# IT'S ABOUT *you!*

# 2025 BENEFITS GUIDE

Bath&BodyWorks®

PUERTO RICO

Bath&BodyWorks

# Welcome

Bath & Body Works invests in **you** by providing benefits and programs that are inclusive and support the diverse needs of you and your family. Our goal is to continually look for ways to make our benefits and programs **better for you.**

Throughout this Benefits Book you will find details about your 2025 benefits, so you can get the most out of them all year long.

## Here's where to find ...



## Stay Connected with Your Benefits

Connect with your benefits all year long at **mybbwbenefits.com**.

To access your personal benefits information during the year, visit HR Access at **HRAccess.bbwcorp.com**. Log on from your computer, smart phone or tablet to:

- Update personal information
- Search for open, internal positions
- Access benefits information
- Access your W-2
- Enroll in benefits, if benefits-eligible, within 30 days of your hire or promotion date. Just click on **Benefits** and follow the instructions to enroll. **Note:** Enrollment elections become effective on your date of hire or the date you become eligible for benefits.

**Questions?** Call Associate Connect at 866.473.4728.

# Connect With Your Benefits

Here are the carriers you can contact with questions about your 2025 benefits:

| | | |
|---|---|---|
| **GENERAL** | | |
| Associate Connect | 1.866.473.4728 | ■ The single resource for all your Bath & Body Works benefits & payroll information. Associate Connect representatives will assist you Monday - Friday between 9 a.m. and 8:00 p.m. EST. |
| HR Access | **HRAccess.bbwcorp.com** | ■ Enroll in benefits (web only).<br>■ Reference, update and access all personal and benefits information.<br>■ Home address<br>■ Benefits information<br>■ PTO (paid time off)<br>■ Access online W-2<br>■ Tax withholding<br>■ Add/update life insurance beneficiaries<br>■ And more!<br>It's your responsibility to ensure that your personal information on file is accurate and up- to-date. |
| Benefits Information | **HRAccess.bbwcorp.com** > Benefits > Benefits Information | Watch videos and find information about all of your benefits. |
| **HEALTH BENEFITS** | | |
| Medical and Dental<br>Mapfre | **mapfre.com**<br>1.787.250.5214, option 5 | Mapfre representatives will respond to your questions about your medical and dental plan from Monday through Friday 7:30 a.m. – 12:00 a.m. and Saturday 7:30 a.m. – 3:00 p.m. payable for the services you receive.<br>The website is available 24/7. |
| WINFertility | 844.343.0667<br>WINFertility Companion app<br>Employer Code: BBW23 | Access to a comprehensive and inclusive family-building benefit toward fertility treatment and related medications, adoption and surrogacy. WIN will help you better understand your options, so you can maximize your benefit and choose the best course of treatment. |
| Vision:<br>VSP | **vsp.com**<br>800.877.7195<br>VSP app | Access information about your vision plan or vision discount. |
| **ADDITIONAL HEALTH BENEFITS** | | |
| Lincoln Financial Group (LFG) Leaves Of Absence | **mylincolnportal.com**<br>(Company code: BBWI) 800.481.2440 | When you need to be off work for family, medical, maternity or parental leave, contact LFG to report your claim. |
| Employee Assistance Program (EAP) | Available 24 hours a day, 7 days a week<br>**guidanceresources.com** (Organization Web ID: BBW) 800.948.3913<br>Download GuidanceNow app | Our EAP provides you eight counseling visits per person per issue each year to support your emotional wellbeing. You can connect to care by face-to-face, video, text, chat, phone, web or app. The EAP provides a lot of other ways to help you balance your work life and your personal life: From referrals and resources to help with just about anything — like hiring movers or finding a home contractor — to financial guidance. The EAP is available at no cost to you, your dependents and housemates (partner, roommate or anyone living under your roof). |
| **SAVINGS AND FINANCES** | | |
| Retirement Savings Plan:<br>Alight | **https://upointhr.com/bbw**<br>888.445.4567 \| Alight Mobile app | Enroll, designate your pre-tax savings amount, name your beneficiary, make your investment choices, and obtain other account information. |
| Tuition Assistance<br>Associate Connect | 1.866.473.4728 | Discuss tuition assistance for work-related undergraduate or graduate course work. |
| **LIFESTYLE AND FAMILY** | | |
| Adoption/Surrogacy Assistance: WINFertility | **www.managed.winfertility.com/**<br>bathandbodyworks<br>844.343.0667 | Support, coaching, and reimbursement for expenses related to adoption and/or surrogacy. |

# About this Benefits Book

Thorough attention to detail was taken to ensure accuracy in this book. However, the wide range of situations that could possibly be included make it almost impossible to ensure that absolutely everything is covered. The constantly changing environment in which we do business, the growth of our company and the desire to always improve are some of the factors that bring about change.

For these and other reasons, the company, from time-to-time, may change various provisions contained in this book.

## No Contract of Employment

The provisions in this book do not constitute an employment contract with you or anyone else and may be changed unilaterally by the company, at any time. Nothing in this book is written or intended to guarantee employment to any Associate, guarantee the terms or conditions of employment, or restrict in any way the right of the company or any Associate to terminate the employment relationship at any time. Employment with the company is at will in all U.S. locations and in locations outside of the U.S. where permissible by law. This means that at any time, with or without prior notice, an Associate is free to resign. Associates can make that decision for any reason they choose, and at the time of termination, all benefits of employment with the company will no longer apply. In addition, at any time, with or without cause and with or without prior notice, it also will be the option of the company to exercise the same decision in terminating an Associate's employment in accordance with applicable law. Unless modified by written agreement, signed by both the Associate and the Vice President of Human Resources or the Office of the General Counsel, no manager or other representative of the company has the authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the provisions of this book or other policies or practices of the company.

## Health Benefits Book "Speak"

The use of the words "you" and "your" refer at all times to active Associates of Bath & Body Works (BBW). "You" and "your" also refer to you and your Covered Dependents as members of our benefits Plans. The use of the words "the company," "our," and "we," refer at all times to the business in which you work.

## Capitalized Terms

Throughout this book you will notice capitalized words embedded within certain sentences. Capitalized terms may indicate those words that are defined in the medical and dental glossary in the back of this book.

## Eligibility

There are several ways Associates become eligible for benefits. See the definition of benefits-eligible associate on page 45.

## When You Have Questions

This book is the place to go first when you have questions. You may find it necessary to get specific interpretations to fully answer some questions—or to determine exactly how a benefit applies to your particular situation. When this happens, your manager, Associate Connect or the benefits administrator (Mapfire, VSP, etc.) will be glad to assist you. Do not hesitate to call on them. Refer to the Connect with Your Benefits section at the front of this book.

## Consequences for Violations of Company Policies

All violations of our policies, or misuse of benefits whether contained in this book, The Code or elsewhere, no matter how trivial they may seem at the time, are harmful to the interests of the company. Associates who violate company policies or misuse benefits are subject to disciplinary action up to and including termination of employment.

Bath & Body Works invests in you by providing benefits and programs that inclusive and support the diverse needs of you and your family. It's up to you to learn about your options and take advantage of all the benefits Bath & Body Works offers, so you can choose the options that are right for you.

# The Bath & Body Works Program is:

## Comprehensive

We design our benefits to support the overall well-being of you and your family with a variety of plans and options, so you can choose coverage that bests meet your needs.

- Medical & Dental
- Pharmacy
- Vision
- Optional life insurance for you and your dependents

Some benefits are provided at no cost to you even if you're not enrolled in any of the above plans.

- Disability
- Life insurance
- Mental Health and Well-Being Employee Assistance Program (EAP)

Lifestyle Benefits

- Merchandise discount
- Vacation and sick time
- Tuition assistance (full-time associates)
- Adoption assistance (full-time associates)

Retirement Savings

- Puerto Rico Retirement Savings Plan

## Cost effective

Bath & Body Works shares in the cost of health care with you by paying over 80 percent of health care costs.

## Competitive

There's nothing like good competition. Throughout the year, we review our benefits plans to ensure we offer you cost-effective options while remaining competitive in the marketplace.

# Your Pay

## Pay Schedule

All associates are compensated on a biweekly pay schedule. Pay periods begin on Sundays and end on Saturdays.

## Direct Deposit or Wisely Payroll Card

The company offers cost effective, environmentally friendly ways of delivering associates' pay: direct deposit or a Visa® Payroll Card. You are eligible and encouraged to sign up for direct deposit of your paycheck into a personal bank account. If you choose not to direct deposit, you will receive your pay via a Payroll Card. This may vary based on state laws. Please refer to your pay method instructions form by logging into HRaccess@lb.com and navigating to the Eforms icon. If you prefer to receive your pay on a Payroll Card, all you need to do is make sure your personal information is accurate in HR Access (i.e. name, address, etc.). We will ensure your Wisely pay card details are on file so there is no action required on your part to receive payment via the Payroll card.

**DIRECT DEPOSIT:** Many associates take advantage of direct deposit. It allows us to deposit your pay directly into the bank account(s) of your choice, in any way you choose. For example, you could have a partial amount of your pay automatically sent to a savings account, while the remaining balance is deposited in your checking account for easy access. Direct deposit takes minimal time to set up and can be done online. If you do not enroll in direct deposit, you will automatically receive your pay on a payroll card.

To enroll in direct deposit, use HR Access or contact Associate Connect at 1-866-473-4728. Following initial enrollment, your direct deposit arrangements may take up to one pay to become active, as account numbers and deposit types are verified for accuracy. Until direct deposit arrangements are active, you will receive your pay on a Payroll Card.

**PAYROLL CARD:** A payroll card is similar to a debit card and will have your name printed on it as well as the Wisely logo. Your payroll card account is loaded with your exact pay biweekly, and your payroll card can be used like a debit card to access your pay. Utilize the cardholder instructions received with the card to locate in network ATMs through the MyWisely App. You will also receive pre-check's that can be made payable to yourself to cash at participating locations. There are fees associated with the use of the payroll card.

Please refer to your cardholder agreement included with the Payroll Card for a schedule of fees.

**HOW TO OBTAIN A PAYROLL CARD:** You will automatically receive a payroll card. There is nothing further you need to do. If your personal information is not up-to-date, you may experience a delay in receiving your new payroll card. If you update your personal information, you will also need to update it with our payroll card vendor, ADP, by calling toll-free at 1-866-313-6901.

## Christmas Bonus

Pursuant to and subject to the limitations of Puerto Rico law, a Christmas bonus contingent on profitability is normally granted to eligible associates between November 15 and December 15 of each year. The bonus is based on eligibility and hire date. You will be eligible for this bonus only if you have worked seven hundred (700) hours or more within the twelve (12) month period from October 1 of the prior year until September 30 of the year in which the bonus is paid.

## Get Your Pay Stub Online

You can get your pay stub online each pay period by logging on to HR Access at **hraccess.lb.com** > About Me > View Payslips.

**No Access to the Internet?** Call Associate Connect at 1.866.473.4728 and hear your pay information via the interactive voice response system.

## Obtaining an Electronic Copy of your W-2

Bath & Body Works' W-2 provider is ADP. All associates will automatically receive their paper W-2 in the mail at the address on file in HR Access and have access to retrieve their W-2 electronically via ADP's website. Your W-2 will be available by the end of January.

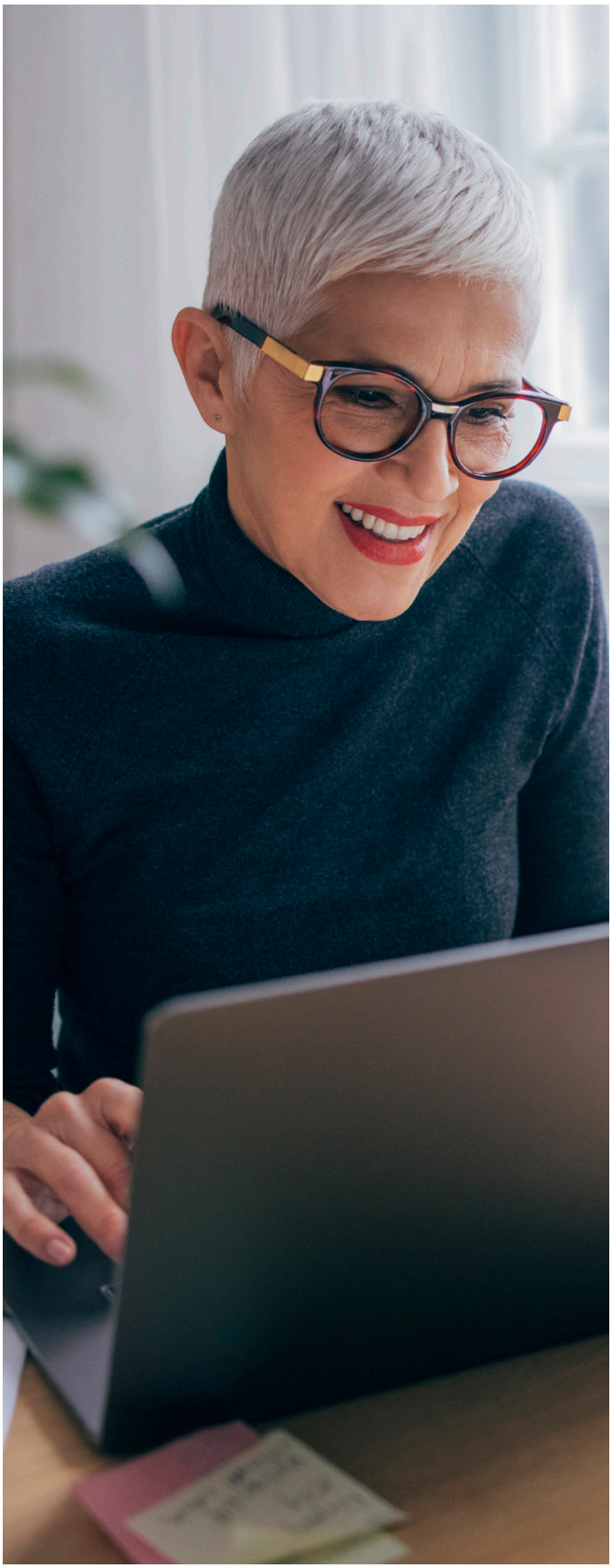
To access an electronic W-2, follow these steps:

- Log on to HR Access at **HRAccess.bbwcorp.com** and click on the "US W2" button; this will take you to the ADP W-2 website
- Once you're on the ADP website, follow the navigation to view, save or print your W-2; you can also select to go paperless and not receive a W-2 in the mail

**GO PAPERLESS:** If you do not want to receive a paper W-2, follow these steps to go paperless:

- Log on to HR Access at **HRAccess.bbwcorp.com** and click on the "US W2" button; this will take you to the ADP W-2 website
- Go to the ADP website via HR Access
- Click on your name in top right corner
- Click "Settings"
- Click "Go Paperless"
- Check box "Receive Paperless Tax Statements" (scroll down to review terms)
- Click "I Agree"

**QUESTIONS?** Contact Associate Connect at 1.866.473.4728.



# The Work Number® Employment Verification

The Work Number® is an automated service that provides employment and income verification for all full-time and part-time associates. This fast, secure service is used when applying for a mortgage or loan, for reference checking, leasing an apartment or any other instances where proof of employment or income is needed. Associates benefit from having control of the process authorizing others access to their information.

Many companies are members of The Work Number®. Companies that are not members will be charged a fee for the verification. Public Assistance Agencies will receive full employment verification free of charge. Ask the company if they are a member of The Work Number® so you can provide them the appropriate contact information.

- Log on to **www.theworknumber.com** or call 1.800.996.7566
- Commercial Verifications: call 1.800.367.5690
- Social Services Agency Line: call 1.800.660.3399

## Other Employment Verification

Contact Associate Connect at 1.866.473.4728 if employment verification is needed for the following:

- Adoption Process
- Bar Exams
- Child Support
- Court Orders
- Education Related/Financial Aid for School
- Lost Wage Statements
- Medicaid

## References

Generally, the company does not provide employment references. Our policy also prohibits any associates, including managers, from providing job references.

In response to an external inquiry for information regarding a current or former Associate, the company will verify only employment dates, employment status (part time or full time), job title and department, and location of an Associate. If you receive a request for a reference, please refer that request to your Human Resources partner for a response.

Verifications of employment for associates working outside of the U.S. must be referred to the Human Resources partner for the brand or function. Verifications of employment for associates working within the U.S. or Puerto Rico can be performed via The Work Number®.

Regarding professional networking sites such as LinkedIn, associates may express personal opinions with respect to their interactions with current or former associates, however, it must be clear that associates are not speaking on behalf of the company

## Questions

Associates who have questions, or need additional instructions, should contact Client Services at The Work Number® at 1.800.996.7566.

| VERIFICATION TYPE | | ACCESS OPTIONS | INFORMATION REQUIRED |
|---|---|---|---|
| **COMMERCIAL**<br>Income requires employee's authorization/salary key.<br><br>**Verification of employment**<br>■ Social Security Number<br>■ Name (Spelled)<br>■ Most recent start date or termination date<br>■ Total time with the company<br>■ Job title (Current or Last)<br>■ Employment Status<br>■ Reference Number | **Verification of income**<br>All Employment information, and…<br>■ Year-to-date Gross Earnings and earnings for the past two years (including base pay, overtime, bonuses and commissions)<br>■ Rate of Pay<br>■ Reference Number | **www.theworknumber.com**<br>1-800-367-5690 | ■ Employer Name or Code*<br>**The employer code for the Bath & Body Works organization is 10217*<br>■ Employee's Social Security Number |
| **SOCIAL SERVICES**<br>Only available to qualifying assistance agencies.<br><br>**Programs**<br>■ Food Stamps<br>■ TANF<br>■ Medicaid<br>■ Housing<br>■ WIC<br>■ Child Support<br>■ Social Security<br>■ and other related services | **Social Services/Wage Audits***<br>Employment & Income Information, plus...<br>■ 36 Month Pay History, Pay Date, Period Ending Date, Number of Hours, Gross Earnings<br>■ Medical/Dental Provider<br>■ Reference Number<br>■ Employment Status<br>■ Reference Number | **www.theworknumber.com**<br>1-800-660-3399 | ■ Employer Name or Code*<br>**The employer code for the Bath & Body Works organization is 10217*<br>■ Employee's Social Security Number |

*In order to obtain a 6-digit Salary key:

1. Log on to **www.theworknumber.com** or dial 1.800.EMP.AUTH (367.2884)
2. Enter company code 10217
3. Enter Social Security number
4. Enter Pin number (your 6-digit date of birth and first two digits of your Social Security number)

The Work Number cannot currently respond to Wage Audit requests from the states of Texas and Minnesota. Legal Note: Bath & Body Works does not establish, maintain, sponsor or endorse any of the services offered by YouDecide.com, Inc. ("YouDecide"). Bath & Body Works makes no endorsements about YouDecide's services or about any Provider offering products or services through the YouDecide program. The YouDecide service is made available to you as a possible money and time saving opportunity and should be used only at your discretion. 

