days for each of two levels of appeal if there are two levels of appeal; 30 days if there is one level of appeal
Concurrent care appeal	Same as preservice, postservice, or urgent care appeals, depending on medical circumstances
Urgent care appeal	72 hours* after your appeal is received
* For an urgent care appeal, you can submit information by any timely method, including fax, telephone, other electronic means, or orally. Important: You must file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision.	

If Your Appeal Is Denied

If your benefit appeal is denied, in whole or in part, the claims administrator will send you a notice that will include the following information:

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.
- Statement of your right to obtain, free of charge, copies of documentation related to the decision.
- Summary of your right to additional appeals or legal action.

- Statement that you can request, free of charge, identification of medical or vocational experts whose advice was obtained by the claims administrator.
- Description of any rule, protocol, or other criterion that was relied on in determining your appeal, and your right to obtain a copy, free of charge, upon request.
- Statement that you can request, free of charge, an explanation of the scientific or clinical judgment that was used if your appeal was denied based on a medical necessity, an experimental treatment, or another similar exclusion or limitation.

The decisions of the insurer or claims administrator are final and binding. Benefits will be paid under the plan only if REI's Appeals Committee decides in its discretion that you have met the eligibility, enrollment and participation requirements and the insurer or claims administrator has determined that you are entitled to the benefits. For more information, please see *Voluntary Appeal to the Appeals Committee* on page 108.

Requesting an External Review

Once you have exhausted the above mandatory claims procedures and the denial of your claim was upheld on appeal, you may be eligible to submit request an external review from an independent review organization (IRO). The only health care claims eligible for external review are those that involve medical judgment or a rescission of coverage.

You must file your request for external review within four months of receiving notice of the denial of your internal appeal. To request an appeal, you must submit your request in writing to the claims administrator.

For urgent care claims: You can request an external review for an urgent care claim by calling the claims administrator (all other requests for external review must be made in writing).

Decisions on Requests for External Reviews

Within five business days following the receipt of the external review request, the claims administrator will determine whether the claim is eligible for external review. Within one business day after completion of the preliminary review, the claims administrator will notify you whether your claim is eligible for external review, or if additional information is needed to make a determination. If your request was complete but not eligible for external review, the notification will include the reason for the ineligibility and contact information for the Employee Benefits Security Administration. If the request was not complete, the notification will describe the information or materials needed to make the request complete, and you will have the longer of 48 hours or the rest of the four-month period to make the request complete.

For urgent care claims: The claims administrator will immediately review requests for expedited review of urgent care claims, and notify you as soon as possible of its determination.

The External Review Process

If your claim is eligible for external review, the claims administrator will assign an independent review organization (IRO) to conduct the external review. Within five days of assignment, the claims administrator will provide the IRO with the documents and information considered in the denial of your claim.

The IRO will provide you with a statement that you may submit additional written information, and the deadline for submitting that information. The IRO will forward any information received from you to the claims administrator. The claims administrator may reverse its decision based on the additional information; in that case, external review will end.

The IRO will review your appeal and any other documents you have submitted and make a decision. The review will not give deference to the initial claim decision or the internal review decision. The IRO will consist of individuals not involved with the prior decisions on your claim. If the review involved medical judgment, a qualified health care professional will be consulted. That health care professional will not be one who was consulted in determining your initial claim and will not be a subordinate of such person.

Time Limits for Decisions on External Review

The IRO will provide written notice of the decision to you and the claims administrator within 45 days after the IRO receives your request.

For urgent care claims: The IRO will provide notice of the decision as soon as possible, but no later than 72 hours after receipt of the request for external review.

If The Denial is Upheld by the IRO
If the IRO upholds the denial of your claim, in whole or in part, the IRO will send you a notice that will include the following information:

- A description of your appeal.
- The date the IRO received your appeal and the date of the IRO's decision.
- References to the evidence or documentation considered in reaching the decision, including relevant Plan provisions.
- The principle reasons for the IRO's decision.
- A statement that the IRO's decision is binding, unless other remedies are available under state or federal law.
- Contact information for health insurance consumer assistance offices.

