RECKITT BENCKISER, LLC

Retiree Health Reimbursement Arrangement

Summary Plan Description

Contents

INTRODUCTION

The Reckitt Benckiser, LLC Retiree Health Reimbursement Arrangement (the "HRA Plan") is provided by Reckitt Benckiser, LLC ("the Company") at no cost to eligible participants. It provides funds you can use to reimburse yourself, tax free, for qualfying medical, dental and vision premiums, and for certain medical, dental, and vision out-of-pocket expenses.

The Company intends for the HRA Plan to qualify as a "health reimbursement arrangement" as that term is defined under IRS Notice 2002-45 and a "medical reimbursement arrangement" under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended. This HRA Plan is also intended to be exempt from many provisions of the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2). The HRA Plan will be interpreted at all times in a manner consistent with this intent.

This booklet is your Summary Plan Description (SPD). It has been developed to help you learn about and understand your benefits under the HRA Plan. The Plan Administrator is responsible for the administration of the HRA Plan. The Plan Administrator has the discretionary authority and the responsibility to, among other things, interpret the HRA Plan provisions, and to exercise discretion where necessary or appropriate in the interpretation, administration, and determination of eligibility for benefits under the HRA Plan. Although this HRA Plan has been summarized in everyday language, this booklet does not replace the legal documents governing the HRA Plan. This SPD describes the HRA Plan benefits in effect as of January 1, 2018.

If there are any differences between this information and the official HRA Plan document, the HRA Plan document governs.

Please keep in mind that although the Company intends to continue this plan in its present form, the Company reserves the right, by action of the appropriate representative, to amend, modify, suspend, or terminate, in whole or in part, the plan at any time. These modifications or terminations may be made for any reasons the Company or its representatives deem appropriate, or as a result of changes in the laws that govern the plan.

Nothing in this booklet says or implies that benefits will remain unchanged in future years.

Please retain this SPD for your records. If you have any questions after reading this booklet, please contact the Retiree Health Insurance Exchange Provider, Mercer Marketplace 365 (MM365) as follows:

- Call Mercer Marketplace 365 at 1-888-281-3667, Monday through Friday from 8:00 a.m. to 5:30 p.m. Eastern Standard Time; deaf or hard of hearing individuals should dial 711 for Telecommunications Relay Service

- Online at http://retiree.mercermarketplace.com/reckittbenckiser

Or you can contact your current Plan Administrator at:

- 973 404 2856 – Benefits Department

- www.USBenefits@RB.com

ELIGIBILITY

Eligible retirees, as described below, are referred to herein as “participants”.

ELIGIBLE RETIREES

To be considered an eligible retiree for purpose of this HRA Plan, you must meet all of the eligibility requirements described below:

- You must be a retiree of the Company who is entitled to Medicare; and
- You were enrolled in the group retiree medical coverage offered by the Company as of 12/31/2017; OR
- You are a new retiree entitled to Medicare or a current pre-Medicare retiree who ages-in and becomes entitled to Medicare and has met the following additional criteria:
    - Hired on or before 12/31/2008
    - Age 55 or older at time of retirement
    - Has to have at least 10 years of service to be eligible to participate in a company sponsored medical program at the time of retirement
    - Age plus service must equal 70 points or higher at time of retirement

DEPENDENTS

You may use your HRA account for reimbursement of your eligible dependent’s eligible expenses if your dependent has enrolled in individual Medicare medical coverage through MM365 and meets the Participation rules outlined below.

Dependents whose eligible expenses can be reimbursed from your HRA account include:

- Your legally married spouse,
- Your children until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support,
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support,
- Any other person (including a domestic partner of the same or opposite sex) who meets the following criteria:
    - Has cohabitated with the retiree for a period of one year, or more
    - Can demonstrate the comingling of financial assets between the retiree and the other person

    Documentation required to support dependent status for anyone not meeting the requirements described in the first three bullets above, will include:

- A signed affidavit from the retiree attesting to the fact that the retiree and other person have lived together for a period of one year or more and

- A joint savings or checking account statement, or other documentation, as approved by the Plan Sponsor, that demonstrates the comingling of financial assets between the retiree and the other person or,

- Documentation such as a signed lease, renter's agreement or mortgage statement that demonstrates that the retiree and person have cohabitated for a period of one year or more.

PARTICIPATION

You may participate in the HRA Plan the first day following your retirement date.

All current Medicare-eligible retirees, new Medicare-eligible retirees and Age-ins must be enrolled in a medical plan through Mercer Marketplace 365 Retiree ("MM365") to be eligible.