# Holidays

## Holidays

The company recognizes nine holidays a year in Puerto Rico:

- New Year's Day
- Three King's Day
- Good Friday
- Easter
- Mother's Day
- Father's Day
- Thanksgiving Day
- Christmas Day
- General Election

## Eligibility

If you are a full-time non-exempt Associate, you will receive one full day's pay equal to eight hours non-exempt for each observed holiday in Puerto Rico.

If you are a part-time associate, with 30 days of employment, you may be eligible for holiday pay. The amount you will receive will vary based on your average hours worked.

If you are on leave of absence during one of the observed holidays, you are not eligible for holiday pay.

## Religious Holidays

If you'd like to observe a religious holiday that's not on the paid holiday list, your time away from work may be counted as vacation.

# Vacation

Vacation hours provide you with flexibility when you want to take time away from work. You will accumulate vacation hours on a monthly basis

## Who is Eligible?

Full-time (exempt and non-exempt) and part-time (non-exempt) associates with 90 days of service, who work at least 80 hours each month

## Accumulating Vacation Hours

- You will accrue 1 1/4 days or 10 hours for each month in which you work at least 115 hours or ½ day (or 4 hours) each month you work 80 -114.99 hours.
- Vacation hours will not be accrued for those months in which you work less then 80 hours.
- The maximum vacation you can accrue in one calendar year is 15 days or 120 hours.
- If you are newly hired, you will begin accruing vacation hours during the first month in which you work 80 hours or more, unless you are hired under a probationary period contract. Associates hired under a probationary period contract will accrue vacation leave after completing the probationary period, but retroactive to the first month of employment. After 90 days you can begin using the vacation hours that you have accrued during the first 90 days.

## Planning Your Vacation

Vacation is a partnership between you and your manager. By working together, you'll be able to take the time off you need but still be sure our business operates smoothly, efficiently and with no interruptions. By planning for the entire calendar year whenever possible, your manager can ensure appropriate staffing levels for your store.

- A request made at least one day in advance (that does not conflict with necessary staffing levels) should be considered scheduled time.
- Generally, you should use vacation hours in 4- or 8-hour increments.
- Make note of any blackout days or weeks during which vacation is not available due to critical business needs on the store vacation calendar.
- Request vacation from your manager.
- Your manager will document your approved, time off request on the store vacation calendar.

## Vacation Denials

Sometimes, vacation requests are denied due to business needs. If this happens, your manager will tell you why your request was denied. For example, if you are requesting vacation when other associates have already scheduled time, your manager may deny your request because of the need to maintain a minimum staffing level.

## Keeping Track of Vacation

It is mandatory that you accurately report all vacation taken, within the appropriate payroll period, to your manager or through HR Access (see chart for your reporting method). Any attempt to misrepresent your vacation may result in termination. If vacation was not entered during the appropriate payroll period, it will need to be reported to Associate Connect. As soon as you believe a discrepancy exists between how much vacation you have used and what Payroll reflects, please direct the issue to your manager for resolution.

| STORE ASSOCIATES | REPORTING METHOD |
|---|---|
| Full-time/Part-time | Report to store management (will enter into Kronos) |
| Store Management | Kronos timecard |
| DM and above | HR Access Employee Self Service |

## Voluntary Time Off

If the company asks for volunteers to leave early or to not come in due to a lack of work, you may use vacation hours but are not required to do so.

## While on Leave of Absence

If you are on a leave of absence at the end of the year and have unused vacation hours remaining, you will be able to carry over to the next year all earned, unused vacation hours. (See Unused Vacation Hours At Year End for details)

## Unused Vacation Hours at Year End

Unused, accrued vacation hours can be carried over for up to a maximum of 2 years (current year and prior year's unused hours)

- **EXEMPT:** A maximum of 240 hours can be carried over to the following year. No additional vacation hours can be accrued for that year until some or all of the hours have been used. Unused vacation hours over 240 hours will be forfeited.
- **NON-EXEMPT:** Supervisors shall not permit non-exempt associates to accumulate more than two years vacation leave (more than 240 hours or 30 days) without requiring associates to take time for vacation leave.

## Transferring Out of Puerto Rico

If you transfer out of Puerto Rico, you will be paid out all accrued, unused vacation hours. Once you transfer to your new location, you will be eligible to take your available paid time off hours under the new program minus any time you have taken in the current year while in Puerto Rico. For example, if your annual available hours under the new program are 136 hours and you took 24 hours of vacation time while working in Puerto Rico, you will be eligible to take 112 hours for the remainder of the year.

## At Termination

If your employment is terminated for whatever reason after the first 90 days of probationary employment, you will be paid for all accrued, unused vacation leave.

# Sick Time

## Who is Eligible?

Full-time (exempt and nonexempt) and part-time (nonexempt) associates with 30 days of service, who work at least 80 hours each month.

## Accumulating Sick Hours

- You will accrue one sick day or 8 hours for each month in which you work at least 115 hours or ½ day or 4 hours each month you work 80 -114.99 hours.
- Sick leave will not be accrued for those months in which you work less then 80 hours.
- The maximum sick days you can accrue in one calendar year is 12 days or 96 hours.
- If you are newly hired, you will begin accruing sick hours during the first month in which you work 80 hours or more. After 30 days you can begin using the sick hours that you have accrued during the first 30 days.

## Unused Sick Hours at Year End

Unused sick hours will accrue for successive years up to a maximum of 15 days or 120 hours. No additional hours will be accrued until some or all sick hours have been used. Unused sick hours in excess of 120 hours or 15 days will not be paid out.

## Using Sick Hours

You should notify your manager of your illness no later than one hour after the scheduled commencement of your shift.

## Effect of Sick Hours on Leaves of Absence

Illnesses in excess of five business days may be paid under the short-term disability program. Documentation will be required, in writing, by a licensed Physician (see Disability). If you have unused sick time, you may be required to use it for any scheduled and unscheduled work time missed.

## Transferring Out of Puerto Rico

Accrued, unused sick hours will not be transferred or paid out if you transfer out of Puerto Rico.

## At Termination

Accrued, unused sick hours will not be paid out if you terminate employment.

# Leaves of Absence

## Applying for a Family / Medical Leave

When you need to be off work for family, medical or maternity leave, notify your manager and then follow the steps below to request a leave of absence. Depending upon your eligibility, you may qualify for a leave under the Family Medical Leave Act (FMLA) or Company Medical leave. Your leave will be managed by Lincoln Financial (LFG), our disability/FMLA provider.

1. Call Associate Connect at 1-866-473-4728 and follow the prompts or
2. Call Lincoln Financial Group (LFG) at 1-844-869-3454; or
3. Log on to **www.mylincolnportal.com** – Company code: BBWI (first time users)
4. Have the following information available when you make your request:
   A. Reason for absence (symptom or diagnosis)
   B. Medical care provider's name, address, telephone and fax numbers
   C. Last day worked, first day of absence and anticipated return to work date
5. LFG will determine your eligibility and notify you regarding next steps. You must provide required documentation within the timeline given to you. Failure to do so may result in the delay or denial of leave and/or benefits and, in some circumstances, violations of the Company's attendance policy.

## Types of Family / Medical Leaves

### FAMILY & MEDICAL LEAVE ACT (FMLA)

**Eligibility:** FMLA leave is governed by applicable law. Eligible Associates must have at least 12 months of service and at least 1,250 hours worked in the 12 months prior to the requested leave.

**Entitlement:** Under the FMLA, you may be eligible to take up to 12 weeks of unpaid leave during a 12-month period for your own or a family member's serious health condition, to bond with a new child, to manage activities related to a call to active military duty, or to take a one-time leave of up to 26 weeks to care for a Covered Service Member of the Armed Forces.

FMLA leave is for:

- Eligible Associates who have new children, whether through birth, adoption or foster care.
- Eligible Associates who have a serious health condition as defined by the FMLA
- Associates who need to care for a spouse, son, daughter, or parent with a serious health condition as defined by the FMLA
- Associates who need to support a spouse, parent, or son or daughter who is on or called to active duty in the Armed Forces (including the National Guard and Reserves).
- Associates who need to care for a spouse, son, daughter, parent or next of kin who is a covered service member with a serious injury or illness suffered in the line of duty.

**Calculation:** The company uses a rolling year method to calculate how much FMLA leave you have to use. Under this method, each time you request FMLA leave, the company measures back 12 months from your first date of absence. You would be eligible for the FMLA leave not used in the preceding 12-month period. For example, if you used 3 weeks of FMLA in the preceding 12 months you would be eligible to use the remainder of 9 weeks.

LFG will let you know if you qualify under the FMLA and how much time you have available. In some cases, you may request that FMLA leave be taken on a reduced leave schedule (shorter work hours or a shorter work week) or intermittent basis.

Please be aware that we may ask for a second opinion, or, in some circumstances, a third opinion. It is your choice if you want to cover your leave with vacation or have it be unpaid. You may also apply for Short- Term or Long-Term Disability to provide for wage replacement during your leave (See Short and Long-Term Disability Pay).

**Definition of Serious Health Condition:** For purposes of this policy, a "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified

family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

**General Information:** The FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

An associate may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. The FMLA does not affect any Federal or State law prohibiting discrimination or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

## COMPANY MEDICAL LEAVE (FOR NON-FMLA ELIGIBLE ASSOCIATES)

Associates who need leave for their own serious health condition and are not eligible under the FMLA or a similar state protected leave may request a company provided medical leave of absence ("Company Medical Leave"). Company Medical Leave covers continuous absences due to illness or injury of 8 or more consecutive days and must be supported by medical documentation from a doctor. It is not for short-term illnesses of 1-7 days such as a cold, stomach flu, etc. and may not typically be used for intermittent leave. Generally, this leave type is unpaid unless you choose to substitute vacation or any sick leave that is available to you. The Company may in its sole discretion fill your role while you are on Company Medical Leave. Please also refer to our policy for "Leaves Greater than 12 Months". You may also apply for Short- Term or Long-Term Disability to provide for wage replacement during your leave (See Short and Long-Term Disability Pay).

## MATERNITY/ADOPTION LEAVE

Under the Puerto Rico Working Mothers' Protection Act (PRWMPA) you may be able to take leave for the birth or adoption of a child.

Who Is Eligible: Exempt and non-exempt associates who are pregnant. All exempt and non-exempt associates who adopt a child and are entitled to a paid leave of absence under any applicable law.

**Maternity Leave:** You are entitled to eight weeks of leave at your regular pay for each pregnancy. Provided the schedule is approved by your physician, the eight weeks can be used in one of two ways:

- Four weeks prenatal and four weeks of postnatal leave, or
- One week prenatal and seven weeks postnatal If your child is born early, you can defer the remaining prenatal time to after the birth and be paid during this time at full salary. If your child is born later than the due date, your prenatal time will be extended (and paid) and does not reduce from your four weeks of postnatal paid time. If you are still having complications after four weeks of postnatal leave, you make take up to another 12 weeks of unpaid time

**Adoption:** After you adopt a child and bring them into the "family circle", you are entitled to eight weeks of leave at your regular pay. The adopted child must be under the age of five.

**Effect of Maternity/Adoption Leave on Disability Leave and FMLA:** The eight-week maternity/adoption leave counts toward the maximum 26-week benefit period and runs at the same time as FMLA leave. Contact Lincoln Financial Group 30 days prior to your leave so they can help arrange your time off.

Note: If you want to cover your child in the health or welfare plans, you must call Associate Connect to add your child within 30 days of the birth or adoption. If you do not add your child within the first 30 days, you will not be able to enroll the child for coverage until the next Open Enrollment period.

PLEASE NOTE: Coverage is not automatic. You must call Associate Connect at 1-866-473-4728 to enroll or no coverage will be provided.

**Pay During a Family / Medical Leave:** If you are a full-time benefits-eligible Associate and are requesting leave for your own health condition, you might be eligible to receive pay through the Short or Long-Term Disability programs. A full-time or part time Associate might also be eligible for government provided paid leave (see Short and Long-Term Disability Pay).

## FOSTER CARE LEAVE

Full-time benefits eligible Associates may qualify for paid Foster Care Leave if a child has been placed into your care through foster care by a state or county agency or gaining temporary custody of a child(ren) through a kinship program by the county or state. Eligible associates can take up to one week of paid leave per placement, for a maximum of three weeks of paid leave in a rolling twelve month period.

## Other Leaves

### MILITARY LEAVE

Military Leave permits full-time and part-time Associates to fulfill their military obligations as members of the Uniformed Services in accordance with federal and state laws. This includes, but is not necessarily limited to, service in the Army, Navy, Air Force, Marines, Coast Guard, National Guard, Reserves, National Medical Disaster Service, or the commissioned corps of the Public Health Service. Military leave allows associates to be away from their job for training and/or active military service for up to five years (and sometimes longer depending upon the type of service) with the right to re-employment and without loss of length-of-service credit. If you need a Military Leave, please inform your manager and then contact Associate Connect at 1-866-473-4728. You will need to provide notice of your need for leave as soon as possible so that we have time to find someone to fill in for you while you're gone and make certain you are paid, when applicable.

**Annual Military Training:** Full-time and part-time Associates may be given a leave of absence with partial pay when required to participate in military training. The company will pay you the difference in your regular salary and your military pay for up to 30 days of training per Calendar Year. Part-time Associates' base compensation is calculated on an average of the last 12 weeks of earnings prior to your Military training. Please submit your training orders to Associate Connect prior to your leave begin date. In addition, please submit your military paystubs in order to be reviewed for military pay differential.

Pay While on Military Service Leave: If you are on a long-term military assignment, you will be paid the difference between your weekly base compensation and your base military pay according to the below chart:

| LENGTH OF SERVICE | PAY DURATION |
|---|---|
| Less than 2 years of consecutive service | Up to 6 months |
| More than 2 years of consecutive service | Up to 12 months |

Part-time Associates' base compensation is calculated on an average of the last 12 weeks of earnings prior to your Military Leave.

Once you return from military service for a period of one year or greater, you may again qualify to receive pay differential during a subsequent long-term military assignment.

Please submit your military/training orders to Associate Connect prior to your leave begin date. In addition, please submit your military paystubs, if applicable, in order to be reviewed for military pay differential to the following:

- Email: **BBWloa@bbw.com**
- Fax: 917-522-7589614-577-3598
- Please contact Associate Connect at 1-866-473-4728 with any questions.

After your military service, you will be eligible for reinstatement provided you have documentation showing you have completed your military service in a satisfactory manner. You must also apply for reinstatement within the time period established by federal law.

**Benefit Coverage While on a Military Service Leave:** You may choose to remain on the company's health, vision and dental plans for you and your dependents for up to 24 months of your military service at full cost through COBRA. Otherwise, all benefit coverage except for company provided basic term life insurance will end on the 30th day after your last day of work before your leave. Basic term life insurance will continue while you are on Military Leave. Optional life insurance for yourself, Spouse, Domestic Partner or Dependent(s) will not continue while on Military Leave.

**How Military Leaves Affect Vacation:** Contact Associate Connect to discuss your vacation benefits during Military Leave.

### PERSONAL LEAVE

After 30 days of service, both full-time and part-time Associates may request a Personal Leave of Absence. Generally, any approved Personal Leave of Absence will be unpaid, unless you request vacation (or use of vacation is required by the approving manager). Generally, personal leaves will not exceed 120 days. Approval is not automatic. Your manager and HR Partner, if applicable, must approve your request for Personal Leave. Your performance and service with the company, the reason for the leave, and whether business conditions can support your time away will all be considered. Examples of reasons a Personal Leave may be granted include a family member or domestic partner's serious illness, extended overseas family visits, or catastrophic personal events.

To request a Personal Leave:

1. Contact Associate Connect at 1-866-473-4728 to request a Personal Leave packet
2. Request a personal leave from your manager
3. Return completed forms, with manager and HR approval, to Associate Connect.

## BEREAVEMENT LEAVE

Full-time benefits-eligible Associates with at least 30 days of service may take Bereavement Leave with pay. If you are a part-time Associate or an Associate with less than 30 days of service and need to take Bereavement Leave, your time off will be unpaid.

Bereavement Leaves are available in the event of the death of a specified family member.

- You may take up to 80 hours of leave for normal scheduled missed shift following the death of your Spouse, Domestic Partner, parent or child.
- You may take up to 40 hours of leave for normal missed shifts following the death of your Spouse's or Domestic Partner's child or parent, or your or your Spouse's or Domestic Partner's grandchild, grandparent, sister, sister-in-law, brother or brother-in-law.
- You (the associate) may take up to 3 days off if you experience a miscarriage.
- Bereavement leave must be taken within 30 days of the passing of the family member. If you need to use bereavement outside of 30 days, please see your manager and/or HR partner.

Time off to attend the funeral or service of another individual may be taken using PTO or unpaid time off.

### Taking Bereavement Leave

- If you need to take time off to attend a funeral or service, your manager will code bereavement hours in the payroll system, so you are appropriately paid.
- Prior to approving pay for the Bereavement Leave, your manager may request proper verification of the funeral/service, date, location and, where applicable, verification of Domestic Partnership. See Covering a Domestic Partner in the Health Benefits Book to view what constitutes a Domestic Partner under this policy.
- The company understands the deep impact that death can have on an individual or family. If you face circumstances that requires additional time off, PTO may be used or unpaid time off may be granted. Please work with your manager prior to taking time off.

## EMERGENCY LEAVE

Full-time benefits-eligible Associates with at least 30 days of service may receive from one- to three-days of Emergency Leave with full pay. If You are a part-time Associate or an Associate with less than 30 days of service and need to take emergency leave, your time off will be without pay from the company.

Emergency Leave is for sudden and unexpected events such as the critical illness or Injury of a family member. This includes your spouse/domestic partner, parents, children, grandparents, grandchildren, sisters, sisters-in-law, brothers, and brothers-in-law of either you or your spouse/domestic partner. Your own illness, staying home to care for a sick child, lack of transportation or issues with available child care are NOT examples of needs for Emergency Leave. Emergency Leave will not be provided during a period of time in which an Associate is already absent from work on a paid or unpaid leave of absence. To request Emergency Leave, contact your manager. You must inform your manager of your situation before you are scheduled to report to work. Your manager may ask for documentation.

## JURY AND WITNESS DUTY

If you have been summoned to serve as a juror or witness in court and you are a full-time benefits-eligible Associate with at least 30 days of service, we will pay you for regularly scheduled hours while on jury duty. If you are a part-time Associate or an Associate with less than 30 days of service and have been summoned to serve as a juror or witness in court, your time off will be without pay from the company, unless otherwise required by applicable law.

You must provide a copy of your summons to your manager as soon as possible after receipt of the summons. If your day ends early, we ask that you report back to work. You will not be paid when you are required to appear in court as a result of your own personal situation unless you use vacation or other paid leave.