The decision of the IRO is final and binding. If you disagree with the decision, you may bring an action in federal court under section 502 of ERISA.

Benefits will be paid only if REI's Appeals Committee decides in its discretion that you have met the eligibility, enrollment and participation requirements and the insurer or claims administrator has determined that you are entitled to the benefits. For more information, please see *Voluntary Appeal to the Appeals Committee* on page 108.

DISABILITY, LIFE, AD&D CLAIMS, BUSINESS TRAVEL ACCIDENT AND DEPENDENT CARE FSA CLAIM PROCEDURES

Time Limits for Decisions on Benefit Claims

The Federal Government sets time periods for reviewing and deciding disability, life, and accident claims. The claims administrator will notify you within the following time limits as to whether your claim is approved or denied, in whole or in part. If your claim is denied, you will have the opportunity to file an appeal within certain time limits also described here. If your claim is denied due to inaccurate or incomplete information, you can correct or submit additional information with your appeal.

TIME LIMITS FOR RECEIVING BENEFIT CLAIM DECISIONS		
TYPE OF CLAIM	**YOU WILL RECEIVE NOTIFICATION OF THE DECISION WITHIN ...**	**BUT IT MAY BE EXTENDED FOR AN ADDITIONAL ...**
Dependent Care Spending Account	30 days after your claim is received	15 days due to matters beyond the control of the claims administrator. You will be notified within the original 30-day review period if this happens. If an additional 15-day extension is needed, you will be notified within the first 15-day extension period.
Short term disability **Long term disability** **Life Insurance disability continuation**	45 days after your claim is received	30 days due to matters beyond the control of the claims administrator. You will be notified within the original 45-day review period if this happens. If an additional 30-day extension is needed, you will be notified within the first 30-day extension period.

TIME LIMITS FOR RECEIVING BENEFIT CLAIM DECISIONS		
TYPE OF CLAIM	**YOU WILL RECEIVE NOTIFICATION OF THE DECISION WITHIN ...**	**BUT IT MAY BE EXTENDED FOR AN ADDITIONAL ...**
Life insurance death benefit **Accidental death and dismemberment** **Business travel accident**	90 days after your claim is received	90 days due to special circumstances. Your beneficiary will be notified within the original 90-day review period if this happens.

If Your Claim Is Denied

If your dependent Care FSA, disability, life, or accident benefit claim is denied, in whole or in part, the claims administrator will send you a notice that will include the following information:

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.
- Description and explanation of any additional information needed to process your claim.
- Description of the Plan's appeal procedures and the applicable time limits, as well as your right to bring legal action if your claim is denied on appeal.
- Statement that you can request, free of charge, copies of documentation related to the decision.

If your disability or dismemberment benefit claim is denied, the notice also will include a:

- Description of any rule, protocol, or other criterion relied on in determining your claim, and your right to obtain a copy, free of charge, upon request.
- Statement that you can request, free of charge, an explanation of the scientific or clinical judgment used in deciding your claim.

How to Appeal If Your Benefit Claim Is Denied

If your benefit claim is denied, in whole or in part, you, your beneficiary, or your designated representative may be able to resolve the denied claim through an informal review process. Simply call the claims administrator and discuss the situation.

If the claim is not resolved with a telephone call, you, your beneficiary, or your designated representative has the right to file a formal (written) appeal with the claims administrator as follows:

- For dependent Care FSA, disability or dismemberment benefit appeals, you must file your appeal within 180 days of the date you are notified of the denial.
- For life or accidental death benefit appeals, your beneficiary or designated representative must file an appeal within 60 days.

To file your appeal, you (or your beneficiary or designated representative) must:

- State, in writing, why you believe the claim should have been approved.
- Submit any information and documents you think are appropriate, including any additional information not submitted with your initial claim.
- Send the appeal and any supporting documentation to the claims administrator at the appropriate claims-filing address.

You may request, free of charge, copies of all documents, records, or other information relevant to your claim for benefits.

The claims administrator will review your appeal and make a decision. The review will be conducted by a person who did not make the decision on your initial claim and is not a subordinate of that person. The review will include all information you submit and will not give deference to the initial claim decision.