CURRENT MEDICARE-ELIGIBLE RETIREES AND THEIR MEDICARE ELIGIBLE DEPENDENTS:

- Retiree: Post-65 or Pre-65 Medicare-eligible: Must enroll in a medical plan through MM365

- Spouse: Post-65 or Pre-65 Medicare-eligible: Must enroll in a medical plan through MM365

- Pre-65 Medicare-eligible Child (Dependent): Must enroll in a medical plan through MM365

- Surviving Spouse: Post-65 or Pre 65 Medicare-eligible: Must enroll in a medical plan through MM365. If an individual passes away while active but would have been eligible for retiree medical, the surviving spouse is eligible.

- Domestic Partner: Post-65 or Pre 65 Medicare-eligible: Must enroll in a medical plan through MM365.

NEW MEDICARE-ELIGIBLE RETIREMENTS AND THEIR DEPENDENTS become eligible for the HRA program the first day of the month following date of retirement. Once Medicare eligible they must follow the opt in/opt out rules and enroll in a medical plan through MM365 to be eligible.

WHAT HAPPENS IN THE EVENT OF DIVORCE OR REMARRIAGE:

- Post-retirement divorce: If the retiree and spouse divorce after retirement, the former spouse would no longer be eligible for HRA benefits. The HRA balance goes to the retiree. If the retiree remarries later, the retiree may add new spouse.

- Post-retirement marriage of surviving spouse: If a surviving spouse who is covered by the HRA remarries, the new spouse is not eligible, but the surviving spouse of retiree remains eligible for the HRA.

Opt In/Opt Out Provisions:

Current retirees transitioning as of 1/1/2018 are not eligible to opt out and then opt back into the program at a later date.

Note: A surviving spouse of retiree who opted out at time of initial eligibility is allowed to opt-in.

If you become eligible for the plan after January 1, 2018, you will have a one-time opt-out option at retirement. You have a one-time opportunity in the future to opt in at a later date and enroll in an MM365 individual medical plan to become eligible for the HRA benefit.

If you are not already covered under this HRA plan as of January 1, 2018, you become eligible for this HRA program as of the first day of the first month you become eligible for Medicare. If your birthday is the first of any month, you become eligible the first of the previous month according to Medicare eligibility rules.

Once in the program, with the exception of if you are eligible for Medicaid or Tricare (see below), if you opt out in the future, you can never opt back in at a later date. If the retiree opts out of the program after opting in, the retiree and their eligible spouse/dependents are no longer eligible to opt back in for any reason in the future.

If you voluntarily drop your exchange based medical coverage or your exchange based medical coverage is terminated without new replacement medical coverage enrolled in through MM365, HRA participation will end when medical coverage terminates and you, your spouse and dependents are no longer eligible to opt back in to this HRA coverage for any reason in the future.

If you die, your HRA eligibility terminates, but your Spouse or other covered dependent(s) will remain eligible.

However, if you opt out due to eligibility for Medicaid or Tricare, you and your spouse/eligible dependents may opt back into the program at a later date.

If your coverage is terminated due to failure to pay premium, your HRA benefits will be suspended until such time that new coverage is obtained through MM365 at the next available date, and upon approval of the plan administrator.

For current retirees who were enrolled in company sponsored group coverage as of December 31, 2017, if you fail to obtain exchange coverage during the initial eligibility period, you may NOT opt-in to this HRA plan in the future. However, if you were currently retired as of December 31, 2017 and eligible for company sponsored retiree medical benefits but were not enrolled in company sponsored group coverage as of December 31, 2017, you will have a one-time opportunity to enroll in exchange coverage in the future and become eligible to participate in the HRA benefit.

If you are a new retiree, you may opt-out at initial eligibility but retain your one opportunity to opt-in later. Your spouse/eligible dependents would also have the opportunity to opt-in at this time (but not independent of only if you (the retiree) opt-in to coverage).

WHEN COVERAGE ENDS

Coverage in the HRA Plan ends on the earliest of the following dates:

- Your death;
- The date you are rehired as an active employee of the Company;
- The date you commit fraud or misrepresentation on the HRA Plan;
- The effective date of a waiver of exchange based medical coverage;
- The date the HRA Plan is amended, resulting in your ineligibility for HRA participation;
- The date the HRA is terminated.

If you die, your HRA will be forfeited as of the date of your death. However, your estate or representative may submit claims for reimbursement of eligible health care expenses incurred during your participation in the HRA.