## ADDITIONAL LEAVE DETAILS

### Returning from Leave

- For leaves longer than two weeks, please check in with your manager two weeks before the date your leave expires. If your leave was shorter than two weeks, please check in a day or two before your leave ends.
- For Medical Leaves, call LFG on your first day back to work. (Store Associates: Your information will not appear in the scheduling system for up to 48 hours after your return to work.)

For all leaves, if we don't hear from you at the end of your approved leave, we'll assume that you have resigned and your employment will be terminated. For information regarding your COBRA, re-hire status, and all related benefits, contact Associate Connect at 1-866-473-4728.

**Job Protection:** Whether or not your old job will be waiting for you upon your return from leave depends upon a variety of factors, including your situation, business needs, and the type of leave you took. When appropriate, you may be able to return to work on a part-time basis provided we have a position available that suits your needs and ours.

Here are the details for some specific situations:

- **FMLA Leave or Maternity Leave:** If you are on an approved FMLA leave or Maternity and come back within the FMLA 12-week leave (26 weeks for Caregiver Military Leave), 8-week Maternity Leave, or state law permitted period, you'll have your old job back, or an equivalent position with comparable benefits and pay.
- **Military Leave:** The company follows the USERRA guidelines with respect to returning from a short or long-term military leave. Contact HRD with questions regarding your return.
- **Company Medical Leave or Personal Leave:** If you are on a leave that is not FMLA protected or otherwise legally job-protected, we will do our best to hold your job, but we cannot make any promises.

**If your Former Position Is No Longer Available:** If your original position is no longer available when you return from leave, we may try to find you something else, and you may be offered a position as similar as possible to your former position. Depending on the kind of leave you take, we may not be required to create an opening for you. If you are being offered a new position, your pay will reflect your new position. If you decide not to accept the new position, your employment will be terminated.

**Special Needs or Restrictions:** If you still have special needs or restrictions after your leave ends, your doctor must explain in writing anything that limits the scope of your normal job. We will work together to make any reasonable accommodations.

**Leaves Greater than 12 Months:** If you are on an extended leave of absence (except Military Leave) and are unable to return to work after 12 months, typically your employment will end. However, we will look at individual circumstances in each case when such leave is related to a disability. If during your leave you returned to work but then went back out on leave again within 90 days, both leave periods will count toward this 12-month policy. Depending upon the circumstances, you may be eligible for rehire following termination under this policy.

**Temporarily Working Another Job:** Leaves are not granted for temporarily working another job. If this happens, your position with the company will be terminated.

**Incentive Compensation (IC) and Bonus Payments:** If you are eligible for IC and work for at least four weeks during the season, your payment will not be impacted by the first 14 weeks of leave. If your leave of absence exceeds 14 weeks during a season, your IC payment will be prorated for any time away from work in excess of 14 weeks for that season. If you are eligible for store bonus or sales incentive programs or plans, your eligibility for payout will be determined by your brand payout policy while on leave.

**Maintaining your Benefits While you're On Leave:** If you are already enrolled in benefits (e.g., health, life insurance etc.), you can continue your coverage while you are on an approved leave of absence.

Normal deductions will be taken from your short-term disability payments. However, if you are receiving long-term disability or are on an unpaid leave, you are required to submit payment for your portion of benefits premiums that would normally have been deducted. Associate Connect will send you invoices for the amounts due. Failure to make the required payments may result in the cancellation of your benefits. Please make payments on a regular basis to avoid cancellation of coverage. Any unpaid premiums will be deducted from your first paycheck upon your return to work.

**What Happens to your FSA while on leave?** Payroll deductions for flexible spending accounts (FSA), both dependent and health care, stop while you are on leave if you are not receiving pay from the company. When you return to work, your payroll deductions will be increased to make up the contributions missed while you were on leave.

**Holidays During Leave of Absence:** If you are on a leave of absence during a company observed holiday, you will not be eligible for holiday pay.

# Work Related Incidents

Full-time and part-time associates who sustain a work-related injury may be eligible for Workers' Compensation.

Below are the steps that must be taken should an Associate be injured on the job.

### STORES

- All incidents and injuries, even if they do not require medical assistance at the time, should be reported to your manager.
- Any Associate who has knowledge of a work injury must report it within 24 hours to Associate Connect at 1.866.473.4728 by following the phone prompts to get to Workers' Compensation. If medical treatment is needed, you will be connected to a nurse (The Associate must be available to speak to the nurse). If no medical treatment is needed or the associate is not available, you will be connected to a claims intake specialist.
- After the work injury is reported, contact the Workers' Compensation Case Manager at Associate Connect at 1.866.473.4728 with any questions regarding the work injury/workers' compensation claim
- If a voicemail is left for Associate Connect, your call will be returned within 24 hours or one business day.

# Associate Discounts

### MERCHANDISE DISCOUNT

All associates receive a 40% discount on Bath & Body Works products.

### HOME, AUTO AND PET INSURANCE

Get access to special discounts and convenient payment options for your personal insurance needs.

### METLIFE PET INSURANCE

**www.metlife.com/mybenefits**
(Company Name: Bath & Body Works)
1-800-438-6388

### FARMERS GROUPSELECT℠

**Auto and Home Insurance**
**www.myautohome.farmers.com**
(Company Name: Bath & Body Works)
1-800-438-6381

# Retirement Savings

## Bath & Body Works Puerto Rico Retirement Savings Plan

We want you to be at your best financially – now, and in your retirement. To support your future savings goals, we've designed the Bath & Body Works Puerto Rico Retirement Savings Plan.

### RETIREMENT SAVINGS PLAN DETAILS

The Retirement Savings Plan provides two ways for all eligible associates to save for their future: Savings and Company Match

- Once eligible, enroll in the Retirement Savings Plan and elect to save up to 15% of your pay (base pay + overtime + incentive compensation/bonus) and the first 4% you save will be matched 100% with an additional 50% on the next 2%. This means if you contribute 6% of your pay you will receive a full 5% match.
- Your account funds will be immediately 100% vested – which means if you were to leave the company, you would take your account balance with you.
- Contributing to your retirement account on a pre-tax basis can help you lower your current income taxes.
- Your contributions are conveniently taken from your paycheck.

### CATCH-UP CONTRIBUTIONS

If you are age 50 or greater at any time before the end of the calendar year, and you have made the maximum savings contributions permitted by tax law or the Plan, you are eligible for additional "Catch-Up Contributions" to the Plan for that calendar year. Once you contribute the maximum allowed by the IRS, you will automatically be enrolled into the catch-up contributions. The maximum amount of Catch-Up Contributions you may make in 2025 is $1,500.

### INVESTMENT FUNDS

The Retirement Savings Account offers a variety of investment options to choose from based on your investment preferences, risk tolerance and retirement age expectancy. Investment options will be outlined in the official Retirement Savings Plan SPD which can be found on HR Access.

### ELIGIBILITY

If you are a full-time or part-time associate who is at least 21 years old, you may contribute to the Retirement Savings Plan after you have completed one year of service.

### HOW TO SAVE

Once eligible you'll receive more information from Alight, like how to enroll, where you can invest your money, when it vests and other related Plan details. And unlike the health and wellness plans, there is no deadline to enroll - and you can enroll or make account changes any time.

### ENROLL!

**www.upointhr.com/bbw**

1-888-445-4567

Create your account and follow the steps to enroll. Be sure to provide your mobile phone number within your profile for future password reset authentications. Once your online account is established, download the Alight Mobile App.

### THERE'S MORE YOU NEED TO KNOW ABOUT THE RETIREMENT SAVINGS PLAN

This is not the official Summary Plan Description for the Bath & Body Works, Puerto Rico Retirement Savings Plan. This is just a brief summary and does not contain all Plan details. The Summary Plan Description can be found on HR Access>Benefits Information, or you can call Associate Connect to request a paper copy be sent to you

# Coverage and Enrollment

## Eligibility and Enrollment Deadlines

We want you to have the coverage you need when you become a full-time associate, which is why you are eligible for the benefits below on your hire or promotion date:

- Combined Medical & Dental Plan
- Vision Plan
- Optional Life Insurance

Make your enrollment elections during annual open enrollment (typically in October each year) or within 30 days of date of hire or becoming eligible for benefits. If you miss it, you'll have to wait until the next open enrollment period to enroll or make changes, unless you experience a "qualified life status change" (i.e. marriage or the birth of a child). See page 23 for more information about making changes during the year.

## New Hires and Newly Eligible Associates

Consider enrolling as soon as possible. Since you're eligible for benefits immediately, the amount you owe for them is calculated as of your date of hire, or the date when you became eligible for benefits, regardless if you used them or when you enrolled. Once enrolled, any missed premiums will be deducted from your next paycheck, which may mean a one-time, temporary reduction in your net pay. And the sooner you enroll, the sooner you'll receive your medical/dental ID Card, any other related information needed to use your benefits.

## Who is Eligible?

You are eligible to enroll in benefits if:

- You are a full-time Associate. A full-time associate is a non-seasonal associate who is classified as full-time (full-time associates are generally expected to work at least 30 hours per week).

## Family

We care about the wellbeing of your family too, which is why we offer coverage for your eligible dependents. Their coverage becomes effective the same day as yours. Eligible dependents include:

- Spouse
- Same or opposite-sex civil union or domestic partner
- Children under the age of 26 through:
  - Birth
  - Legal adoption or the verifiable process of legal adoption
  - Marriage, civil union or domestic partnership
  - Foster care
  - Legal guardianship

## Covering a Child

Your child is eligible, regardless of whether they are a student, married, eligible for coverage through their own job, or your tax dependent. However, in the case of a child of your domestic partner or a child subject to guardianship, you may be taxed on the value of the child's benefits if they are not your tax dependent.

## Covering a Domestic Partner

A same or opposite-sex domestic partnership or civil union partnership must meet the following requirements:

- You have a legal civil union in a state that uses the civil union to formally recognize same-sex relationships or, if you don't have a civil union, you:
  - Are in a single dedicated relationship of at least 60 months and intend to remain in the relationship indefinitely; and
  - Share the same permanent residence and have done so for at least 60 months.
- Are not related by blood or a degree of closeness that would prohibit marriage in the law of the state in which you reside.
- Each are at least 18 years old.
- Each are mentally competent to consent to a contract.
- Neither you nor your domestic partner is married to another person under either statutory or common law.
- Are financially interdependent.
- Both would sign an affidavit of domestic partnership and provide evidence of the partnership if asked.

To receive appropriate tax treatment, be sure to properly designate your dependent during your benefits enrollment:

- Domestic partner: for same or opposite sex domestic partnerships, or for civil union partnerships
- Child of your domestic partner, or child subject to guardianship who is not your tax dependent

# Before You Enroll

- **Document** your enrollment deadline based on your hire date, or the date you became eligible for benefits.
- **Read** this book and review our benefits website at **mybbwbenefits.com** to understand the benefits available to you
- **Compare** Bath & Body Works benefits with those of your Spouse or Domestic Partner to determine which options best suits your and your family's needs.
- **Gather** all information you need to enroll:
  - Dependent(s) date(s) of birth
  - Dependent(s) Social Security number(s)
- **Assign** beneficiary(ies) to your life insurance

## How to Enroll

Enroll online through HR Access 24/7 on any computer, smartphone, or tablet with an internet connection.

**Make changes** or edits to your benefits at any time during the open enrollment period.

**Enrollment** elections become effective on your date of hire, or the date you became eligible for benefits.

**Be careful...don't miss it!** If you miss this opportunity, you'll have to wait a year to enroll or make changes unless you experience a qualifying event, such as marriage or the birth of a child.

## What Happens After You Enrolled

**PAYROLL DEDUCTIONS:** Payroll deductions for your benefits elections will be taken from your first paycheck (if enrolled) and will continue for each pay period throughout the year. If you're not enrolled right away, deductions will be taken as of your eligibility date.

**CONFIRMATION STATEMENT:** Following open enrollment, a confirmation statement will be mailed to your home confirming your enrollment elections. It is important that you review the confirmation statement and notify Associate Connect if it is not correct **as soon as possible**.

Newly hired or newly-eligible associates (enrolling outside of the open enrollment time frame), can view/print a confirmation statement after enrolling through HR Access.

**MEDICAL/DENTAL ID CARDS:** You'll receive a new combined medical and dental ID card before the beginning of the plan year.

**VISION BENEFITS:** You will not receive a vision ID card for the Vision Plan. See page 35 for information about how to receive your benefits.

**HRAccess.bbwcorp.com**

Log on, then click on **Benefits** and follow the steps to enroll.

## Making Changes During the Year

You must experience a qualified life status change to change your elections after Open Enrollment ends. Changes must be made within 30 days of the event. Events include:

- Birth or adoption or placement for adoption of a child
- Marriage
- Divorce or legal separation
- Termination of same or opposite-sex domestic partnership, or civil union relationship
- Death of a spouse or dependent
- Dependent child reaches age 26*
- Termination of foster care placement or guardianship
- Change in employment status impacting your dependent's benefit eligibility
- National Medical Child Support Notice or Qualified Medical Child Support Order (not limited to 30 days but coverage won't be retroactive)
- Entitlement to Medicare or Medicaid
- Loss of other health insurance (for a reason other than failure to pay premium)
- Unpaid leave of absence
- Loss of Medicaid or SCHIP or becoming eligible for premium assistance under Medicaid or SCHIP (change must be made within 60 days for Medicaid and SCHIP events)
- A status change (full-time to part-time or part-time to full-time) will impact your benefits eligibility.

*Coverage will end on the last day of the month of the dependent's 26th birthday.

## Connect with Your Benefits

To manage your benefits, see the Connect with Your Benefits section at the front of this book for details on how to connect with the various benefits carriers.

## What Happens to Your Benefits If:

**YOU LEAVE THE COMPANY:** Your benefits end on the date your employment with the company ends. Generally, this will be your last day worked. To continue health benefits, please see Continuing Your Health Benefits on page 50.

**YOU'RE REHIRED:** You will be eligible for health benefits immediately upon rehire. (Enrollment information is located on page 23.) If you are rehired within 30 days, you will be re-enrolled into the same benefits you had when you were previously employed. If you are rehired after 30 days, you will need to re-enroll in benefits. In either situation, you have 30 days from the date you were rehired to make changes to your elections.

**YOU ARE ON AN APPROVED LEAVE OF ABSENCE:** Please call Associate Connect at 866.473.4728 to learn how to continue your benefits. You'll find more information on Leaves of Absence in the Leaves of Absence Guide on **mybbwbenefits.com** under Resources.

**YOU DO NOT PAY THE COST OF COVERAGE:** Your benefits will end if you fail to pay for your benefits coverage.

**YOU NO LONGER MEET THE ELIGIBILITY REQUIREMENTS:** Your health benefits end on the date you no longer meet the Plan's eligibility requirements.

## Additional Information

See additional health benefits information in the Administrative Information section in this guide:

- Coordinating with other Plans
- Subrogation and reimbursement requirements
- How to File/Appeal a Claim

Bath & Body Works intends to maintain the health benefits programs indefinitely, but reserves the right to terminate, suspend, discontinue or amend any program at any time. If any health or welfare benefits program is terminated, your rights are limited to Covered Charges incurred before termination.

# Your Medical Plan

Bath & Body Works offers a comprehensive medical plan through Mapfre for eligible Puerto Rico associates. This section provides details about your benefits under the plan. For additional plan details, contact Mapfre at 1.787.250.5214, option 5, or log on to **mapfre.com**.

## Medical and Dental Biweekly Premiums

| | Mapfre Puerto Rico |
|---|---|
| Associate Only | $43.77 |
| Associate + Spouse/ Domestic Partner | $92.10 |
| Associate + Child(ren) | $87.27 |
| Associate + Family | $115.88 |

## Mapfre Medical Choice Unlimited co-payments

| | Co-payments |
|---|---|
| **Physician Office Visits** | |
| Generalist | $5 |
| Specialist | $10 |
| Sub-Specialist | $15 |
| Psychiatrist | $10 |

## Medical Co-insurance and out-of-pocket maximums

| | Co-payments |
|---|---|
| Major Medical Individual Calendar Year Deductible | $100 |
| Major Medical Family Calendar Year Deductible | $200 |
| Major Medical Co-insurance | 20% |
| Maximum Out-of-Pocket (medical and pharmacy) | $6,350 Individual<br>$12,700 Family |

## A Word About Out-of-Pocket Maximums

Out-of-pocket maximums apply each calendar year to covered expenses.

- Co-pays do not count toward the Out-of-Pocket maximum.
- When the Individual Out-of-Pocket maximum is reached for any one Covered Person in a calendar year, Covered Expenses are payable at 100% for the rest of that year.
- When the family Out-of-Pocket maximum is reached for all Covered Persons in a calendar year, Covered Expenses are payable at 100% for all Covered Family Members for the rest of the year.
- Each Out-of-Pocket maximum will accumulate separately. For example, Covered Expenses that accumulate toward a NETWORK Out-of-Pocket maximum will NOT accumulate toward an out of NETWORK, Out-of-Pocket maximum.

**Is my doctor in the network?**

To determine if your doctor is in the Mapfre network, call the number on the back of your medical ID card 1.787.250.5214, option 5 or log on to **mapfre.com**.

### SIGN UP FOR A VIRTUAL CONSULTATION WITH TELEMEDIK

Interact with a doctor or nurse live online through your cell phone (IOS or Android), computer, tablet and mobile device.

- Available in real-time, 24 hours a day / 7 days a week
- First visit is free with following visits $20.00.

1. To register, call TeleMedik at l-787-999-6194.
2. Have your health plan card available.
3. After the representative creates your account you will receive an email to activate your account.
4. Download the Telemedik Innova app.
5. If you register your dependents, each must have an independent email.
6. Now your virtual consultation service will always be available by you or your dependents by calling 1-787-999-6194.