If deciding the appeal involves medical judgment, such as determining disability or paralysis, a qualified health care professional will be consulted. That health care professional will not be one who was consulted in determining your initial claim and will not be a subordinate of such person. In reviewing your appeal, the claims administrator will use its discretion in interpreting the terms of the Plan and will apply them accordingly.

Time Limits for Decisions on Benefit Appeals

The Federal Government provides time limits for reviewing and deciding disability, life, and accident benefit appeals. If the claims administrator denies your appeal, in whole or in part, you will be notified as follows:

TIME LIMITS FOR RECEIVING BENEFIT APPEAL DECISIONS		
TYPE OF CLAIM	**YOU WILL RECEIVE NOTIFICATION OF THE DECISION WITHIN ...**	**BUT IT MAY BE EXTENDED FOR AN ADDITIONAL ...**
Short term disability **Long term disability** **Life insurance disability extension**	45 days after your appeal is received	45 days due to special circumstances. You will be notified within the original 45-day review period if this happens.
Life insurance death benefit **Accidental death and dismemberment** **Business travel accident**	60 days after your appeal is received	60 days due to special circumstances. You will be notified within the original 60-day review period if this happens.

If Your Appeal Is Denied

If your benefit appeal is denied, in whole or in part, the claims administrator will send you a notice that will include the following information:

- Specific reasons for the denial.
- Reference to the specific Plan provisions on which the claim determination was based.
- Statement of your right to obtain, free of charge, copies of documentation related to the decision.
- Summary of your right to additional appeals or legal action.

If your disability or dismemberment benefit claim is denied, the notice also will include a:

- Statement that you can request, free of charge, identification of medical or vocational experts whose advice was obtained by the claims administrator.
- Description of any rule, protocol, or other criterion relied on in determining your appeal, and your right to obtain a copy, free of charge, upon request.

The decisions of the insurer or claims administrator are final and binding. Benefits will be paid under the plan only if REI's Appeals Committee decides in its discretion that you have met the eligibility, enrollment and participation requirements and the insurer or claims administrator has determined that you are entitled to the benefits. For more information, please see *Voluntary Appeal to the Appeals Committee*.

Voluntary Appeal to the Appeals Committee

Once you have exhausted the above mandatory claims procedures and the denial of your claim was upheld on final appeal, in certain limited situations you may be eligible to submit a voluntary appeal to REI's Appeals Committee. The Appeals Committee ***will not*** make benefit determinations. It will only review and make a determination (1) on eligibility and enrollment disputes; or (2) on those claims involving situations where the Committee, in its sole discretion, determines that the appeal involves the interpretation of a Plan term that is vague. However, the Committee will never hear appeals concerning medical necessity or similar medical issues. It is not necessary for you to exhaust this voluntary level of appeal before you bring a suit under ERISA Section 502(a). It is, however, necessary if you wish to appeal to the Appeals Committee that you submit your appeal in writing to the below address within 30 days of the final appeal denial date. The Appeals Committee will respond to your appeal in writing within 30-90 days of receipt of your voluntary appeal.

Employee Service Center –
Appeals Committee
REI
1700 45th Street East, Suite 101
Sumner, WA 98352

ADMINISTRATIVE FACTS

ADMINISTRATIVE FACTS	
Name of Plan	Recreational Equipment, Inc. Benefit Plan, sometimes referred to as the "Plan." It is reported to the Internal Revenue Service and Department of Labor as the *Recreational Equipment, Inc. Group Life and Medical Plan*.
Plan Number	501
Plan Year	The Plan year is January 1 through December 31. The Plan's fiscal year is January 1 through December 31.
Plan Sponsor	Recreational Equipment, Inc. 1700 45th Street East, Suite 101, Sumner, WA 98352 1-800-999-4734
Employer Identification Number	91-0656890
Participating Employer	Recreational Equipment, Inc.
Plan Administrator and Agent for Legal Process	Benefits Committee of the REI Benefit Plan c/o Recreational Equipment, Inc. 1700 45th Street East, Suite 101 Sumner, WA 98352 (800) 999-4734
Type of Administration	The Benefits Plan is administered by the plan sponsor in accordance with plan documents, including summary plan descriptions, insurance contracts and policies and administrative agreements.
Sources of Plan Funding	The Plan is funded by contributions made by the Plan participants and REI. The amount of contributions to be made by Plan participants is determined by REI. The amount of these contributions may be changed from time to time, and the amount of contributions made by one or more Plan participants need not be identical to the amount of contributions made by other participants.