FUNDING OF THE HRA PLAN AND YOUR BENEFIT DOLLARS

All funds placed into your HRA account are owned by the Company. Funding is provided periodically and in amounts determined at the discretion of the Company into a notional account reflecting a bookkeeping concept. There are no assets actually set aside for the exclusive purpose of providing benefits to the participants or that are protected from the Company's creditors. Under federal law, you are not permitted to make any contributions to your HRA account, whether made on a pre-tax or after-tax basis. However, to the extent COBRA applies, the Plan will accept payments from or on behalf of COBRA Qualified Beneficiaries.

The Company determines the contribution amount each year to be allocated to your HRA account to be used for eligible health care expenses. As of the Effective Date and continuing annually thereafter, the Company will make an annual contribution based on your years of service. For the first year of your HRA participation, the allocation will be prorated for months of participation based on the effective date of medical coverage. For example, if you retire effective July 1 of any year, and enroll in new medical coverage as of July 1, the HRA amount in the initial year will be prorated as 6/12 of the annual amount for the initial year.

The HRA amounts were derived through an independent actuarial evaluation. These amounts will be subject to a 2% inflationary factor which will be reviewed annually subject to the RB Benefits Committee approval.

For 2018, the initial base HRA amounts were determined based upon years of service as follows:

Years of Service	Amount of HRA Contribution
25 or More	$3,497
24	3,456
23	3,415
22	3,373
21	3,332
20	3,291
19	3,250
18	3,209
17	3,168
16	3,127
15	3,086
14	3,044
13	3,003
12	2,962
11	2,921
10	2,880

ROLLOVER

Unused catastrophic Rx Part D HRA dollars and catastrophic out-of-pocket medical HRA Plan account balances will not rollover to the following year. However, your unused Base HRA dollars will rollover from year-to-year. For purposes of the plan, an expense is considered to be incurred on the date which medical services or goods are furnished.

ELIGIBLE REIMBURSEMENTS

You may use your HRA for reimbursement of certain eligible expenses, provided the expense:

- Has been incurred by you, your spouse, or your dependents as defined on page 4;
- Is not reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement;
- Does not exceed your HRA account balance;
- Is incurred while you are participating in the HRA; and
- Is considered to be tax-deductible under Internal Revenue Code Section 213.

Further, any medical care expense that is attributable to a premium payment made on a pre-tax basis or a deduction allowed under Internal Revenue Code Section 213 that has been claimed for any taxable year is **not** reimbursable from the HRA.

Eligible Expenses	
Individual health/prescription drug insurance premium purchased through MM365	Eligible for reimbursement
Medicare Part B premium and Part B and Part D IRMAA premiums.	Eligible for reimbursement
Dental insurance premium	Eligible for reimbursement
Vision insurance premium	Eligible for reimbursement
All Section 213(d) medical expenses	Eligible for reimbursement
Medicare Part D Phase 1, 2 and 3 RX Expenses	Expenses incurred in Phases 1, 2, and 3 are reimbursable once the plan year is complete and it has been verified you did not enter Phase 4 Catastrophic. In order to be reimbursed, you must submit a claim supported by all pages of month-end prescription drug plan Explanation of Benefits (EOBs). See below for more details
Medicare Part D Phase 4/Catastrophic phase	➢ Catastrophic Rx Part D HRA to cover 100% of your share in Catastrophic phase of Part D for plans purchased through MM365. ➢ See below for more details
Catastrophic Medical Expenses	➢ Catastrophic Medical HRA for out-of-pocket (non-premium) medical expenses between $2,000 and $7,000 (only available for first 5 years of program). ➢ See below for more details

PRE-CATASTROPHIC RX COPAY PHASE REIMBURSEMENT REQUIREMENTS:

You may use your annual HRA funds to submit claims for expenses applied against your deductible (Phase 1), co-pays incurred in Phase 2 (“initial coverage”), and Phase 3 (the “coverage gap” or “donut hole”) once the plan year is complete and it has been verified that you did not enter Phase 4 Catastrophic. In order to be reimbursed, you must submit a claim supported by all pages of month-end prescription drug plan Explanation of Benefits (EOBs).

Submission must be made AFTER December 31st and will only be accepted if you do not enter the Catastrophic Phase in the particular plan year.

You must show proof from the carrier that Catastrophic phase was not entered and documentation of amount of out-of-pocket co-pay expenses incurred.

CATASTROPHIC PHASE RX COPAY REIMBURSEMENT REQUIREMENTS:

The Plan provides additional funding beyond yearly allocated HRA household amounts for those who enter the Phase 4 Catastrophic phase of Part D. This benefit is separate and in addition to your Base HRA benefit.

In order to qualify for this additional reimbursement, you must submit proper claims showing proof that the Catastrophic phase of Part D was entered. You must also provide documentation from the carrier showing the amount of out-of-pocket cost incurred.