Bath&BodyWorks

# Medical Coverage

| Covered Services & Supplies | Mapfre Network |
|---|---|
| **Emergency Room Copay** | |
| Emergency Room | $0/accident; $50/sickness |
| Urgent Care | $0/accident; $50/sickness |
| **Inpatient Hospital Co-pay** | $50 |
| **Outpatient Surgery Co-pay** | $25 with pre-authorization; $50 without pre-authorization |
| **Emergency Room Copay** | |
| Primary Care Physician | Generalist $5 |
| Specialist | $10 |
| Sub-specialist | $15 |
| **Allergy Test** | 20% Coinsurance |
| **Autism** | Genetics<br>■ Neurology<br>■ Immunology<br>■ Gastroenterology and Nutrition<br>Therapies (includes visits referred by a physician, without age restriction):<br>■ Speech and Language<br>■ Psychological<br>■ Occupational<br>■ Physical<br>We will not rescind, refuse, deny coverage or services because the insured is diagnosed with autism. |
| **Oral Chemotherapy** | 20% Coinsurance |
| **Chiropractor, Osteopathic Manipulative Therapy, Physical Therapies and** | 20 sessions for physical therapy, osteopathic manipulative therapy, acupuncture (pain management) and chiropractor. Combined limit 20 sessions per |
| **Acupuncture** | calendar year; therapy co-payment $7. |
| **Durable Medical Equipment** | 20% Coinsurance |
| **Emergency Room** | $0/accident; $50/sickness |
| **Home Health Care** | 20% Coinsurance |
| **Laboratory Services** | 20% Coinsurance |

| Covered Services & Supplies | Mapfre Network |
|---|---|
| **Learning Disabilities** | ■ Speech Therapy<br>■ Occupational Therapy<br>Insured must submit Speech Pathologist report and referral to MAPFRE Life. |
| **Dialysis and hemodialysis** | Covered under Major Medical |
| **Maternity Care Benefits** | Covered as essential benefit |
| **Pulmonary Rehabilitation** | Respiratory Therapy: $7 co-pay. Limited to 20 therapies per calendar year. |
| **Outpatient Occupational Therapy** | Covered under Major Medical |
| **Outpatient Physical Therapy** | Covered under Major Medical |
| **Physician Office Services** | Physician Office: 100% after payment of $5 Generalist/$10 Specialist/<br>$15 Sub-Specialist Co-pay. |
| **Podiatric care** | $10 specialist co-payment<br>Treatment is based on medical necessity. |
| **Preventive Healthcare** | Services will be covered at 100% based on Health Reform Protocols |
| **Prosthetic Devices** | Covered under Major Medical |
| **Rehabilitation Therapy** | Covered under Major Medical |
| **Skilled Nursing Facility Inpatient Rehabilitation Facility** | 20% Coinsurance |
| **Speech Therapy** | Covered under Major Medical |
| **Substance Abuse** | $10/outpatient services<br>$50 admission/inpatient services |
| **Transplantation Services (Organ/Tissue)** | Covered at 100% up to $500,000 per calendar year. After the satisfaction of the calendar year Deductible: Includes Heart, Lung, heart/Lung, Liver, Kidney, Pancreas, Kidney/pancreas, Bone marrow transplant: Limitations on maximum amounts apply |

*Before hospitalizations, surgeries and certain diagnostic tests will be performed you will need pre-authorization from Mapfre. To obtain authorization, please call Mapfre at 1.787.250.5214, option 5.

# Preventive Services

Preventive Services will be covered with a $0 Co-pay and $0 Co-insurance.

## Affordable Care Act program per category

| PREVENTIVE SERVICE | Male | Female | Child |
|---|---|---|---|
| Physical examination | x | x | x |
| CBC (Complete Blood Count) | x | x | x |
| CMP (Comprehensive Metabolic Panel) | x | x | x |
| Urinalysis | x | x | x |
| PSA (Prostatic Specimen Antigen) | x | x | x |
| Pap Smear | x | x | NO |
| Mammography (50-74 yrs of age) every 1-2 yrs | NO | NO | NO |
| Ocular Prophylaxis | NO | X | NO |
| Subjective assessment of vision and hearing | x | x | x |

## Guides for Preventive Health Care

| PREVENTIVE SERVICE | Birth - 1 Year | 1-4 Years | 5-12 Years | 13-18 Years |
|---|---|---|---|---|
| Schedule of office preventive visits | ▪ Within first 2 weeks<br>▪ 2 months<br>▪ 4 months<br>▪ Between 6-9 months | ▪ 15 months<br>▪ 2 years<br>▪ Once between 3-4 years | ▪ 5 years<br>▪ Once between 7-9 years<br>▪ 12 years | ▪ Once between 13-18 years |
| Components and | ▪ Physical and medical history<br>▪ Height and weight<br>▪ Head circumference<br>▪ Ocular Prophylaxis<br>▪ Hemoglobin blood test<br>▪ Preventive health counseling and education<br>▪ Dental caries prevention<br>▪ Subjective assessment of vision and hearing<br>▪ Developmental screening Injury prevention | ▪ Physical and medical history<br>▪ Height and weight<br>▪ Preventive health counseling and education<br>▪ Dental caries prevention<br>▪ Vision screen 3-4 years<br>▪ Subjective assessment of hearing<br>▪ Developmental screening<br>▪ Blood pressure<br>▪ Injury prevention | ▪ Physical and medical history<br>▪ Height and weight<br>▪ Preventive health counseling and education<br>▪ Dental caries prevention<br>▪ Vision screen<br>▪ Hearing screen<br>▪ Blood pressure<br>▪ Injury prevention | ▪ Physical and medical history<br>▪ Height and weight<br>▪ Preventive health counseling and education<br>▪ Dental caries prevention<br>▪ Blood pressure<br>▪ Injury prevention |

| Preventive Services | 19-49 Years | 50-54 Years | 55+ |
|---|---|---|---|
| **Adult physical examination** | Every 5 years | Every 2 years | 1 per calendar year |
| Blood pressure check | Every 2 years | Every 2 years | 1 per calendar year |
| Blood, Cholesterol (Total and HDL) | Every 5 years | Every 2 years | 1 per calendar year |
| Complete Blood Count (CBC) | Every 5 years | Every 2 years | 1 per calendar year |
| Chemistry panel | Every 5 years | Every 2 years | 1 per calendar year |
| Hemoccult | Not Covered | Every 5 years beginning at age 50 | Every year |
| Colonoscopy or Flexible Sigmoidoscopy | Not Covered | Every 5 years beginning at age 50 | Every 5 years |
| Vision Screening | Not Covered | Not Covered | Every 1-2 years beginning at age 75 |

# Guides for Preventive Health Care

| COUNSELING & PREVENTIVE MEDICINE | |
|---|---|
| **Aspirin to prevent cardiovascular conditions (CVD) (Rx)** | Men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. |
| **Aspirin to prevent cardiovascular conditions (CVD) (Rx)** | Women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage. |
| **Folic Acid** | Women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid. |
| **Iron Supplements** | Children between 6-12 months/ high risk/ patients with anemia |
| **Tobacco Abuse Consultation** | Counseling and Intervention for adults who use tobacco products |
| **Breast feeding Consultation** | (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.<br>Adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. |
| **Depression Consultation** | Screening 6-17 years of age |
| **Obesity Consultation** | Screening and intensive counseling - obese women and men |
| **Healthy Diet Counseling** | Adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. |
| **STI Counseling** | Counseling- Sexually active teens and adults in high risk |
| **Alcohol Abuse Consultation** | Screening and Counseling- men, women and pregnant women |
| **BRCA** | Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing. |
| **SCREENINGS** | |
| **Bacteriuria Asymptomatic** | Asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prental visit, if later |
| **Chlamydia** | Screening women 24 or less/25 or more in high risk |
| **Hypothyroidism** | Screening for new born |
| **HIV** | Screening adults and teenagers in high risk<br>Screening pregnant women |
| **Hepatitis B Virus** | Screening pregnant women |
| **Lipid Disorders** | Screening- men 35 or more<br>Screening- women 45 or more, with high risk of coronary disease (CHD) |
| **Phenylketonuria (PKU)** | Screening for new born |
| **Rh(D) Factor** | Screening pregnant women- first visit related to pregnancy |
| **Sickle cell disease** | Screening for new born |
| **Syphilis** | Screening pregnant women |
| **Abdominal Aortic Aneurism** | Screening men 65-75 who smoke |
| **Gonorrhea** | Screening - pregnant women and women in risk |
| **Osteoporosis** | Screening- postmenopausal women 65 or more with out health risk factors, 60 or more with health risk factors |
| **Diabetes Mellitus** | Screening for women and men with arterial pressure 135/80+ |
| **Colorectal Cancer** | Screening for women and men over 50 |
| **Anemia** | Screening on a routine basis for asymptomatic pregnant women |
| **Autism** | Screening for children at 18 and 24 months |

| IMMUNIZATIONS | |
|---|---|
| **Hepatitis B (Hep B)** | At moment of birth |
| **Diphtheria, Tetanus and Pertussis** | 2 & 6 month of age/4 yrs |
| **Tetanus & Diphtheria (Tdap)** | 11 yrs/12 threw 18 if not vaccinated |
| **Inactivated Poliovirus (IPV)** | 2,4 & 6 months of age/4 yrs of age |
| **Haemophilus Influenza, Type B (Hib)** | 2,4 & 15 months of age. If administered between 15 to 59 months of age no additional dosage is required. |
| **Pneumococcal (PCV) & (PPV)** | 2 to 59 months of age/4,6,15 months of age. If administered between 24 months of age no additional dosage is required. |
| **Measles, Mumps and Rubella (MMR)** | 12 months of age/4 yrs of age |
| **Mumps (VAR)** | 12 months of age/4 yrs of age (second dosage) |
| **Hepatitis A (Hep A)** | 12 months of age. A second dosage is required 6 months after first dosage is administered. |
| **Meningococcal (MCV) & (MPS)** | 11-18 yrs of age/children 2-10 yrs of age with health risk factors |
| **Influenza A (H1N1)** | Emergency service personnel Pregnant women<br>People who take care of children less than 6 yrs of ag 6 months to 24 months of age<br>24-64 yrs of age with health risk factors |
| **IMMUNIZATION TEENAGERS AND ADULTS** | |
| **Tetanus Diphtheria Pertussis (Td/Tdap)** | Adults 19-64 yrs/ every 10 yrs / > 65 yrs of age every 10 yrs |
| **Human Papillomavirus** | 19-26 yrs of age/ 3 doses (females) |
| **Mumps (VAR)** | 19-65 yrs of age ( 2 doses) |
| **Zoster** | 60-65 yrs of age 1 doses |
| **Measles, Mumps and Rubella (MMR)** | 19-49 yrs of age (1 to 2 doses) / 50-65 yrs ( 1 doses) |
| **Influenza** | 50-65 yrs ( 1 doses annually) |
| **Pneumococcal** | 19-64 yrs (1 to 2 doses ) / > 65 yrs (1 doses) |
| **Hepatitis A (Hep A)** | 19-65 yrs (2 doses) |
| **Hepatitis B** | 19-65 yrs (3 doses) |
| **Meningococcal** | 19-65 yrs ( 1 or more doses) |
| **Influenza A (H1N1)** | Emergency service personnel Pregnant women<br>People who take care of children less than 6 yrs of age<br>6 months to 24 months of age<br>24-64 yrs of age with health risk factors |

## Services Not Covered by the Plans

| SERVICES NOT COVERED BY THE PLAN | MAPRE CHOICE UNLIMITED | |
|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK |
| Abdominoplastys | X | X |
| Chelation Therapy | X | X |
| Cosmetic or reconstructive surgery or treatment | X | X |
| Custodial Care | X | X |
| Dental Care | X | X |
| Disposable Medical Supplies | X | X |

| SERVICES NOT COVERED BY THE PLAN | MAPRE CHOICE UNLIMITED | |
|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK |
| Experimental or investigational services or supplies | X | X |
| Eye and hearing aid services and supplies | X | X |
| Hair services and supplies | X | X |
| Herbal medicine, holistic or homeopathic care, including drugs | X | X |
| Immediate family treatment | X | X |
| Learning Disabilities | X | X |
| Liposuction | X | X |
| Marital counseling | Covered through EAP | X |
| Private Duty Nursing Care | Not Covered | Not Covered |
| Surgical treatment of temporomandibular joint syndrome (TMJ) | X | X |
| Stand by services required by a Physician | X | X |
| Telephone consultations | X | X |
| Tobacco dependency | Based on Health Reform Protocols | Based on Health Reform Protocols |
| Training | X | X |
| Transplantation Services | X | X |
| Volunteer Services | X | X |
| Membership Costs | X | X |
| Non-Medical Practitioners | X | X |
| Nutrition and Health Education | X | X |
| Obesity treatment | X | X |
| Occupational Injury or Sickness | X | X |
| Personal convenience or comfort items | X | X |
| Pre-exiting Conditions | Based on Health Reform Protocols | Based on Health Reform Protocols |
| Private Duty Nursing | X | X |
| Reproduction | X | X |
| Reversal of Sterilization | X | X |
| Sex-change surgery | X | X |
| Surgical correction or other treatment of malocclusion | X | X |
| Surgical eye procedures | Non medical | X |

## Alternate Care Proposal

The cost of services, treatments or supplies described in an Alternate Care Proposal (ACP) may be considered a Covered Service by the plan. An ACP is a cost effective course of treatment developed by Mapfre and authorized by Bath & Body Works as an alternative to the services and supplies that would otherwise have been considered Covered Services and Supplies. Unless the ACP states otherwise, all provisions of the program shall apply to services under an ACP as they would to any Covered Service listed here.

## Wellness Services and Disease Management Programs

Contact Mapfre to learn about their related wellness, medical and disease management programs, including:

- Employee Assistance programs through FHC

## Live well with Diabetes and MAPFRE

Get a free Blood Glucose Meter, test strips and lancets at a fixed copay of $15. Call 1.787.783.9855 to learn more.

# Pharmacy Coverage

An overview of coverage is outlined in this section. For additional plan details contact Mapfre at 1.787.250.5214, option 5 or log on to **mapfre.com**.

## Pharmacy Plan

What you'll pay for prescriptions

| | |
|---|---|
| Non-Preferred Brand | $20 |
| Preferred Brand | $15 |
| Bioequivalent | $10 |
| Specialty Rx thru | $20 |
| Mail Order 90 Days | $40/$30/$20 |
| Oral Chemotherapy | 20% |

## Drugs Covered

- Legend drugs. Exceptions: See Drugs Excluded list below
- Diabetic Care: Insulin on prescription
- Compounded medication or which at least one ingredient is a legend drug
- State Controlled Drugs. Any drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber.
- Tretinoin (e.g. Retin-A®) and isotretinoin (e.g. Accutane®) for individuals through age 21.
- Contraceptives: Oral, Generics only and via mail order
- Immunization agents, specialty: vaccines, covered for individuals through age 17, as recommended by The American Academy of Pediatrics.
- Drugs to treat ADD/Narcolepsy for individuals through 18 years of age – including amphetamine mixed salts, e.g. Adderall®, Adderall XR®

## Drugs Excluded

- Adenosine preparations
- Anabolic steroids
- Abortifacients (e.g. Mifeprex®)
- Immunization Agents (e.g. immune globulina, Anti Rho (D) immune globulin), allergens, blood plasma, blood serum and related substances; except: vaccines, which are excluded for individuals 18 years of age or older.
- Antiobesity, including: D-Amphetamine sulfate (e.g. Dexedrine®), or ortistat (e.g. Xenical®)
- Botulinum toxin (e.g.) Botox®)
- Anti-Wrinkles (e.g. Renova®)
- Contraceptives: Diagphragms/Kits/Cervical Caps, Implant, Injectable, Intrauterine Devices, Non-Legend,/ Emergency, Transdermal/Intravaginal Ring (Including levonorgestrel, e.g. Norplant®); except: oral, which is covered only generics and through mail order.
- Drug for the treatment of alcoholism, specifically: Antabuse® (e.g. disulfiram), acamprosate (e.g. Campral®)
- Drugs for the treatment of chemical dependency, specifically: methadone, psychoactive drugs (naloxone, nalmefene, naltrexone, flumazenil)
- Diagnostic agents (e.g. Telepaque®, Bilopaque®, Hypaque®)
- X-ray Evacuants (e.g. Colyte®)
- Scierosing agents
- Linezolid (e.g. Zyvox®)
- Drugs to treat ADD/Narcolepsy for individuals 19 years of age or older – including amphetamine mixed salts, e.g. Adderall®, Adderall XR®
- Drugs to treat myasthemia gravls, specifically: pyridostignmine, neostigmine
- Protease inhibitors, specifically: atazanavir (e.g. Reyataz®), Saquinavir (e.g. Invirase®) (e.g. Crixivan®), ritonavir (e.g. Norvir®), amprenavir/vitamin e (e.g. Agenerase®), fosamprenavir (e.g. Lexiva®), nelfinavir (e.g. Viracept®)
- Shampoo and Dandruff preparations

- Drugs to treat impotence/erectile dysfunction (e.g. methyltestosterone, testosterone enanthate, testosterone cypionate, yohimbine, slidenafil)
- Enzyme Deficiency Agents, for example: Cerazyme®
- Fertility medications, regardless of intended use
- Fluoride Supplements
- Growth Hormones, regardless of intended use
- Hair Growth Removers (e.g. Vaniga®)
- Hair Growth Stimulants
- Hematinics; except: folic acid, which is covered.
- Non-Legend drugs other than insulin
- Nutritional Supplements
- Potassium Supplements
- Pigmenting/Depigmenting agents
- Specific Antagonists & Antidotes
- Scabicides & Pediculicides
- Smoking Deterrents
- Tretinoin (e.g. Retin-A®) and isotretinoin (e.g. Accutane®) for individuals 22 years of age or older.
- Therapeutic devices or appliances (includes needles and syringes) unless listed as a covered product.
- Vitamins and minerals; except: pre-natal vitamins, which are covered.

## Prior Authorization Drugs

For the following drugs or drugs categories, prior authorization is required:

- Antineoplastics & immunosuppressives agents (e.g. Zoladex®) (injectable), including monocional antibodies, e.g. Synagis®
- Bio-Technological Drugs (As per MAPFRE's list)
- Butorphanol (e.g. Stadol®)
- Nalbuphine (e.g. Nubain®)
- Pamidronate (e.g. Aredia®)
- Drugs to treat Amyotropic Lateral Scierosis or Multiple Sclerosis therapy, specifically: riluzole (e.g. Rilutek®), glatiramer (e.g. Copazone®), interferon (e.g. Betaseron®), Avonax®)
- Antiarthritics, specifically: etanercept (e.g. Enbrel®), adalimumab (e.g. Humira®)
- Drugs to treat Cystic Fibrosis, specifically: domase alpha inh sol (e.g. Pulmozyme®), tobramycin inh sol (e.g. Tobi®)
- Antidiuretic hormones, e.g. DDAVP
- Antiemetics, specifically: dolasetron (e.g. Anzemet®), granisetron (e.g. Kytril®), ondansetron (e.g. Zofran®)
- Antimalarial agents, elg. Plaquenil®
- Goserelin acetate (e.g. Zoladex®)
- Recombinant Blood Cell e.g. Epogen®, Procrit®, Neupgen®
- Hepatitis B & C Treatment, specifically: adefovir, lamivudine (e.g. Epivir HBV®), interferon, ribavirin/ interferon
- Immunosupressives (oral), e.g. azathioprine
- Osteosporosis Treatment (injectables), specifically: calcitonin-salmon (e.g. Calcimar®), Miacalcin®), teriparatide (e.g. Forteo®)
- Drug to treat narcolepsy, specifically: modafinil (e.g. Provigil®)
- Antifunjal agents, e.g. Sporanox®, Lamisil®
- Drugs to treat hemophilia, Von Willbrand Disease and related bleeding disorders, specifically: anti-hemophilic factor

## Dispensing Limitation

The amount normally prescribed by physician, but not to exceed 15 day supply. Refills are not covered.