The following plans are self-funded by REI. Benefits for these are paid directly from REI's general assets under the direction of the claims administrators as noted:

REI Choice and Custom Choice Medical Plan, and REI Saver or Custom Saver Medical Plan Control No. 393630 Aetna 151 Farmington Avenue Hartford, CT 06156 1-800-USAETNA (1-800-872-3862)	Employee Assistance Program Aetna (REI Health Guide) 151 Farmington Avenue Hartford, CT 06156 1-800-USAETNA (1-800-872-3862)
Dental Group No. 09340 Delta Dental P.O. Box 75983 Seattle, WA 98175-0983 206-522-2300 1-800-554-1907	Flexible Spending Accounts HealthEquity 15 W Scenic Point Dr, Ste 100 Draper, UT 84020 1-844-351-6849

ADMINISTRATIVE FACTS	
Vision Group No. 12149216 VSP 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195	Prescription Drugs Express Scripts P.O. Box 66587 St. Louis, MO 63166-6857 1-800-462-5916
Health Savings Account HealthEquity 15 W Scenic Point Dr, Ste 100 Draper, UT 84020 1-844-351-6849	
The following plans are insured. Premiums for this insurance and the applicable insurance companies or HMOs are paid directly from REI's general assets under the direction of the insurers. Benefits are paid by the applicable insurance company.	
Basic and Supplemental Life Insurance Group No. GL-804664 Group Benefit Claims Life Claims Office The Hartford PO Box 14299 Lexington, KY 40512-4299 1-888-563-1124 1-866-954- 2621 (fax)	Business Travel Accident, Group No. GTP 9137842 AIG Benefits Travel Assist Services P.O. Box 29587 Shawnee Mission, KS 66225-5987 1-877-244-6871 (within the US) 1-715-346-0859 (outside of the US)
Basic and Supplemental Accidental Death and Dismemberment (AD&D), Group No. GL-804664 Group Benefit Claims Life Claims Office The Hartford PO Box 14299 Lexington, KY 40512-4299 1-888-563-1124 1-866-954- 2621 (fax)	Long Term Disability, Group No. GF3-890-LF0250-01 Lincoln Financial Group 1301 S. Harrison Street Fort Wayne, IN 46802-3425 1-888-970-2457
RethinkCare Employee Benefits Program 19 West 21st Street, Suite 403 New York, NY 10001 1-800-714-9285	Quit for Life® 11000 Optum Circle MN101 E800 Eden Prairie, MN 55344 1-866-784-8454 www.quitnow.net/REI
Commuter Benefits HealthEquity 15 W Scenic Point Dr, Ste 100 Draper, UT 84020 1-844-351-6849	

ADMINISTRATIVE FACTS	
Health Maintenance Organizations:	
Kaiser Foundation Health Plan, Inc., Group No. 03513 1950 Franklin Street Oakland, CA 94612 1-800-464-4000 Northern California Region	Kaiser Foundation Health Plan, Inc. So. Calif. Region Group No. 226768 393 E Walnut Street Pasadena, CA 91188 1-800-464-4000 Southern California Region
Kaiser Foundation Health Plan – Colorado Group No. 01282 10350 East Dakota Avenue Denver, CO, 80231 1-800-632-9700 Colorado Region	Kaiser Permanente, Group No. 0616700 Kaiser Permanente 1300 27th Street Renton, WA 98057 1-888-901-4636 Washington Region

GLOSSARY

Life and AD&D Definitions

Active service – life and AD&D plans. If you're an employee, you're in active service on a day that is one of your employer's scheduled workdays, if either of the following conditions is met:

- You are actively at work. This means you are performing your regular occupation for REI on a full-time or part-time basis, either at one of the employer's usual places of business or at some location to which the employer's business requires you to travel.
- The day is a scheduled holiday, vacation day or period of employer-approved paid leave of absence. Note: You are in active service on a day that is not one of REI's scheduled workdays only if you were in active service on the preceding scheduled workday.