This additional funding covers eligible approved out-of-pocket Rx costs incurred in the Catastrophic Rx Phase ONLY.

CATASTROPHIC MEDICAL EXPENSE REIMBURSEMENT REQUIREMENTS: *(ONLY AVAILABLE FOR FIRST 5 YEARS OF PROGRAM, 2018-2022)*

If you incur medical expenses beyond $2,000 and up to $7,000 during a calendar year, certain additional expenses are eligible for reimbursement. This benefit is separate and in addition to your Base HRA benefit.

Eligible Medical expenses under this provision include co-pays, deductible and out-of-pocket medical expenses, but EXCLUDE MONTHLY PREMIUMS, as these are covered under your Base HRA benefit.

You may submit claims requests to the HRA Administrator and provide proper documentation and proof of medical out–of- pocket expenses over $2,000 in any calendar year.

RB will provide additional assistance up to $5,000.00 per calendar year for eligible expenses; these funds are in addition to yearly allocated HRA benefit.

This feature is only available for first five (5) years of the program (through the end of 2022).

ELIGIBLE OUT OF POCKET EXPENSES FOR HRA REIMBURSEMENT

Expenses eligible to be reimbursed from the HRA Account include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

Below is a partial list of expenses eligible for reimbursement under the HRA Account:

- Medical Expenses
  - Deductibles
  - Copayments
  - Charges for routine check-ups, physical examinations, and tests connected with routine exams
  - Charges over the "reasonable and customary" limits
  - Expenses not covered by the medical plan due to exclusion by the insurance company

  - Certain other over-the-counter items such as bandages, crutches, and other supplies will be reimbursable, but only to the extent applicable regulations permit

  - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)

  - Other selected expenses not covered by the medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).

- Dental Expenses

  - Deductibles

  - Copayments

  - Expenses that exceed the maximum annual amount allowed by your dental plan

  - Charges over the “reasonable and customary” limits

  - Orthodontia treatments that are not strictly cosmetic

- Vision and Hearing Expenses

  - Vision examinations and treatment not covered by insurance plan

  - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner

  - Cost of hearing exams, aids and batteries

- Transportation - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

Ineligible Expenses

Below is a partial list of expenses ***not*** eligible for reimbursement under the HRA Account:

- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.

- Expenses Related to General Health - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally, only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

REQUESTING REIMBURSEMENT FROM YOUR HRA ACCOUNT

FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a daily basis and reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator (as identified below).

All claims for a Plan Year must be submitted to the Claims Administrator within fifteen months after such claim was incurred. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator, even if there are funds in your HRA Account.

To be reimbursed for an eligible expense, submit a reimbursement form, for the eligible medical or premium expense incurred. Proof of the paid premium or eligible medical expense must be included. Proof of premium documentation should include the participant's name, billing period date and premium amount, and can be in the form of a welcome letter, an invoice or account statement summary, a declaration page or an Annual Notice of Change. For other eligible medical expenses, proof may be in the form of an Explanation of Benefits (EOB) from an insurance carrier or a statement or invoice from a health care provider.

Claims may be submitted directly through the website portal, emailed, faxed or sent through the mail to the appropriate contact information listed below.

The Claims Administrator for the HRA Account is MM365 and can be contacted at:

- Online at http://retiree.mercermarketplace.com/reckittbenckiser to read more about the process and how to access the HRA portal.

- Call Mercer Marketplace 365 at 1-888-281-3667, Monday through Friday from 8:00 a.m. to 5:30 p.m. Eastern Standard Time; deaf or hard of hearing individuals should dial 711 for Telecommunications Relay Service.

COBRA

Under federal law, eligible dependents may lose coverage due to a COBRA qualifying event such as a divorce, death or a child ceasing to be an eligible dependent.

Eligible dependents are required to notify the Plan Administrator in writing of a qualifying event within 60 days of the event or they will lose the right to continue coverage under the Plan. If an eligible dependent elects to continue coverage, he/she is entitled to the level of coverage the Plan in effect immediately preceding the qualifying event.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of the qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA is exhausted;

- The date the qualified beneficiary notifies the Plan Administrator that he/she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he/she becomes covered under another group health plan or becomes entitled to Medicare; or
- The employer ceases to provide any group health plan.

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

CLAIMS DENIALS AND APPEALS

This section provides general information about the claims and appeals procedure applicable to the HRA Plan under ERISA.

CLAIM-RELATED DEFINITIONS

"Claim" is any request for plan benefits made in accordance with the plan's claims-filing procedures.