**EXCEPTION:**

1. **FOR THE FOLLOWING MAINTENANCE DRUG CATEGORIES**, the amount normally prescribed by physician, but not to exceed 30 day supply. Authorized written refills are covered up to 6 months form the original date of prescription.
    - Anticoagulants
    - Anticonvulsants
    - Antihyperlipidemics and Lipotropics
    - Antineoplastics & Immunosuppresives agents (Oral): except: immunosuppresives (oral), which prior authorization is required.

- Antiparkinsonism Drugs
- Antivirals indicated HIV/AIDS
- Benign Prostatic Hyperthropy/Micturition
- Cardiovascular Agents (e.g. antihypertensives, vasodilators, antiarrhythmic agents, digital and derivatives, calcium Channel blockers, alpha/beta blockers, etc.)
- Diabetic Care: Oral Hypoglycemics
- Diabetic Care: Insulin
- Diuretics
- Glaucoma Preparations (Opht)
- Osteoporosis Treatment (Oral), specifically: alendronate sodium (e.g. Fosamax®), raloxifene (e.g. Evista®), risedronate (e.g. Actonel®)
- Pre-Natal Vitamins
- Folic Acid
- Respiratory Therapy
- Sex Hormones
- Thyroid and Derivatives
- Uricosuric agents (gout), e.g. allopurinol, colchicines
- Pschotherapeutic drugs (tranquilizers, antidepressants, lithium products, alzeheimers and ADD (Attention Deficit Disorder) and Narcolepsy). Note: ADD/Narcolepsy are covered with age limit for individuals through 18 years of age.

2. **MAIL ORDER ONLY:** For the following drugs or drug category, the amount normally prescribed by physician but not to exceed 90 day supply. Authorized written refills are covered up to a maximum of 3 refills.
   - Contraceptives: Oral, Generics only

This is a summary reference and does not contain all coverage and exclusions of the plan benefit.

Bath&BodyWorks

# Your Dental Plan

Bath & Body Works provides a comprehensive dental plan through Mapfre for eligible Puerto Rico associates. This section provides an overview of your dental benefits. For additional plan details, contact Mapfre at 1.787.250.5214, option 5 or log on to **mapfre.com**.

## Dental Coverage

### Preventive and Diagnostic Services

**LEVEL 1: NO COST (0%)**

- Routine periodic examination every six months
- Emergency exams (2 per year)
- Consults with specialists (every twelve months)
- Bitewing radiographs every 6 months
- Full mouth" x-rays every 24 months
- Dental prophylaxis (cleaning) every six months, for adults and children
- Topical application of fluoride to children under 19 years of age. Limited to one every six months
- Sealants for children under 14 years of age on permanent and deciduous teeth
- Wisdom teeth removal surgery in the office of an Oral and Maxillofacial Surgeon

### Restoration Services

**LEVEL 2: 30% (THE PORTION YOU PAY)**

- Extractions and oral surgery, including preand post-operative care and general anesthesia
- Restorations in Amalgams (Silver) in molars (every 12 months)
- Resin restorations, limited to anterior teeth
- Endodontics: includes canal treatment and canal filling for all dentures
- Periodontics: Includes all procedures necessary for the treatment of diseases of the gums and the bone that supports the teeth, including periodontal surgery
- Exostosis (removal of abnormal formation of a bony growth on a tooth)
- Frenectomy (frenulum correction/excision)
- Palliative treatment (temporary treatment to relieve pain or discomfort)
- "Habit" breaker
- Space maintainers

### Major Restoration Services

**LEVEL 3: 50% (THE PORTION YOU PAY)**

- Crowns (every 12 months)
- Fixed Bridges / Removable Bridges
- Complete Dentures "Maryland Bridge"
- Repair of complete and partial dentures
- Stainless steel crowns on deciduous teeth

***MAXIMUM PER PERSON PER CALENDAR YEAR $1,500**

# Vision

We offer flexibility when it comes to your vision coverage. Through Vision Service Plan (VSP), you have two options to choose from:

- VSP Vision Signature
- VSP Vision Signature Plus

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you and discover savings with Exclusive Member Extras.

## Bi-weekly Vision Premiums

| | VSP Vision Signature | VSP Vision Signature Plus |
|---|---|---|
| Associate Only | $4.14 | $6.00 |
| Associate + Spouse/ Domestic Partner | $6.14 | $8.89 |
| Associate + Child(ren) | $5.60 | $8.12 |
| Associate + Family | $11.14 | $16.14 |

### Check if Your Provider is In the Network

To determine if your doctor is a part of the VSP provider network:

- Log on to **www.vsp.com**
- Select Members or Prospective Members
- Find a VSP Network Doctor or call 800.877.7195

Not every doctor will be in-network. However, it's your choice — if you choose a network doctor you will save money! Keep in mind it is not necessary to specify if your doctor is in- or out-of-network at the time of enrollment.

# Vision Plan Benefits: At a Glance

Both options provide comprehensive vision care; however, with the VSP Vision Signature Plus option, you have a higher frame allowance, and you have additional benefits, including VSP EasyOptions and VSP LightCare.

## VSP Vision Signature

| Benefit | Description | Copay |
|---|---|---|
| **WellVision Exam** | ■ Focuses on your eyes and overall wellness<br>■ Routine retinal screening<br>■ Every calendar year | $15<br>Up to $39 |
| **Essential Medical Care** | ■ Retinal imaging for members with with diabetes covered-in-full<br>■ Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions, such as dry eye, diabetic eye disease, glaucoma and more.<br>■ Coordination with your medical coverage may apply. Ask your VSP network doctor for details.<br>■ Available as needed | $20 per exam |
| **Prescription Glasses** | | |
| **Frame** | ■ $200 Featured Frame brands allowance<br>■ $180 frame allowance<br>■ 20% savings on the amount over your allowance<br>■ $100 Costco frame allowance<br>■ Every calendar year | Included in prescription glasses |
| **Lenses** | ■ Single vision, lined bifocal,and lined trifocal lenses<br>■ Impact-resistant lenses for dependent children<br>■ Every calendar year | Included in prescription glasses |
| **Lens Enhancements** | ■ Standard progressive lenses<br>■ Premium progressive lenses<br>■ Custom progressive lenses<br>■ Impact-resistant lenses (adult)<br>■ Average savings of 40% on other lens enhancements<br>■ Every calendar year | $0<br>$80 - $90<br>$120 - $160<br>$0 |
| **Contacts** (Instead of Glasses) | ■ $180 allowance for contacts; copay does not apply<br>■ Contact lens exam (fitting and evaluation)<br>■ Every calendar year | Up to $60 |

## VSP Vision Signature Plus

| Benefit | Description | Copay |
|---|---|---|
| **WellVision Exam** | ■ Focuses on your eyes and overall wellness<br>■ Routine retinal screening<br>■ Every calendar year | $15<br>Up to $39 |
| **Essential Medical Care** | ■ Retinal imaging for members with diabetes covered-in-full<br>■ Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.<br>■ Coordination with your medical coverage may apply. Ask your VSP network doctor for details.<br>■ Available as needed | $20 per exam |
| **Prescription Glasses** | | |
| **Frame** | ■ $230 Featured Frame brands allowance<br>■ $230 Visionworks frame allowance on any frame<br>■ $180 frame allowance<br>■ 20% savings on the amount over your allowance<br>■ $100 Costco frame allowance<br>■ Every calendar year | Included in prescription glasses |
| **Lenses** | ■ Single vision, lined bifocal, and lined trifocal lenses<br>■ Impact-resistant lenses for dependent children<br>■ Every calendar year | Included in prescription glasses |
| **Lens Enhancements** | ■ Standard progressive lenses<br>■ Premium progressive lenses<br>■ Custom progressive lenses<br>■ Impact-resistant lenses (adult)<br>■ Average savings of 40% on other lens enhancements<br>■ Every calendar year | $0<br>$80 - $90<br>$120 - $160<br>$0 |
| **Contacts** (Instead of Glasses) | ■ $180 allowance for contacts; copay does not apply<br>■ Contact lens exam (fitting and evaluation)<br>■ Every calendar year | Up to $60 |
| **Additional Benefits** | | |
| **VSP EasyOptions** | ■ An additional $100 frame allowance, or fully covered premium or custom progressive lenses, or fully covered light-reactive lenses, or fully covered anti-glare coating, or an additional $100 contact lens allowance<br>■ Every calendar year | Included in prescription glasses |
| **VSP LightCare** | ■ $280 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts<br>■ Every calendar year | $25 |

## Additional Savings under the Vision Options

### Glasses and Sunglasses

- Discover all current eyewear offers and savings at **vsp.com/offers**.
- 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.

### Laser Vision Correction

- Average of 15% off the regular price; discounts available at contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

### Exclusive Member Extras for VSP Members

- Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**.
- Save up to 60% on digital hearing aids with TruHearing. Visit **vsp.com/offers/special-offers/hearing-aids** for details.
- Everyday savings on health, wellness, and more with VSP Simple Values

## Vision Plan Expenses Not Covered

We offer a comprehensive vision plan. However, it is not possible to cover every expense. The following list will tell you generally what is not covered. This is not a complete or all-inclusive list, so if you still have questions, call 800.877.7195 for more information. Below is a partial list of vision expenses not covered:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a + .50 diopter power)
- Two pairs of glasses in lieu of bifocals
- Replacement of lenses and frames that are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an employer as a condition of employment
- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK surgery

## Receiving Benefits Authorization Under the Vision Plan

If you enroll in the vision plan, you must receive benefit authorization before receiving services.

You will not receive a vision ID card from VSP, and you will not be required to fill out any claim forms if you use an in-network provider. Once you have been confirmed as a VSP member, your doctor will take it from there! It's that easy.

- Call 800.877.7195 or log onto **vsp.com** to locate a VSP doctor (also see is my doctor in the network?).
- Make an appointment and tell the doctor's office you are a VSP member.
- Provide the doctor's office with your date of birth and last four digits of your Social Security Number. The doctor's office will use this information to obtain benefits authorization.
- Review your coverage details before your appointment.

**Important Note:** If you are in the vision plan and receive services from an in-network doctor prior to receiving benefit authorization, the services will be paid at the out-of-network level even if received by an in-network doctor.

# Mental Wellbeing

We care about the whole you, that's why we offer the Employee Assistance Program (EAP), which offers no cost, confidential support, resources and someone to talk to whenever and wherever you need them – they'll be there for you 24/7. Provided through ComPsych, the EAP provides:

**CONFIDENTIAL EMOTIONAL SUPPORT.** Highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

**WORK-LIFE SOLUTIONS.** Specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

**LEGAL GUIDANCE.** Talk to attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

- Financial Resources. Financial experts can assist with a wide range of issues. Talk to them about:
  - Retirement planning, taxes
  - Relocation, mortgages, insurance
  - Budgeting, debt, bankruptcy and more

**INTERACTIVE DIGITAL TOOLS.** Digital self-care platform offers interactive behavioral health tools and resources. Log on for:

- Guided programs for anxiety, depression, mindfulness, sleep, stress and more
- Personalized, guided resources & motivational support
- Secure access through GuidanceResources® Online

**WELL-BEING COACHING.** Certified coaches work one-on-one with you to address health and well-being issues holistically, before they become long-term, costly problems. Call for help with:

- Burnout and work-life balance
- Developing self-compassion
- Goal-setting and building resiliency
- Coping with stress, improving sleep and more

**ONLINE SUPPORT.** GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- GuidanceConnect℠, which allows you to find a network therapist through the portal
- Articles, podcasts, videos, slideshows
- On-demand trainings

## Who's Eligible

All U.S. associates – including seasonal associates – their dependents and housemates – including partners, roommates or anyone else living under your roof. You do not need to be enrolled in a Bath & Body Works medical plan to use the EAP.

The services provided through the EAP are strictly confidential. ComPsych will not release any information about you, your family members or housemates, unless you give written permission or unless the law requires it.

## How to access ComPsych

There are three ways to access ComPsych:

1. Download the GuidanceNow App. Go to the App Store or Google Play and search for "GuidanceNow" to download the app.
2. Visit GuidanceResource Online. Go to **guidanceresources.com** (Organization Web ID: BBW)
3. Call 800.948.3913. When you call ComPsych, a GuidanceResources counselor will listen to your concerns and get a referral for you to talk to an expert counselor located in your area. During the appointment, the counselor will discuss your situation and help you develop a plan of action. You can visit a ComPsych counselor up to 8 times per person per issue each year at no cost to you, your dependents or housemates. If it is determined you need additional services beyond 8 visits, your medical plan may cover any additional care.

Bath&BodyWorks

# Life Insurance

Bath & Body Works provides Life insurance for you and your dependents to provide the financial protection you need if you or your dependent die.

## Basic Term Life Insurance

Bath & Body Works provides all full-time benefits-eligible associates, at no cost, with basic term life insurance at one time your annual base salary through Lincoln Financial Group (LFG).*

We automatically enroll you whether or not you enroll in the medical or dental plan. So, for example, if you enroll in your spouse's medical plan, you'll still have life insurance provided and paid for by Bath & Body Works.

*The maximum coverage amount is $2 million.

## Optional Life Insurance

If you want to increase your total life insurance coverage beyond the basic term life insurance coverage that Bath & Body Works provides, you may choose and pay for optional life insurance coverage through LFG. You'll also have the option to purchase life insurance for your spouse, civil union or domestic partner and/or dependents.

**Associate Coverage**

All full-time, benefits-eligible associates may purchase from one to six times their annual base salary, up to $3 million. This coverage is offered through LFG at affordable group rates and, in most cases, below what you could purchase on an individual basis.

The optional life insurance rates are based on your age and your annual base salary. Rates and coverage amounts will automatically adjust during the year as you receive pay increases.

You will be guaranteed coverage up to three times your annual base salary at the highest multiple of your annual base salary that does not exceed $500,000. Any coverage you elect above these amounts will require Evidence of Insurability (EOI) prior to being granted. Evidence of insurability = proof of good health.

**Evidence of Insurability (EOI)**

Sometimes when you select additional life insurance coverage, LFG will want to verify whether or not you qualify for the new level of coverage. In this case, you must complete a health questionnaire – also known as Evidence of Insurability (EOI)—within 31 days of your election. You can access the application link through the Benefits home page on HRAccess. LFG will approve or deny coverage based on the information you provide. Until approval is received from LFG, you will be covered at the maximum guaranteed issue amount that does not require EOI. If approved, Bath & Body Works will be advised of the higher level of coverage and your coverage and premium will increase. However, if you are not actively at work on the date an increase in Optional Life Insurance coverage would be effective, the increase in coverage will be postponed until you return to work.

**Coverage Maximums**

- Basic Term Life: $2 million
- Optional Life: $3 million
- Combined Maximum (Basic Term Life and Optional Life): 7 x annual base salary

## Associate Calculation

If you would like to purchase optional life insurance for yourself, please refer to the Rate Calculation Chart below. To calculate your cost per pay after tax, divide the dollar amount of coverage you would like to purchase by 1000 and multiply by the rate associated with your age range.

**Rate Calculation Chart**

| Associate Age | Biweekly Rate per $1,000 of Coverage | Associate Age | Biweekly Rate per $1,000 of Coverage |
|---|---|---|---|
| under 25 | $0.014770 | 50 - 54 | $0.066920 |
| 25 - 29 | $0.017080 | 55 - 59 | $0.124150 |
| 30 - 34 | $0.023540 | 60 - 64 | $0.190620 |
| 35 - 39 | $0.026310 | 65 - 69 | $0.366920 |
| 40 - 44 | $0.028620 | 70 and above | $0.594920 |
| 45 - 49 | $0.043850 | | |

## Optional Dependent Life Insurance

**Spouse/Domestic Partner Coverage/Child(ren)**

You can purchase life insurance for your spouse/domestic partner or child(ren) starting from birth through age 25 in the following amounts:

| | Spouse/ Domestic Partner | Children (Birth through age 25) |
|---|---|---|
| Coverage Amount Choice | $10,000<br>$20,000<br>$30,000<br>$40,000<br>$50,000<br>$60,000<br>$70,000<br>$80,000<br>$90,000<br>$100,000 | $5,000<br>$10,000<br>The coverage amount you choose covers each eligible child for the full dollar amount. |
| Evidence of Insurability (EOI) | $10,000 - $20,000 – no EOI required<br>$30,000 - $100,000 – EOI required* | Not required |
| Termination of Coverage | At termination of employment, divorce or termination of the domestic partnership. See Continuing Life Insurance below. | At termination of employment or the child reaches age 26. See Continuing Life Insurance below. |

* If you enroll your spouse/domestic partner in coverage amounts that require EOI, you must complete the EOI application within 31 days of your election. You can access the application link on the Benefits page in HR Access. LFG will approve or deny coverage based on the information you provide. Until approval is received for the coverage amount selected, your spouse/domestic partner will be coverage at the maximum guaranteed issue amount ($20,000)

### Rate Calculation Chart

| Spouse/ Domestic Partner Age | Biweekly Rate per $1,000 of Coverage | Spouse/ Domestic Partner Age | Biweekly Rate per $1,000 of Coverage |
|---|---|---|---|
| under 25 | $0.027230 | 55 - 59 | $0.270000 |
| 25 - 29 | $0.032770 | 60 - 64 | $0.499380 |
| 30 - 34 | $0.043380 | 65 - 69 | $0.853380 |
| 35 - 39 | $0.048920 | 70 - 74 | $1.272920 |
| 40 - 44 | $0.054460 | 75 - 79 | $2.091230 |
| 45 - 49 | $0.086770 | 80 and above | $3.327230 |
| 50 - 54 | $0.165230 | | |

| Child | Biweekly Rates |
|---|---|
| $5,000 | $0.336900 |
| $10,000 | $0.673800 |

## Take Note

- If an associate is enrolled in Optional Life, they cannot be covered by a spouse/domestic partner under Spousal Life when both work for Bath & Body Works.
- An associate cannot enroll in Optional Life if they are already covered by a spouse/domestic partner under Spousal Life when both work for Bath & Body Works.
- If an associate is enrolled in Optional Life, they cannot be covered by the Parent under Child Life when both work for Bath & Body Works.
- An associate cannot enroll in Optional Life if already covered by parent (when both work for Bath & Body Works) under Child Life.
- If an associate is covering children under Child Life, the same children cannot be covered by their spouse (when both work for Bath & Body Works) under Child Life.
- Benefits-eligible part-time associates are not eligible for Optional Associate and Dependent Life Insurance.
- A spouse/domestic partner or child who is in the military or who is living outside the United States and Canada cannot be covered.
- The amount of life insurance you, your spouse or domestic partner has or may purchase will be reduced by 25% at age 65 and 50% at age 70.

## Beneficiaries

You can name one or more beneficiaries to your life insurance benefits at any time. To designate or change a beneficiary, log on to HR Access at **HRAccess.bbwcorp.com** or contact Associate Connect at 866.473.4728. If no beneficiary exists at the time of your death, your life benefits may be paid to one or more of the following who survive you: your estate, your spouse/domestic partner, your child(ren), your parent(s) or your sibling(s).