Annual base pay. Your annual wage or salary as an REI employee. It doesn't include:

- Bonuses;
- Awards;
- Commissions;
- Overtime or other extra pay for more than 40 hours per week; or
- Other extra compensation.

For new employees, annual base pay is determined as of the date coverage begins. After that, annual base pay is based on the salary on the date of death or date last actively at work.

Comatose. Coma means complete and continuous: 1) unconsciousness; and 2) inability to respond to external or internal stimuli, as verified by a physician.

Child care center (Supplemental AD&D). Day Care or Day Care Program means a program of child care which: 1) is operated in a private home, school or other facility; 2) provides, and makes a charge for, the care of children; and 3) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located; or 4) if licensing is not required, provides childcare on a daily basis for 12 months a year.

Evidence of insurability (EOI). Evidence of Insurability must be satisfactory to The Hartford and may include, but will not be limited to: 1) a completed and signed application approved by The Hartford; 2) a medical examination; 3) an attending physician's statement; and 4) any additional information The Hartford may require. Evidence of Insurability will be furnished at The Hartford's expense except for Evidence of Insurability due to late enrollment. The Hartford will then determine if you or your dependents are insurable for initial coverage or an increase in coverage as described in the Increase in Amount of Life Insurance provision

Disability Definitions

Actively at work. Performing in the usual way all the essential functions of your regular occupation on your normal (i.e., part-time or full-time) basis at:

- REI's usual place of business;
- A location to which REI's business requires you to travel; or
- Your home if that is the business location REI has agreed to and you are physically able to work at another location if REI required it.

You are considered to be actively at work if you meet the conditions stated above but are absent from work on a day that is a holiday, vacation day or regularly scheduled day off for you, as long as you were actively at work on your preceding regularly scheduled workday.

Any occupation. Any occupation or employment that you are able to perform, whether due to education, training or experience.

Disability (LTD). Due to physical disease, injury, pregnancy or mental disorder:

- During the 26-week (specifically 180-day) benefit waiting period and first 24 months of LTD benefits, you're unable to perform with reasonable continuity the essential functions of your own occupation and you have a loss of at least 20% in indexed predisability earnings when working in your own occupation.
- After 24 months of LTD benefits, you're unable to perform with reasonable continuity the essential functions of any occupation.

You're not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

Disability (STD). Due to physical disease, injury, pregnancy, or mental disorder:

- You're unable to perform with reasonable continuity the essential functions of your own job; and
- You have a loss of at least 20% of your pre-disability earnings.

The STD plan does not cover any disabilities arising out of or in the course of any employment for wage or profit.

Drug and/or alcohol abuse also known as substance abuse. The continued use of alcohol, drugs or medicines or any chemical compound not intended for introduction into the human body, and any resulting physical or mental illness which is characterized by:

- Severe impairments in social and/or occupational functioning;
- Severely debilitating physical condition;
- Diminution in cognitive functioning;

Inability to abstain from or reduce consumption of a substance or the need for daily use of a substance to function.

Indexed predisability earnings. During your first year of disability, these are the same as your predisability earnings. After that, your indexed predisability earnings are adjusted annually to reflect any increases in the previous year's Consumer Price Index, to a maximum of 7%.

Essential functions. The essential tasks, functions and operations and the skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event does the insurance company consider working an average of more than 40 hours per week to be a material duty.

Mental illness. A psychiatric or psychological condition regardless of cause such as schizophrenia, depression, manic depressive or bipolar disorders, anxiety, personality disorders, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

This limitation will not apply to a mental illness if it is a result of:

- Stroke;
- Trauma;
- Viral infection;
- Alzheimer's disease; or
- Other conditions not listed that are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Mental disorder. An illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

Any one of the following conditions is a mental disorder under this plan:

- Anorexia/bulimia nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including autism).
- Psychotic disorders/delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Also included is any other mental condition that requires medically necessary treatment.