"Adverse Benefit Determination" is a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review; and
- A service being characterized as experimental or investigational or not medically necessary or appropriate.

INITIAL CLAIM DETERMINATION

The HRA Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the HRA Plan has to evaluate and respond to a claim begins on the date the HRA Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator. The timeframes on the following pages apply to the claims that you may make under the Plan.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;

- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

TIME FRAMES FOR INITIAL CLAIMS DECISIONS

Time frames generally start when the Plan receives a claim. Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days.

	The HRA Plan
Time frame for Providing Notice	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.
Extensions	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*
Period for Claimant to Complete Claim	You have at least 45 days to provide any missing information.
Other Related Notices	N/A

*15 extension period is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

APPEALING A CLAIM

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing and should be filed with the Claims Administrator as listed on page 18.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a

document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 14. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

The time periods for providing notice of the benefit determination on review are described in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

LEGAL ACTION

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

TIME FRAMES FOR APPEALS PROCESS

The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	The HRA Plan
Period for Filing Appeal	You have at least 180 days.
Time frame for Providing Notice of Benefit Determination on Review	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.
Extensions	None.

YOUR RIGHTS UNDER ERISA

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

Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of 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. 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

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.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans:

Plan Name	Reckitt Benckiser Retiree Health Reimbursement Plan
Plan Number	50002
Plan Sponsor	Reckitt Benckiser, LLC 399 Interpace Parkway, PO Box 225, Parsippany, NJ 07054
Employer Identification Number	16-1095651
Plan Administrator	Reckitt Benckiser, LLC 399 Interpace Parkway, PO Box 225, Parsippany, NJ 07054 (973) 404-2856
Claims Administrator	Mercer Marketplace 365 Retiree • http://retiree.mercermarketplace.com/reckittbenckiser to read more about the process and how to access the HRA portal. • Call Mercer Marketplace 365 at 1-888-281-3667, Monday through Friday from 8:00 a.m. to 5:30 p.m. Eastern Standard Time; deaf or hard of hearing individuals should dial 711 for Telecommunications Relay Service.
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type	Retiree Health Reimbursement Account
Source of Contributions	Reckitt Benckiser, LLC pays 100% of the cost of the Health Reimbursement Account, except for COBRA contributions. Reckitt Benckiser, LLC, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time.

Plan Document

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

Plan Amendment and Termination

Reckitt Benckiser, LLC reserves the right to amend the HRA Plan in whole or in part or to completely discontinue the Plan at any time.

Any amendment, termination or other action by Reckitt Benckiser, LLC will be done in accordance with Reckitt Benckiser, LLC's normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Reckitt Benckiser, LLC, the Plan shall terminate unless the Plan is continued by a successor to Reckitt Benckiser, LLC.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Reckitt Benckiser, LLC to the extent permitted under applicable law.

Plan Administration

Reckitt Benckiser, LLC is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD or in the Plan document. Reckitt Benckiser, LLC has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of retirees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and Reckitt Benckiser, LLC will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor Reckitt Benckiser, LLC will be liable in any manner for any determination made in good faith.

Reckitt Benckiser, LLC may designate other organizations or persons to carry out specific fiduciary responsibilities for Reckitt Benckiser, LLC in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;

- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and

- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

Reckitt Benckiser, LLC will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

HIPAA

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by RECKITT BENCKISER, LLC Retiree Health Reimbursement Arrangement. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the RECKITT BENCKISER, LLC Retiree Health Reimbursement Arrangement (referred to as "the Plan" in this notice, unless specified otherwise).

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Reckitt Benckiser, LLC as an employer — that's the way the HIPAA rules work. Different policies may apply to other Reckitt Benckiser, LLC programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Reckitt Benckiser, LLC

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Reckitt Benckiser, LLC for plan administration purposes. Reckitt Benckiser, LLC may need your health information to administer benefits under the Plan. Reckitt Benckiser, LLC agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The only employees who will have access to your health information for plan administration functions will be the HR Generalist and Benefits Administration, the HR Manager, HR Specialist and Payroll, the Chief HR Officer.

Here's how additional information may be shared between the Plan and Reckitt Benckiser, LLC, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Reckitt Benckiser, LLC, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to Reckitt Benckiser, LLC information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Reckitt Benckiser, LLC cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Reckitt Benckiser, LLC from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement),

or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an “accounting of disclosures.” You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a “limited data set” (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date

by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2018. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice via first class mail.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact the Reward Lead Benefits at the Parsippany, NJ corporate office.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact the Reward Lead Benefits at the Parsippany, NJ corporate office.