## Continuing Life Insurance Coverage

If you leave the company, (or lose coverage for a certain reason) but still want life insurance coverage, there is a conversion option or a portability feature that will allow you to continue your basic term life and associate/dependent optional life insurance. Information about the life insurance portability and conversion options will be mailed to your home address after coverage has ended.

Bath&BodyWorks

# Disability Coverage

If you need to take time away from work due to an injury or illness for an extended period of time, we provide Short-Term and Long-Term Disability benefits. This provides you the financial protection you need while you recover.

Full-time Benefits-Eligible Associates are eligible for Short-Term and Long-Term Disability on their first day of active service with the company.* These plans are designed to provide you income, so you can focus on taking care of yourself. Disability benefits do not provide job-protected leave; rather, they can be used along with job-protected leave to provide income supplementation.

*Please note, if this description of short-term disability or long- term disability plans conflicts with the terms of the actual plans, the language in the plans prevails.

## Short-Term Disability*

You may qualify for Short-Term Disability (STD) benefits if you are unable to work at all or if your doctor puts you on a reduced schedule due to physical limitations.

To apply for STD benefits, notify your manager, then:

1. Call Associate Connect at 866.473.4728 and follow the prompts or
2. Call Lincoln Financial Group (LFG) at 844.869.3454; or
3. Log on to **www.MyLincolnPortal.com**.
   - First time users must register using Company Code BBWI
4. Please have the following information available when you report your claim:
   - Reason for absence (symptom or diagnosis)
   - Your medical care provider's name, address, phone and fax numbers
   - Your last day worked, first day absent from work, and anticipated return to work date

Short-Term Disability (STD) benefits begin on your eighth consecutive calendar day of absence. During your first through seventh calendar days of absence, you will have the option to take them unpaid or use your PTO (if available). Unless you request the time to be unpaid by calling Associate Connect, the Company will automatically apply any available PTO (up to 40 hours). If approved, STD benefits may be paid following the below schedule:

| Day 1 – 7 | **Day 8 – 30** | Day 31 – 181 |
|---|---|---|
| Unpaid or Vacation | 100% of base pay | 66-2/3% of base pay |

* STD and LTD benefits are subject to review and approval by LFG according to established duration and treatment guidelines

## Long-Term Disability*

If you are a full-time Benefits-Eligible Associate, Long-Term Disability (LTD) coverage is automatically provided at no cost to you, regardless of whether you are enrolled in the medical plan. If approved, LTD benefits may be paid following the below schedule:

| Day 182+ |
|---|
| 60% of base pay (up to $25,000 per month) |

If your long-term disability is approved, you'll be paid an income equal to 60% of your base salary**, up to a maximum annual benefit of $300,000 ($25,000 per month). This amount will be coordinated with other sources of compensation, including Workers' Compensation, Social Security, federal, and state or Employer-Sponsored Plans. LTD benefits are coordinated with Social Security benefits for you and your family members attributable to your disability. LTD does not include a percentage of overtime, bonuses or any other special form of payment. This means that the total combined monthly benefit you receive from the LTD plan and from the above sources of disability income will be 60% of your pre-disability monthly base earnings.

LTD benefits are insured by Lincoln Financial Group (LFG). All determinations regarding eligibility and benefits are by LFG. Your pay will be sent by LFG directly to your home.

Federal and state tax deductions are voluntary and must be requested by contacting LFG.

*STD and LTD benefits are subject to review and approval by LFG according to established duration and treatment guidelines

**Base pay is determined by your rate of pay as of the beginning of your leave. until your Social Security normal retirement age or, if later:

## How LTD Benefits are Paid

LTD benefits will continue as long as you remain totally and permanently disabled, until your Social Security normal retirement age or, if later:

| Age When You Become | Duration Of Benefits (In Years) | Age When You Become | Duration Of Benefits (In Years) |
|---|---|---|---|
| 61 or less | to age 65 | 66 | 1 3/4 |
| 62 | 3 1/2 | 67 | 1 1/2 |
| 63 | 3 | 68 | 1 1/4 |
| 64 | 2 1/2 | 69 or more | 1 |
| 65 | 2 | | |

To receive LTD benefits, you must be under a doctor's care and be determined by the Claims Administrator to be unable to perform the material duties of your job. Benefits continue under this definition for 24 months. After that, you may continue to receive LTD benefits if the Claims Administrator determines you to be "totally disabled." All disabilities are subject to periodic review and additional ongoing medical certification.

If you do not pursue Social Security benefits within the established timeframe, the Social Security benefits that the Claims Administrator estimates you and your family Members would be eligible to receive may be deducted from your LTD benefit payments.

**Important Notes**

- If you receive STD benefits, it does not guarantee you'll be approved for LTD benefits.
- If you work in a state that has a state disability or paid medical leave benefit, your disability benefits will be reduced by the amount payable under the state program. Except for associates working in New York or Hawaii, it is the associate's responsibility to apply for and coordinate directly with the state to receive the state benefits. Please contact the state agency responsible for administration of these benefits as soon as possible. If you are awarded statutory benefits, you must provide a copy of your award letter to Lincoln Financial to calculate your benefits due under the company paid disability program. Until Lincoln Financial receives the awards letter, your disability pay will be reduced by an estimated amount.
- In no instance will the combined state and L Brands benefit exceed the applicable STD/LTD pay schedule. Contact LFG for more information.

## Puerto Rico Temporary Disability Benefits

Puerto Rico Temporary Disability Insurance (Disability Benefits for Workers Covered by Act 139 (SINOT)) Benefit is designed to partially replace wages if you suffer a temporary disability due to an illness or accident that is unrelated to your job or to any vehicle accident.

To be eligible for Disability Benefits you must meet the following eligibility requirements:

- Become disabled due to an illness or injury unrelated to your employment or to an automobile accident.
- Receive medical treatment by an authorized and licensed physician or chiropractor.
- Earned at least $150 in covered employment during the year.

The benefit mandates a minimum weekly benefit of $12 up to a maximum weekly benefit of $113. Benefits will be payable as long as the person is disabled or up to a maximum of 26 weeks in any 52-week period. Benefit payments begin on the first day of hospitalization, if any. If there is not a hospitalization, benefit payments will begin at the eighth day.

Your company provided disability benefits will be reduced by the amount payable under the government program. If your government benefits are denied, please provide the denial letter to Lincoln Financial Group so that your payment amount can be adjusted.

In no instance will the combined government and Bath & Body Works benefit exceed the applicable STD/LTD pay schedule. Contact LFG for more information.

## Limitations and Exclusions

**LIMITATIONS:** A pre-existing condition is any sickness or Injury that began or occurred during the three months immediately prior to the Effective Date of insurance (LTD coverage). This includes conditions for which an Associate received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines during the three months immediately prior to their Effective Date of insurance (LTD coverage). If you become disabled during your first 12 months of coverage and the

disability is a result of (in whole or in any part) a pre-existing condition, you will not be entitled to LTD benefits.

If your LTD claim is denied under the pre-existing clause, you must return to work full-time before you can file another claim for the same condition.

**MENTAL HEALTH/SUBSTANCE ABUSE:** Benefits for disabilities resulting from alcoholism, drug addiction, chemical dependency or mental and/or nervous disorders are subject to a lifetime limit of 24 months.

**EXCLUSIONS:** Our LTD plan does not cover disabilities due to any of the following:

- Intentionally self-inflicted injuries.
- Act of war, declared or undeclared.
- Pre-existing conditions.
- Injury, sickness or pregnancy not treated by a doctor.
- Injury incurred while committing or attempting to commit a felony.
- Injury or sickness incurred while confined in any penal or correctional institution.

**PARTIAL DISABILITY:** You may have instances in which you are placed on partial Disability Leave or are released for a partial return to work. In these instances, you should work with your manager and human resources department to determine what work you are able to do and what restrictions are to be placed on your work routine and hours. These restrictions must be put in writing by a licensed Doctor and submitted to LFG. Partial disability may be used during both STD and LTD periods.

**CONTINUING BENEFITS DURING DISABILITY:** You may continue your medical, dental, vision, life insurance and legal, benefits while you are on an approved leave of absence provided you timely pay the applicable premiums. Please refer to the Leave of Absence Guide at **mybbwbenefits.com** under Resources.

# Medical Glossary

## A

**ASSOCIATE:** To be eligible for the benefits described in this book, you must be classified in the payroll system of a Bath & Body Works business as a full-time, Benefits-Eligible Associate.

## B

**BENEFITS-ELIGIBLE:** An Associate who is classified in the payroll system of a Bath & Body Works business as working full-time. No temporary or seasonal Associate is Benefits-Eligible even if classified as working full-time.

## C

**CALENDAR YEAR:** A period of one year beginning on January 1

**COINSURANCE:** The cost that you and Bath & Body Works share for covered medical services, once the deductible is met.

**CO-PAY/CO-PAYMENT:** The amount of Covered Expenses the Covered Person must pay to a Network Provider at the time the services are given.

**COVERED FAMILY MEMBERS OR COVERED PERSON(S):** Any Dependent in a Benefits-Eligible Associate family who meets all the requirements of the Eligibility section of this book, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

**COVERED SERVICES AND SUPPLIES:** Services and Supplies to which the Covered Person is entitled to have the plan pay subject to the terms and limitations of the plan.

Covered Services and Supplies are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a Sickness, injury, or symptoms. Covered Services and Supplies must be provided:

- When the plan is in effect.
- Prior to the date of the individual termination conditions set forth in this summary plan description.
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the plan.

A Covered Service and Supply must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
  - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  - Well-conducted cohort studies (patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group).
  - It is the most cost-effective method and yields a similar outcome to other available alternatives.
  - It is a health service or supply that is described in this section, and which is not excluded under Services Not Covered by the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

## D

**DEDUCTIBLE:** The amount of Covered Expenses the Covered Person must pay before benefits under the plan are payable.

**DOMESTIC PARTNER:** A same or opposite-sex domestic partnership or civil union partnership must meet the following requirements:

- You have a legal civil union in a state that uses the civil union to formally recognize same-sex relationships or, if you don't have a civil union, you:
- are in a single dedicated relationship of at least 12 months and intend to remain in the relationship indefinitely; and
- share the same permanent residence and have done so for at least 12 months
- You are not related by blood or a degree of closeness that would prohibit marriage in the law of the state in which you reside
- Each of you are at least 18 years old
- Each of you are mentally competent to consent to a contract
- Neither of you are currently married to another person under either statutory or common law
- You are financially interdependent
- You both would sign an affidavit of domestic partnership and furnish evidence of the partnership if asked

To receive appropriate tax treatment, be sure to properly designate your dependent partner during your benefits enrollment:

- Same-sex spouse: for marriages in states which recognize (see "Spouse - Same or Opposite-Sex Civil Union")
- Domestic partner: for same or opposite sex domestic partnerships, or for civil union partnerships

## E

**EMERGENCY CARE:** Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed

in serious jeopardy.
- Bodily function would be seriously impaired.
- There would be serious dysfunction of a bodily organ or part.

Examples include:
- Appendicitis
- Chest pain
- Loss of consciousness
- Poisoning
- Seizure
- Severe bleeding
- Stroke

In addition, Emergency Care includes immediate Mental Health/Substance Abuse/Chemical Dependency Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

**EMPLOYER:** An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer

**EXPERIMENTAL OR INVESTIGATIONAL:** A service or supply is still under study and is not yet recognized throughout the U.S. medical profession as safe and effective for diagnosis or treatment under the professional standards set by the Federal Food and Drug Administration (FDA) and the American Medical Association (AMA). When a service or supply is not rated by the FDA, the AMA, or both, the claims administrator will determine whether it is Experimental or Investigational based on prevailing medical opinion regarding the service or supply as found in the commissioned studies, opinions, or references of the relevant medical associations or federal government agencies. This determination is subject to review by the plan administrator.

# H

**HOME HEALTH CARE AGENCY:** An agency or organization which provides a program of home health care and which meets one of the following three tests:
- It is approved under Medicare;
- It is established and operated in accordance with the applicable licensing and other laws;
- It meets all of the following tests:
  - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available;
  - Its employees are bonded and it maintains malpractice insurance.

**HOSPICE:** An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:
- It is approved by Medicare as a Hospice.
- It is licensed in accordance with any applicable state laws.
- It meets the following criteria:
  - It provides 24-hour-a-day, 7-day-a-week service.
  - It is under the direct supervision of a duly qualified Physician.
  - It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
  - The main purpose of the agency is to provide Hospice services.
  - It has a full-time administrator.
  - It maintains written records of services given to the patient.
  - It maintains malpractice insurance coverage.

*Please note: A Hospice which is part of a Hospital, as defined under the plan, will be considered a Hospice for the purposes of the plan.*

**HOSPITAL:** An institution, operated as required by law, which is: primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, Mental Health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution

# I

**INPATIENT STAY:** An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

**INPATIENT REHABILITATION FACILITY:** A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

# L

**LICENSED COUNSELOR:** A person who specializes in Mental Health/Substance Abuse/Chemical Dependency Treatment and is licensed as a Licensed

Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

# M

**MEDICAL NECESSITY OR MEDICALLY NECESSARY:** Health care Services and Supplies which are determined by the plan to be medically appropriate and:
- Necessary to meet the basic health needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of health service.
- Consistent in type, frequency, and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the plan.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the comfort or convenience of the Covered Person or his or her Physician.
- Of demonstrated medical value.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, Sickness, or mental illness or Substance Abuse or Chemical Dependency does not mean that it is Medically Necessary.

**MEDICARE:** The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act

**MENTAL HEALTH/SUBSTANCE ABUSE/ CHEMICAL DEPENDENCY TREATMENT:** Treatment for both of the following:

- Treatment for any Sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and;
- Any Sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

Please note: All inpatient services, including Room and Board, given by a Mental Health facility or area of a Hospital which provides Mental Health Treatment or Substance Abuse Treatment or Chemical Dependency Treatment for a Sickness identified in the DSM, are considered Mental Health/Substance Abuse/Chemical Dependency Treatment, except in the case of multiple diagnoses:

- If there are multiple diagnoses, only the treatment for the Sickness which is identified in the DSM is considered Mental Health/Substance Abuse/Chemical Dependency Treatment;
- Detoxification services given prior to and independent of a course of psychotherapy or substance-abuse treatment are not considered Mental Health/Substance Abuse/Chemical Dependency Treatment.

# N

**NETWORK:** A system of contracted Physicians, Hospitals and ancillary Providers that provides health care to members.

**NETWORK DESIGNATED TRANSPLANT FACILITY:** A facility designated by Mapfre to render Medically Necessary Covered Services and Supplies for qualified procedures under the plan

**NETWORK PHARMACY:** A registered and licensed pharmacy which participates in the Network, including mail order pharmacy.

**NETWORK PROVIDER, HOSPITAL OR PHARMACY:** A Provider which participates in the Network

**NURSE-MIDWIFE:** A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of the following requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of nurse-midwives.

**NURSE-PRACTITIONER:** A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of the following requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Practitioners.

# O

**OTHER SERVICES AND SUPPLIES:** Services and supplies furnished to the Covered Person and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

**OUT-OF-NETWORK HOSPITAL, PROVIDER OR PHARMACY:** A Hospital which does not participate in the Network.

**OUT-OF-POCKET EXPENSE:** The expense the Covered Person is required to pay because that expense is not covered under the plan.

**OUT-OF-POCKET MAXIMUM:** The maximum amount of money you will be required to pay in a calendar year for covered medical services. Once your share of the covered medical expenses reaches this maximum, Bath & Body Works will pay 100% of your Covered Charges for the balance of the year (other than Co-Pays).

# P

**PHYSICIAN:** A legally qualified:

- Doctor of Medicine (M.D.)
- Doctor of Chiropody (D.P.M.; D.S.C.)
- Doctor of Chiropractic (D.C.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Podiatry (D.P.M.)

**PRESCRIPTION DRUGS:**

- Federal Legend Drugs. (This is any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled "Caution—Federal Law prohibits dispensing without prescription.")
- Drugs which require a prescription under state law but not under federal law.
- Compound drugs. (This is a drug that has more than one ingredient. At least one of the ingredients has to be a Federal Legend Drug or a drug which requires a prescription under state law).
- Injectable insulin.
- Needles and syringes.

**PREVENTIVE CARE:** Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization and well-person care.

**PSYCHOLOGIST:** A person who specializes in clinical psychology and fulfills one of the following requirements:

- A person licensed or certified as a Psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

# R

**REASONABLE CHARGE:** Charges for services rendered by or on behalf of a Network Physician: An amount not to exceed the amount determined by Mapfre in accordance with the applicable fee schedule. Other charges: An amount measured and determined by Mapfre by comparing the actual charge for the service or supply with the prevailing charges made

for it. Mapfre determines the prevailing charge and takes into account all pertinent factors including the following:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the Provider is located and other geographic areas having similar medical cost experience.

**REHABILITATION FACILITY:** A facility accredited as a Rehabilitation Facility by the Commission on Accreditation of Rehabilitation Facilities.

**RESIDENTIAL TREATMENT FACILITY:** A facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs;
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- It provides at least the following basic services in a 24-hour per day, structured milieu:
- Room and Board;
- Evaluation and diagnosis;
- Counseling; and
- Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

**ROOM AND BOARD:** The term includes room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

# S

**SICKNESS:** The term, when used in connection with newborn children, includes congenital defects and birth abnormalities, including premature births.

**SKILLED HOME HEALTH CARE:** Skilled Home Health Care is skilled nursing, skilled teaching, and skilled rehabilitation services when all the following are true:

- Is ordered by a Physician
- Must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not custodial care

**SKILLED NURSING FACILITY:** If the facility is approved by Medicare as a Skilled Nursing Facility, then it is covered by the plan.

If the facility is not approved by Medicare, it may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Sickness.
- It maintains a daily medical record of each patient who is under the care of a licensed Physician.
- It is authorized to administer medication to patients on the order of a licensed Physician.
- It is not, other than incidentally, a home for the aged, the blind, or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

Please note: A Skilled Nursing Facility which is part of a Hospital, as defined under the plan, will be considered a Skilled Nursing Facility for the purposes of the plan.

# T

**TREATMENT CENTER:** A facility which provides a program of effective Mental Health/Substance Abuse/Chemical Dependency Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a treatment program approved by a Physician and Mapfre.
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
  - Room and Board (if the plan provides inpatient benefits at a Treatment Center);
  - Evaluation and diagnosis;
  - Counseling;
  - Referral and orientation to specialized community resources.

Please note: A Treatment Center which qualifies as a Hospital, as defined under the plan, is covered as a Hospital and not as a Treatment Center

# U

**UTILIZATION REVIEW:** A review and determination as to whether a Service or Supply is considered a Covered Services and Supplies.