Other income. Any other sources of income you receive or are eligible to receive due to your disability in addition to benefits payable by disability plans. For the LTD plan, this also includes any such income your spouse or your eligible children receive or are eligible to receive due to your disability.

Own occupation. Any employment, business, trade, profession, calling or vocation that involves essential functions of the same general character as the occupation you are regularly performing for your employer when disability begins. In determining your own occupation, the insurance company is not limited to looking at the way you perform your job for your employer but may also look at the way the occupation is generally performed. If your own occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your own occupation is as broad as the scope of your license.

Physician (for disability benefits). A person who is a legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

Regular care of a physician means you are attended by a physician:

- Who is not you or related to you;
- Who is practicing within the scope of his or her license;
- Who has the medical training and clinical expertise suitable to treat your disabling condition;
- Who specializes in psychiatry, if your disability is caused, to any extent, by a mental health or psychiatric condition; and
- Whose treatment is:
  - Consistent with the diagnosis of the disabling condition; and
  - According to guidelines established by medical, research and rehabilitative organizations; and
  - Administered as often as needed.

Psychiatric physician. A physician who specializes in psychiatry or has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or mental disorders.

Predisability earnings. For STD, the plan uses your lost monthly and weekly income, including pre-tax contributions you make to the Benefits Plan, including the Commuter Plan, and/or REI retirement plan. Predisability earnings do not include shift differential pay, employer contributions on your behalf to the retirement plan, contributions you make to a non-qualified deferred compensation plan or any other form of extra compensation or fringe benefit.

For LTD, the plan uses your monthly pay on the day before a disability starts, including commissions, awards, overtime pay (averaged over the last 12 months of actual employment or a shorter period if actual employment was for fewer than 12 months) and any pre-tax contributions you make to the Benefits Plan, REI retirement plan or an executive non-qualified deferred compensation plan. Predisability earnings do not include employer contributions on your behalf to the retirement plan or a deferred compensation plan.

Rehabilitation facility. A facility, or a distinct part of a facility that provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative services. The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by illness or injury.

Residential treatment facility (mental disorders). This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;

- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist**.**

Residential treatment facility (substance abuse). This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- Has a medical director that is a physician who is an addiction specialist.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An R.N. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a physician.

Substance abuse. A physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of

DSM); for example, an addiction to nicotine products, food or caffeine intoxication.

Flexible Spending Account Definitions

Dependent care center. A facility that provides care for more than six non-resident individuals and receives a fee, payment or grant for providing services for any other individuals. Whether or not the center is operated for profit, it must comply with applicable state and local government laws and regulations.

Earned income (Dependent Care FSA). The amount of compensation you earn as an employee or from self-employment. It doesn't include any pension or annuity benefits or amounts you're reimbursed by the Dependent Care FSA.

Benefits Plan Facts Definitions

Qualified domestic relations order (QDRO). A court judgment, decree or order governing child support, spousal support, alimony or marital property rights.

Qualified medical child support order (QMCSO). A judgment, decree or order issued by a court or through an administrative process established by state law, under which an employee or spouse must provide medical coverage for a dependent child. This might apply, for example, following a divorce. Under such an order, REI may be authorized to make the applicable payroll deductions to pay for the coverage

Eligibility Definitions (for part-time employees)

Administrative period. The administrative period is the time we need to review your hours and process your eligibility. This occurs at the end of your initial and ongoing evaluation of hours and before your coverage begins.

Average weekly hours. Hours tracked over a defined 12-month period to determine benefits eligibility for part-time employees. The 12-month time period is called an evaluation of hours, defined below.

If a part-time employee works on average 20 or more hours per week during their evaluation of hours they are eligible for benefits.