# Dental Glossary

## A

**ANESTHESIA:**
General Anesthesia: The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Local Anesthesia: The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

**ANESTHETIC:** A drug that produces loss of feeling or sensation either generally or locally.

## B

**BITEWING:** Dental X-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

## C

**COVERED CHARGES:** Charges that may be used as the basis for a claim.

## D

**DENTIST:** A person who is either of these:

- A licensed Dentist acting within the scope of the dental profession.
- Any other doctor furnishing dental services that he or she is licensed to perform.

## E

**ENDODONTICS:** See Root Canal Therapy.

## F

**FILLINGS:**
Silver Amalgam: Material used to fill cavities. It is usually placed on the tooth surface that is used for chewing because it is a particularly durable material.

Porcelain, Silicate, Acrylic, Plastic, or Composite Fillings: Materials used to fill cavities. They have less durability than Silver Amalgam Fillings, so are placed on the non-stress-bearing surfaces of front teeth because the color more closely resembles the natural tooth.

**FLOURIDE:** A solution of Fluorine which is applied Topically to the teeth for the purpose of preventing dental decay.

## G

**GINGIVAE:** The gums or soft tissue surrounding the teeth and bone.

**GINGIVECTOMY:** The cutting away of the diseased gums (Gingivae) when the underlying bone is not yet affected.

## O

**ORAL SURGERY:** Surgery pertaining to the teeth and surrounding gum tissues.

## P

**PERIODONTAL DISEASE:** A disease which weakens and destroys the gums, bone, and membrane surrounding the teeth. Periodontal Disease is the principal cause of tooth loss in people over age 30. This disease is sometimes called Vincent's Disease, Gingivitis, or Pyorrhea.

**PERIODONTIST:** A Dentist whose practice is limited to the treatment of Periodontal Disease.

**PRE-DETERMINATION OF BENEFITS:** An optional procedure used if filing claims over $300 under the dental plan.

**PROPHYLAXIS:** The removal of tartar and stains from your teeth through a cleaning by your Dentist or dental hygienist.

## R

**REASONABLE AND CUSTOMARY CHARGE:** The benefits available for eligible dental expenses, as determined by the claims administrator.

**REASONABLY NECESSARY:** Customary dental care services.

**ROOT CANAL THERAPY:** The treatment of a tooth with a damaged pulp. This is usually performed on the pulp, sterilizing the pulp chamber and root canals, and filling the spaces with sealing material. Also called Endodontic Therapy.

## S

**SCALE:** The removal of calculus (tartar) and stains from teeth with special instruments.

## T

**TOPICAL:** Dental procedures performed on the surface of something. Fluoride treatment is Topical, because it paints the surface of teeth. Some Anesthetic treatments are also Topical because they are applied as a cream-like Anesthetic formula to the surface of the gum.

# Administrative Information

## Summary Plan Description

This book is the official summary plan description for the Bath & Body Works, Inc. Health and Welfare Benefits Plan for full-time Benefits- Eligible associates and is current as of January 1, 2025. Since this is the current description of Bath & Body Works, Inc. Health and Welfare Benefits Plan, it takes the place of any older Summary Plan Descriptions you may have.

Not all the details of the Bath & Body Works Health and Welfare Benefits Plan are provided. For more information about the plan documents, refer to the section, ERISA. For complete and total details, please consult the official plan documents and group disability, vision and life insurance by contacting Associate Connect.

This book is not the official Summary Plan Description (SPD) for the Puerto Rico Retirement Savings Plan. The Puerto Rico Retirement Savings Plan is only summarized in this book. Find the Puerto Rico Retirement Savings Plan SPD on HR Access. Once eligible, if you request an enrollment kit, you will receive a full SPD for the Puerto Rico Retirement Savings Plan.

If there is any conflict or inconsistency between the terms and provisions of the official plan documents and policies and the terms and provisions of this Summary Plan Description, the terms and provisions of the official plan documents and insurance policies will govern. The plan administrator has the discretion to interpret the terms of any and all parts of the Bath & Body Works benefits programs and has the discretion to make determinations as to benefits, eligibility and the payment of claims. Each claims administrator also has discretion to interpret the terms of each benefit program administered by the claims administrator and has the discretion to make determinations as to benefits, eligibility and the payment of claims.

We have the right to change or discontinue all or any part of the health and welfare benefits program at any time. The Summary Plan Description does not create a contract of employment.

See Bath & Body Works ERISA plans in the chart on page 35. If you want a paper copies of the of benefits books, legal notices and/or any other materials related to your benefits, call Associate Connect at 1.866.473.4728 to request that a free paper copy be mailed to you.

## ERISA

### STATEMENT OF EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this document.

You may examine, without charge, all plan documents including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the Employee Benefit Security Administration (EBSA). You can examine copies of these documents in the plan administrator's office, or you can ask your manager where copies of the documents are available.

If you want a personal copy of the plan documents or related materials, you should send a written request to the plan administrator. You will be charged only the actual cost of these copies.

You are entitled to 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

You are also entitled to:

- Receive a statement that tells you your accumulated balance under the Bath & Body Works Puerto Rico Retirement Plan. This statement must be requested in writing and is not required to be given more than once a year. The company must provide this statement free of charge.
- Continue health care coverage for yourself or enrolled dependents if there is a loss of coverage under the medical plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description to determine your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre- existing conditions under the medical plan, if you have creditable coverage from another plan.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- If medical coverage ends, you and Covered Family Members will receive a certificate (called a "certificate of creditable coverage") that shows the period of coverage under the Bath & Body Works medical program (called "creditable coverage"). You may need to furnish the certificate if you become eligible under another health plan. If you have a sufficient creditable coverage under the Bath & Body Works plan and you do not incur a break in coverage (63 continuous days of no creditable coverage), you may be able to reduce or eliminate the application of a pre-existing condition exclusion in another health plan. You may also need the certificate to buy an individual policy that does not exclude pre-existing conditions. To request a certificate, call Mapfre. The certificate is available up to 24 months after medical coverage ends.
- Benefit from the Newborns' and Mothers' Health Protection Act. In connection with a birth, you are allowed benefits for hospitalization of a mother and newborn not below 48 hours for a normal delivery (or 96 hours for cesarean sections), unless the attending medical professional in consultation with the mother approves an earlier discharge. Additionally, the medical plan does not use financial incentives or financial or other penalties to discourage mothers from seeking or doctors from providing such care.
- Benefit from the federal Women's Health and Cancer Rights Act of 1998. The medical plan covers certain elective reconstructive surgical procedures for you in connection with a mastectomy. In a manner determined in consultation with the treating Physician, the medical plan provides benefits for: reconstruction of a breast on which a mastectomy was performed; reconstruction of another breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Associate benefit plan. These individuals, called fiduciaries, have an obligation to administer the plan prudently and to act in the interest of plan participants and beneficiaries. The claims administrators, listed on page 35, are fiduciaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining or receiving benefits or exercising your rights under ERISA. When you become eligible for payments from the plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

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

- If you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If you have a claim for benefits which is ignored, or a final appeal 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. For example, if you are successful, the court may order the person who was sued to pay these costs and fees. If you lose, or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.
- If you have questions about the plan, you should

contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining plan 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.

# Benefit Plans Information

## NAMES AND NUMBERS

All benefits programs identified with plan number 501 below are part of the Bath & Body Works Health and Welfare Benefits Plan and are sponsored by L Brands Service Company. L Brands Service Company has entered into arrangements with various carriers as described below.

## PLAN AMENDMENT AND TERMINATION

L Brands Service Company reserves the right to modify, suspend, or terminate any benefits plan at any time. Bath & Body Works does not promise the continuation of any benefits, nor does it promise any specific level of benefits at or during retirement. Any benefits, rights, or obligations of participants and beneficiaries under any plan following employment termination are described in detail in the body of this document.

## SOURCE OF CONTRIBUTIONS AND FUNDING

All benefits under the plans are funded through trust accounts sponsored by L Brands Service Company as described below.

The company's contribution toward the cost of each plan is at a rate determined by Bath & Body Works.

| | BATH & BODY WORKS BENEFIT PLANS | | | |
|---|---|---|---|---|
| | **Medical & Dental** | **Vision** | **Life Insurance** | **Long-Term Disability** |
| ID number | 31-1048997 | | | |
| Plan Number | 501 | | | |
| Plan Sponsor | L Brands Service Company, LLC | | | |
| Type of Plan | Welfare Benefit Plan | | | |
| ERISA Plan** | ✔ | | | |
| Plan Year | Calendar Year | | | |
| Plan Administrator | L Brands Service Company, LLC<br>3 Limited Parkway, Columbus, OH 43230 | | | |
| Funding Arrangement | Self-Insured | Fully-Insured | Fully-Insured | Fully-Insured |
| Claims Administrator and/or Insurer | Mapfre<br>P.O. Box 70333<br>San Juan, PR 00936-8333 | Vision Service Plan Member Services<br>3333 Quality Drive Rancho Cordova, CA 95670 | Lincoln Financial Group<br>Group Life Claims<br>P.O. Box 2578<br>Omaha, NE 68172-9688 | Lincoln<br>Financial Group<br>8801 Indian Hills Drive<br>Omaha, NE 68114 |
| Plan Costs | Paid by Associate and Company contributions | Paid by Associate contributions | Paid by Associate and Company contributions | Paid by Associate contributions |
| Agent for Service of Legal Process* | General Counsel | | | |

* Process may also be served on the Plan Administrator or Trustee

** All other benefits described in this book are not covered under ERISA.

## Notice of Health Plan Privacy Practices (HIPPA)

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

This Notice applies to the Bath & Body Works medical, dental and vision and EAP benefits effective January 1, 2025. For purposes of simplification, this Notice uses the term "plan" to refer to these different benefits. This Notice does not apply to other Bath & Body Works benefit programs such as long- and short-term disability, workers compensation, life insurance, or travel accident insurance.

The Bath & Body Works benefits under the plan are administered through insurance companies and other service providers. For purposes of simplification, this Notice will use the term "claims administrator" to refer to Mapfre, MetLife, and Vision Service Plan. You may receive separate Notices from one or more of the claims administrators describing how they use and disclose protected health information. If so, the claims administrator will follow its own privacy practices to the extent those practices are more restrictive (i.e., more protective of your privacy) than those described in this Notice.

The plan is required by law to maintain the privacy of participants' protected health information and to provide participants with notice of its legal duties and privacy practices regarding your protected health information.

Your health information is highly personal, and the plan is committed to safeguarding your privacy. For plan administration purposes, the plan and the claims administrators (and any other outside service providers working with the plan) create records (such as records of health claims), which comprise your protected health information, and this Notice applies to all such records. Your actual health care provider (like your doctor) may deliver its own notices and practices, as well.

This Notice summarizes how the plan may use and disclose your protected health information and describes your ability to access and control the use and disclosure of your protected health information.

The plan must abide by the terms of this Notice of Privacy Practices as currently in effect. Bath & Body Works reserves the right to change the terms of this Notice and to make the new Notice effective for all protected health information held by or on behalf of the plan. In the event of a change, you will be provided with a revised dated Notice of Privacy Practices.

### USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

The plan may use or disclose your protected health information without your authorization for the following reasons:

**Treatment**
Your protected health information may be used or disclosed to carry out medical treatment or services by providers. For example, in carrying out treatment functions, the plan claims administrators could use or disclose your protected health information to protect you from receiving inappropriate medications or share information with relevant parties about prior prescriptions if a newly prescribed drug could cause problems for you. The plan also may share information about prior treatment with a provider who needs that information to treat you or your family properly.

**Payment**
Your protected health information may be used or disclosed to determine your eligibility for plan benefits, to coordinate coverage between this plan and another plan, and to facilitate payment for services you receive. For example, the plan may share your information with an outside vendor, to review how certain services are used, or to help ensure that the plan is properly reimbursed, where a third party is ultimately responsible for bearing the medical costs in question.

**Health Care Operations**
Your protected health information may be used and disclosed for various administrative purposes that are called health care operations of the plan. For example, your information might be included as part of an audit designed to ensure that the plan's outside claims administrator is performing its job as well as it should be. And your information, along with that of all other participants,

may be used and disclosed each year to set appropriate premiums for the plan or to secure insurance to protect the plan or its sponsor, financially. The plan may not use or disclose genetic information for underwriting purposes.

**Communications about Benefits**
The plan may use or disclose your protected health information to send you (1) treatment reminders for services like mammograms or prostate cancer screenings, and (2) information about alternative medical treatments and programs or health-related products and services that may interest you. For example, the plan might send you information about smoking cessation or weight-loss programs.

**Disclosures to the Plan Sponsor**
To determine if and when you and your family members are covered by the plan, the plan will share enrollment information about you and your family members with Bath & Body Works. The plan will also periodically disclose protected health information to designated employees of Bath & Body Works so that they can (1) assist participants with benefits questions, problems and appeals; (2) perform financial planning and projections; (3) monitor the performance of third parties; and (4) oversee and assist with the administration of the plan. Bath & Body Works will only use the protected health information for these purposes, for the purposes you authorize, or as the law requires.

**Disclosures to Business Associates**
The plan often relies on the Claims Administrator and outside service providers (generally known as "business associates") to handle important administrative tasks on behalf of the plan. These business associates are contractually required to safeguard your information and perform its duties in a manner consistent with this Notice.

**As Required by Law**
The plan will use or disclose your personal health information when required to do so by federal or state law, including in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process. The plan also may disclose protected health information to law enforcement personnel or similar persons to avoid a serious threat to the health or safety of a person or the public.

**Disclosures to Friends and Family**
With your authorization, the plan may disclose protected health information to a family member, a friend or any other person you identify, provided that information is directly relevant to enable that person's involvement with your health care or payment for that care. You have the right to stop or limit this kind of disclosure.

**No Other Uses or Disclosures without Your Authorization**
Other than the uses and disclosures described in this Notice, the plan may not disclose your protected health information or make any other use of it without your written authorization. Certain actions — such as most uses or disclosures of psychotherapy notes, the use or disclosure of protected health information for marketing purposes, or the sale of protected health information — may be made only with your written permission (authorization). You may revoke any such authorization by writing to the claims administrator. Once you revoke your permission, the plan will stop using or disclosing such information for the reasons covered by your written authorization. However, the plan cannot take back any disclosures made with your permission. To submit or revoke authorizations for other Bath & Body Works Plans, please write to:

Vision Service Plan (VSP)
3333 Quality Drive
Rancho Cordova, CA 95670

Mapfre
P.O. Box 70333
San Juan, PR 00936-8333

Lincoln Financial Group
PO Box 2578
Omaha, NE 68103

Certain states provide special privacy protections for particularly sensitive conditions or illnesses such as HIV/AIDS. The plan will disclose protected health information related to those conditions or illnesses only in a manner that is consistent with those laws.

## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

**Right to Inspect and Copy**
You may access your protected health information maintained by the plan. You will be able to inspect and copy your protected health information as long as it is maintained by the plan or on behalf of the plan. You must make your request for access to your information in writing to the appropriate claims administrator contact.

The claims administrator may deny your request for access to your protected health information only under certain limited circumstances. In the event of a denial, the claims administrator will provide access to any part of the requested material that would not cause these problems. In most situations, you are entitled to request review of an access denial. In these instances, a health care professional that the claims administrator has chosen may review your protected health information. This person will not have been involved in the original decision to deny your request. Generally, your information will be provided to you in a form regularly maintained by the claims administrator. If you consent, the claims administrator may provide a summary or explanation of your information that it holds instead of providing you access to the information.

You may be charged a reasonable fee to cover costs related to copying your protected health information, preparing an explanation or summary of it, and paying for postage.

**Right to Request an Amendment**
If you feel the medical information the plan has about you is incorrect or incomplete, you may request to amend your protected health information. To do so, you must make your request for amendment of your protected health information in writing to the appropriate claims administrator and provide a reason to support your request. Your request for amendment may be denied if the:

- plan or its claims administrators (or its service providers) did not create the information;
- information is not part of the records maintained by or on behalf of the plan;
- information would not be available for your inspection (for one of the reasons described above); or
- claims administrator determines that the information is accurate and complete without the amendment.

If your request for changes in your protected health information is denied, you will be notified in writing of why it was denied, and of your right (along with procedures) for submitting a written statement of disagreement.

**Right to Request an Accounting of Disclosures**
You may request a list of the disclosures of protected health information that the plan has made within the last six years (1) for purposes other than treatment, payment, healthcare operations and certain other purposes, or (2) in reliance of your written authorization. You must make your request for an accounting of disclosures of your protected health information in writing to the claims administrator.

For each disclosure, you will receive:

- the date of the disclosure;
- the name of the receiving entity and address, if known;
- a brief description of the protected health information that was disclosed; and
- a brief statement of the purpose of the disclosure, or a written copy of the request that necessitated the disclosure, if any.

In any given 12-month period, you may receive one accounting of the disclosures of your protected health information, at no charge. Any additional request for an accounting during that period may result in a reasonable fee to cover the plan's costs in preparing the accounting.

**Right to Restrict or Limit Disclosures**
You may request restrictions on certain uses and disclosures of your protected health information, even to carry out treatment, payment or health care operations functions as described in this Notice. Your request must be made in writing to the appropriate contact for the applicable benefit option, as listed below. Your request must state the specific restriction requested and to whom you want it to apply.

The claims administrator is not required to agree to the requested restriction, unless it relates to an item or service for which you paid in full and out of pocket. In this case, you may request that the plan not share health information

pertaining only to that product or service for the purposes of carrying out payment or healthcare operations. If the claims administrator does agree to honor your request, it will not use or disclose your information in the way you specified unless it is required by law or needed for emergency treatment.

**Right to Request Confidential Communications**
In certain circumstances, you may ask to receive confidential communications of protected health information by other means or at different locations. For example, if receiving communications at a particular location could put you in danger, you may request that the claims administrator contact you only at your work telephone number or address. Reasonable requests that clearly state, in writing, that the disclosure of all or part of your protected health information could endanger you will be honored by the claims administrator.

**Right to Notification in the Event of a Breach**
Consistent with federal and state laws, the claims administrator will notify you in the event your unsecured protected health information is used or disclosed by an unauthorized individual or is lost or stolen.

**Copy of Notice**
If this Notice is provided to you in electronic form, you may obtain a paper copy of it by printing this electronic copy or by requesting one from Associate Connect.

Contacts

Mapfre: 1.787.250.5214

Vision Service Plan: 1.800.877.7195

**Eligibility, enrollment and contribution information.**
Associate Connect: 1.866.473.4728

**Complaints**
If you believe the plan has violated your privacy rights, you may file a complaint in writing directly with the claims administrator or you may call 1.787.250.5214.

You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or through its regional office in Chicago at 233 N. Michigan Ave., Suite 1300, Chicago, IL 60601. The complaint must be filed within 180 days of the alleged violation.

You will not be penalized in any way for filing such a complaint.

**Additional Information**
For further information regarding the issues covered by this Notice of Health Plan Privacy Practices, please contact:
Bath & Body Works Health Plan Privacy Office PO Box 16000 Columbus, OH 43216

# Additional Health & Welfare Plan Information

## COORDINATING WITH OTHER PLANS

When you or your dependents are covered by more than one medical or dental plan, we need to coordinate benefits. We do this by designating one plan primary and the other plan secondary.