Evaluation period. A defined 12-month period. Hours are tracked during this period to determine benefits eligibility for part-time employees. An employee's evaluation of hours is determined based on how long an employee has been with REI:

- **Ongoing evaluation period:** Always occurs from October 4 to October 3 of each year and applies to employees who have been with REI greater than 12 months.
- **Initial evaluation period:** Corresponds with an employee's date of hire (or rehire date if the employee has been separated from REI for more than 6 months).

For example, if an employee is hired/rehired on April 15, 2022, he/she will have an initial evaluation period between May 1, 2023 – April 30, 2024.

Typically, employees will only have one initial evaluation period, which will catch them up to the ongoing evaluation period that is reviewed in October of each year.

Guaranteed coverage period. Employees who have averaged 20 or more hours worked during their evaluation period will be covered under the Plan for at least 12 months.

CONTACT INFORMATION

Visit *For Your Benefit* at **www.foryourbenefit-rei.com** to find important benefit plan contact information.

APPENDIX A

EXTENSION OF CERTAIN DEADLINES UNDER THE PLAN

Due to the COVID-19 pandemic, the federal government issued guidance extending deadlines for taking certain actions regarding the Plan. When calculating the deadlines set forth below, the Plan will not count the period beginning on March 1, 2020, and ending July 10, 2023. **However, the deadlines will not be extended for more than one year under this federal guidance.** Plan deadlines that expired prior to March 1, 2020, are not being extended.

1. Special Enrollment Deadlines.

In certain circumstances, you have the right to enroll yourself and/or your eligible family members in the medical, dental and vision benefits of the Plan midyear when certain events occur triggering 30-day or 60-day Special Enrollment periods. The deadlines for you to request special enrollment under these benefits have been extended, if the deadlines occur on or after March 1, 2020 and before July 11, 2023. The deadlines that have been extended are:

a. 30-day deadline to enroll yourself, your new spouse and eligible children after a marriage.
b. 30-day deadline to enroll yourself, your new child and other eligible family members due to the birth, adoption or placement for adoption of a child.
c. 30-day deadline to enroll yourself and/or other eligible family members due to loss of other group health plan coverage.
d. 60-day deadline to enroll due to loss of Medicaid or state Children's Health Insurance Program (SCHIP) coverage or due to eligibility for premium subsidy from Medicaid or SCHIP.

Even though these HIPAA special enrollment deadlines are being extended, coverage for you and/or your family members who are enrolling in these benefits under the HIPAA special enrollment rules will not become effective until the first day of the month after you request such a special enrollment. Thus, the earlier that you enroll after the triggering event, the sooner the coverage will begin. There is one exception to this rule: when you request special enrollment due to birth, adoption, or placement for adoption of a new child, coverage will effective retroactively to the date of the birth, adoption or placement for adoption.

2. COBRA Continuation Coverage Deadlines.

The following deadlines for COBRA continuation coverage that occur on or after March 1, 2020, but before July 11, 2023, have been delayed by this federal guidance. (Deadlines that expired prior to March 1, 2020 are not being extended.) This applies to any COBRA continuation coverage provided by the Plan.

a. The 60-day deadline to elect COBRA coverage
b. Deadlines for making COBRA premium payments
c. Deadlines for individuals to notify the Plan of a COBRA qualifying event (such as notification of a divorce)
d. Deadline to notify the Plan of a determination of disability by the Social Security
e. Administration (for purposes of the 11-month disability extension provided by COBRA)

3. Deadlines for Filing Claims and Certain Appeals.

The federal guidance also delays the deadline for filing a claim for benefits and the date by which you must file an appeal of a denial of a claim for benefits. This applies to all benefits provided by the Plan that are subject to ERISA. The federal guidance also delays certain timeframes relating to a request for an external

review under the REI major medical plan options administered by Aetna and the Kaiser HMOs. Please note that some benefits described in this booklet are not subject to ERISA, and thus, there are no deadline delays for these benefits. The benefits described herein that are not subject to ERISA are: the Dependent Care FSA, the Health Savings Account benefits, the Salary Continuation benefits and the Commuter Benefits.

For more information on the deadline delays, please contact the REI Employee Service Center.


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BENEFIT