**Other Plans**
Other plans are any of the following types of plans that provide health benefits or services for medical care or treatment:

- Another employer's medical or dental plan
- Government or tax-supported programs, but not Medicare or Medicaid

**Primary vs. Secondary**
The primary plan pays benefits first. Basically, it ignores the fact that you're covered under another plan and pays you the full benefits for which you are eligible.

The secondary plan pays next. First, it temporarily ignores the fact that you're covered under another plan and calculates your benefits.

Next, it takes the benefits you're due, subtracts the amount the primary plan paid, and gives you or your provider the difference. When your secondary plan is through our company, the amount you can be paid in total will not be more than the plan would have paid alone. Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot exceed more than the reasonable expenses charged for that Calendar Year. The expenses must be covered in part under at least one of the plans.

**Determining Which Plan is Primary**
The following rules are used to determine which is the primary plan and which is the secondary plan.

Rule #1:
You must provide any facts about coverage needed to pay the claim.

Rule #2:
If one of the plans does not have a Coordination of Benefits (COB) provision, the plan without COB provisions pays its benefits first. If both plans have COB provisions, the following rules apply.

Rule #3:
If you are covered as an Associate by one plan and as a dependent by another, the plan that covers you as an Associate will pay the benefits first.

Rule #4:
If you and your child's other parent are married (not separated) or living together, your dependent children will receive primary coverage from the parent whose birth date occurs first in a Calendar Year. If both parents have the same birth date, the primary plan is the one that has been in effect the longest. This rule applies to Same Sex Domestic Partnerships.

Rule #5:
If two or more plans cover a dependent child of divorced or separated parents (or unmarried parents living apart) and if there's no court decree stating that one parent is responsible for health care, the primary plan is determined in this order:

1. First, the plan of the parent with custody of the child
2. Second, the plan of the spouse of the parent with custody of the child (the step-parent)
3. Finally, the plan of the parent who does not have custody of the child

Rule #6:
If you have coverage as an Associate (or as a dependent of an Associate) from Bath & Body Works or another employer and COBRA continuation coverage, the plan that covers you as an Associate (or a dependent of an Associate) is primary and continuation coverage is secondary.

**When Two Plans Pay for the Same Expense**

This situation involves the rights of Subrogation and Reimbursement. The following are examples of these rights:

- If "Plan A" pays an amount that should have been paid under "Plan B," the two plans straighten it out. "Plan B" pays "Plan A" back. "Plan A" then lists it as a paid benefit and will not have to pay that amount again.
- If the amount of payments made by a plan is more than should have been paid, the plan can take it back. It may recover funds from an individual, insurance companies or any other organization that received payment.
- If you have a claim against any third party for medical expenses paid by a plan, the plan has the right to recover those payments. This amount includes the reasonable cash value of any benefits provided in the form of services.

You and your dependents agree to help the plan use this right when requested. The amount of the reimbursement will be reduced to cover your proper share and any legal fees and expenses needed to obtain the reimbursement.

Please note: Coordination of Benefits (COB) does not apply to the Outpatient Prescription Drug Benefits

## EFFECT OF GOVERNMENT PLANS ON THIS PLAN

If the Covered Person is also covered under a government plan, the plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to the Covered Person under the government plan.

This provision does not apply to any government plan which by law requires the plan to pay primary.

Please note: A government plan is any plan, program, or coverage, other than Medicare or Medicaid, which is established under the laws or regulations of any government, or in which any government participates other than as an employer

## EFFECT OF MEDICARE

When a Covered Person becomes eligible for Medicare, the plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law.

**When the Plan is Primary to Medicare**
The plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the Associate has current employment status with Bath & Body Works, as defined by federal law and determined by Bath & Body Works.

- Eligibility for Medicare is due to disability and the Associate has current employment status with Bath & Body Works, as defined by federal law and determined by Bath & Body Works.
- Eligibility for Medicare is due to end-stage renal disease (ESRD)
  *Exception: The plan is primary only during the first 30 months of entitlement to Medicare due to ESRD.*

Medicare pays primary to the plan if the above are not met and if so required under federal law.

## EFFECT OF MEDICAID AND TRICARE

The Plan is always primary to Medicaid and TRICARE

## SUBROGATION & REIMBURSEMENT

The plan does not cover the treatment and services provided for Sickness and/or injury if the Covered Person is entitled to reimbursement or recovery from a third party. However, if the plan does pay for such services, the plan has a right to subrogation and/or reimbursement of any benefit payments made because of the Sickness or injury.

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you may make a lawful claim, demand or right of recovery, the plan has the right to assert the claim, demand or right of recovery against the third party. This process is called subrogation. If you receive a benefit payment from the plan for an injury caused by a third party, and you later receive any payment for that same condition or injury from another person, organization or insurance company, the plan has the right to recover any payments made by it to you or on your behalf. This process of recovering earlier payments is called reimbursement. The Covered Person is obligated to cooperate with the plan and its agents in order to protect the plan's subrogation and reimbursement rights.

Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation and/or reimbursement claim, and obtaining the consent of the plan or its agents before releasing any party from liability for payment of medical expenses.

The plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as third parties).
- You, for amounts you receive from a third party, including amounts that are held in a constructive trust.

You agree as follows:

- To assign to the plan all rights of recovery against third parties, to the extent of the reasonable value of services and benefits the plan provided, plus reasonable costs of collection.
- To cooperate with the plan or its agents in protecting the plan's legal rights to subrogation and reimbursement.
- That the plan's subrogation and reimbursement rights will be considered as the first priority claim against third parties or against any recovery from third parties.
- That you will do nothing to prejudice the plan's rights under this provision, either before or after the need for services or benefits under the plan.
- That the plan or its agents may, at its or their option, take necessary and appropriate action to preserve the plan's rights under these subrogation provisions, including filing suit in your name.
- That regardless of whether or not you have been fully compensated, the plan may collect from the proceeds of any full or partial recovery that you or your legal representative obtain or that you or your legal representative have a legal right to obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services or benefits provided under the plan.
- To the extent of benefits paid, to hold in trust for the plan's benefit under the gross proceeds of any recovery.
- That the common fund doctrine will not apply to any funds recovered by any attorney you hire regardless

of whether funds recovered are used to repay benefits paid by the plan.

- That the plan shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse the plan without the written approval of the plan or its agents.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records) and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as the plan or its agents may reasonably request from you.
- The plan will not pay fees, costs or expenses you incur with any claim or lawsuit, without the prior written consent of the plan or its agents

### REFUND OF OVERPAYMENTS

If the plan pays benefits to or on behalf of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the plan if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the plan made exceeded the benefits under the plan.

The refund equals the amount the plan paid in excess of the amount it should have paid under the plan. If the refund is due from another person or organization, the Covered Person agrees to help the plan obtain the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the plan may reduce the amount of any future benefits that are payable under the plan. The reductions will equal the amount of the required refund. The plan may have other rights in addition to the right to reduce future benefits.

## How to file/Appeal a Claim

### MEDICAL, PRESCRIPTION DRUG AND DENTAL

You have a right to appeal any decision that Mapfre makes that denies payment on your claim or your request for coverage of a health care service or treatment (medical, pharmacy or dental).

To learn more about the process, contact Mapfre at 1.787.250.5214, option 5 or log on to mapfre.com to access the grievance and appeals procedures.

**Right of Appeal**

If your claim is denied, you may ask the claims administrator for a review. A request for review of a denied claim must be submitted, in writing (or, in the case of an urgent care appeal, orally), to the claims administrator within 180 calendar days after the date that the claim is denied. Include the identifying information submitted with your first appeal. You may submit any additional written comments, documents, records and other information relating to your claim that you think the claims administrator should see in connection with deciding your appeal.

You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge. Mail your appeal to:

Mapfre
P.O. Box 70333
San Juan, PR 00936-8333

If (and only if) you have an urgent pre-service claim, you may appeal the denial by calling the claims administrator's customer service telephone number, 1.787.250.5214, option 5.

The person who decides the appeal will not be the same individual who decided the claim (or a subordinate of the individual who decided the claim). For a decision based on medical judgment, the person deciding the appeal will consult with a health care professional. The health care professional will not be a health care professional who was consulted in connection with the decision on the claim (or a subordinate of a health care professional who was consulted in connection with the decision on the claim).

**Review Procedure**

The claims administrator will make a decision on the appeal of a claim within 30 calendar days (72 hours in the

case of an urgent care appeal) after receipt of the request for review. Notice of the decision on an urgent care appeal may be oral if the claims administrator sends written notice within three calendar days after the oral notice.

## VSP CLAIM DECISIONS AND APPEALS PROCEDURES

Covered Persons have the right to expect quality care from VSP Network Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to:

VSP
3333 Quality Drive
Rancho Cordova, CA 95670-7985
Or verbally by calling VSP's Customer Care Division at 1.800.877.7195.

VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

### CLAIM PAYMENTS AND DENIALS

#### Initial Determination

VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

#### Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

#### Initial Appeal

The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

#### Second Level Appeal

If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

#### Other Remedies

When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Covered Person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

#### Time of Action

No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

## EAP CLAIMS PROCEDURES

All requests for benefits must be approved by the claims administrator before you can receive any care from an EAP NETWORK Psychologist. If you attempt to request pre-certification, but do not follow the appropriate procedures for filing a pre-service claim, the claims administrator will notify you in writing, electronically or orally within five calendar days (24 hours in the case of an urgent care claim). The notice will explain the proper procedures to be followed in filing a claim.

**Urgent Care Claims**
If your request is an urgent care request — meaning basically that a failure to act quickly could subject someone to severe pain or could seriously jeopardize life, health or ability to regain maximum function — you may be referred to a Hospital for an inpatient psychiatric evaluation (Hospital inpatient stays may be covered by medical program, but they are not covered by the EAP program).

**Processing a Claim**
When you request pre-certification, you will usually be notified within 15 calendar days (72 hours in the case of an urgent care claim) of the benefit determination. If you do not provide the necessary information, the claims administrator may either deny pre-certification or contact you to obtain the missing information. You will be notified, as soon as possible, but not later than 15 calendar days (24 hours in the case of an urgent care claim) after receipt of the claim of the specific information necessary to complete the claim.

You will be given a period of 45 calendar days (48 hours, in the case of an urgent care claim) to provide the missing information. If due to matters beyond its control the claims administrator needs more time to decide a claim, it may take a 15-day extension on a non-urgent pre- service claim (not applicable to an urgent care claim). If an extension is taken, you will be notified of the circumstances and the date by which the claims administrator expects to decide the claim.

**Denial of a Claim**
If pre-certification is denied, you will be notified in writing of the decision. In the case of an urgent care claim, notice of the decision may be oral if the plan sends written notice within three calendar days after the oral notice.

**Right of Appeal**
If your claim is denied, you may ask the claims administrator for a review. A request for review of a denied claim must be submitted, in writing (or, in the case of an urgent care appeal, orally), to the claims administrator within 180 calendar days after the date that the claim is denied. Include the identifying information submitted with your first appeal. You may submit any additional written comments, documents, records and other information relating to your claim that you think the claims administrator should see in connection with deciding your appeal.

You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge. Mail your appeal to:

Mapfre
P.O. Box 70333
San Juan, PR 00936-8333

If (and only if) you have an urgent pre-service claim, you may appeal the denial by calling the claims administrator's customer service telephone number, 1.787.250.5214, option 5.

The person who decides the appeal will not be the same individual who decided the claim (or a subordinate of the individual who decided the claim). For a decision based on medical judgment, the person deciding the appeal will consult with a health care professional. The health care professional will not be a health care professional who was consulted in connection with the decision on the claim (or a subordinate of a health care professional who was consulted in connection with the decision on the claim).

**Review Procedure**
The claims administrator will make a decision on the appeal of a claim within 30 calendar days (72 hours in the case of an urgent care appeal) after receipt of the request for review. Notice of the decision on an urgent care appeal may be oral if the claims administrator sends written notice within three calendar days after the oral notice

## DISABILITY CLAIM PROCEDURES

Notice of the disability must be submitted to the Claims Administrator within 30 days after the start of your disability or as soon as reasonably possible. In any event, notice of the disability must be given within one year after the start of your disability unless you are legally incapable of doing so

**Processing a Claim**

When a claim for benefits is presented to the Claims Administrator, it will usually be processed within 45 calendar days after receipt of the claim. If your claim does not include necessary information, the Claims Administrator may either deny your claim or contact you to obtain the missing information. If you are contacted, you will be given a period of 45 calendar days to provide the missing information. If due to matters beyond its control the Claims Administrator needs more time to decide a claim, it may take up to two 30-day extensions. If an extension is taken, you will be notified of the circumstances and the date by which the Claims Administrator expects to decide the claim.

| DISABILITY CLAIMS PROCEDURES | |
|---|---|
| Step 1 | Call Associate Connect at 1-866-473-4728 and follow the prompts or Call Lincoln Financial Group (LFG) at 1- 888-481-2440; or Log on to www.mylincolnportal.com<br><br>Company code: LBRANDS (first time users) |
| Step 2 | Have the following information available when you make your request:<br>■ Reason for absence (symptom or diagnosis)<br>■ Medical care provider's name, address, telephone and fax numbers<br>■ Last day worked, first day of absence and anticipated return to work date |
| Step 3 | LFG will determine your eligibility and notify you regarding next steps. You must provide required documentation within the time line given to you. Failure to do so may result in the delay or denial of leave and/or benefits and, in some circumstances, violations of the Company's attendance policy. |

You will receive a written notice of denial if your claim is denied.

**Right of Appeal**

If your claim is denied, you may ask the Claims Administrator for a review. A request for review of a denied claim must be submitted, in writing, to the Claims Administrator within 180 calendar days after the date that the claim is denied. Include identifying and contact information. You may submit any written comments, documents, records and other information relating to your claim that you think the Claims Administrator should see in connection with deciding your appeal. You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge. Mail your appeal to:

LINCOLN LIFE ASSURANCE COMPANY OF BOSTON
Attn: Appeal Review Unit
Group Benefits Disability Claims
P.O. Box 7213
London, KY 40742-7213

The person who decides the appeal will not be the same individual who decided the claim (or a subordinate of the individual who decided the claim). For a decision based on medical judgment, the person deciding the appeal will consult with a health care professional. The health care professional will not be a health care professional who was consulted in connection with the decision on the claim (or a subordinate of a health care professional who was consulted in connection with the decision on the claim).

**Review Procedure**

A decision on your appeal will normally be made within 45 calendar days after receipt of your request for review.

If the Claims Administrator needs to take an extension due to special circumstances, you will be notified of the circumstances requiring the delay and the date that the Claims Administrator expects to make a decision. The extension will not exceed an additional 45 calendar days

## LIFE INSURANCE CLAIMS PROCEDURES

**Processing a Claim**

When a claim for benefits is presented to the Claims Administrator for payment, it will usually be processed within 90 calendar days after receipt of the claim. If due to special circumstances the Claims Administrator needs more time to decide a claim, it may take up to a 90-day extension. If an extension is taken, you will be notified of the circumstances and the date by which the Claims Administrator expects to decide the claim.

You will receive a written notice of denial if your claim is denied.

**Right of Appeal**
If your claim is denied, you may ask the Claims Administrator for a review. A request for review of a denied claim must be submitted, in writing, to the Claims Administrator within 180 calendar days after the date that the claim is denied. Include identifying and contact information. You may submit any written comments, documents, records and other information relating to your claim that you think the Claims Administrator should see in connection with deciding your appeal. You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits, free of charge. Mail your appeal to:

Lincoln Financial Group
PO Box 2578
Omaha, NE 68103

**Review Procedure**
A decision on your appeal will normally be made within 60 calendar days after receipt of your request for review. If the Claims Administrator needs to take an extension due to special circumstances, you will be notified of the circumstances requiring the delay and the date by which the Claims Administrator expects to make a decision. The extension will not exceed an additional 60 calendar days.

## EXPLANATION OF DECISIONS ON CLAIMS AND APPEALS

Disagreements about benefits are rare. However, if any portion of your claim is denied or if a claim denial is upheld on appeal, you will receive written explanation.

An explanation of a denial of a claim will state:

- the reasons for the denial;
- a reference to the relevant Plan provisions;
- a description of any additional information needed and an explanation of why the additional information is needed;
- an explanation of the appeal procedures; and
- a statement regarding your right to bring an action under Section 502(a) of ERISA following exhaustion of the appeal procedures.

An explanation of a denial of a medical, prescription drug, dental, vision, disability or EAP claim will also include:

- if relevant to the denial, a copy of any specific internal rule, guideline, protocol, or other similar criterion relied upon; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request; and
- if the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

An explanation of a denial of an appeal will state:

- the reasons for the denial;
- a reference to the relevant Plan provisions;
- 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 your claim for benefits;
- an explanation of any additional appeal procedures including any additional voluntary appeal procedures offered by the claims administrator; and
- a statement regarding your right to bring an action under Section 502(a) of ERISA following exhaustion of the appeal procedures.

An explanation of a denial of an appeal of a medical, prescription drug, dental, vision, disability or EAP claim will also include

- if relevant, a copy of any specific internal rule, guideline, protocol or other similar criterion relied upon; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request; and
- if the adverse benefit determination is based on a medical necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific

or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request

In the event a Claims Administrator offers a voluntary level of appeal, you will receive sufficient information relating to the appeal procedure to enable you to make an informed judgment about whether to submit the benefit dispute to the voluntary level of appeal. You must complete all levels of appeal under the Plan prior to participating in a voluntary appeal.

## LIMITATION OF ACTION

The Claims Administrator (or, in the case of a second appeal of a medical claim, the Plan Administrator) will make a determination, in its sole discretion, based upon the applicable provisions of the Plan, whether to approve or deny appeals. Benefits will be paid only if the Claims Administrator decides in its discretion that a claimant is entitled to benefits under the terms of the Plan. The construction, interpretation, and application of Plan provisions are vested with the claims administrator (or Plan Administrator), in its absolute discretion, including, without limitation, the determination of facts, benefits, and eligibility.

You cannot bring any action to recover denied benefits against the Plan, the Plan Administrator or a Claims Administrator until you have exhausted all of the administrative remedies available under the Plan with the exception of any voluntary appeals offered by a claims administrator. Failure to comply with the time frames for submitting claims and appeals constitute a failure to exhaust your administrative remedies available under the Plan and precludes you from bringing any action to recover denied benefits against the Plan, the plan administrator or a Claims Administrator.

An action to recover denied disability benefits, an action to recover denied benefits against the Plan, the Plan Administrator or a Claims Administrator must be filed within three years of the date you are notified of the final decision on your claim. An action to recover denied disability benefits must be filed within three years after written proof of loss is given to the Claims Administrator. The time frame will be tolled for any period that you participate in a voluntary appeal offered by a Claims Administrator.

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The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official plan documents will govern.