

BENEFITS GUIDE

2019



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TTI 2019 BENEFITS PROGRAM

TTI offers a consolidated benefits program for TTI employees in the U.S. By offering a single benefits program, we can provide you with benefits at the best possible cost and have consistent benefits for all TTI employees.

At TTI, we believe that our benefits make a difference... to you, your job, and the life you lead outside of work. That is why we offer a comprehensive benefits program that can meet your needs—whether you're single, married or have others depending on you for their well-being.

This Guide will provide an overview of the benefits under the 2019 TTI Benefits Program. Whether you are a current TTI employee reviewing your benefit elections during Open Enrollment in the fall of 2018, or a newly hired employee in 2019 making your initial TTI benefit elections, this Guide together with other written benefit plan materials that have been provided to you, will give you a thorough description of plan benefits, costs and options.

For existing TTI employees, Open Enrollment is your chance to take a fresh look at your benefits and make choices for the coming year. For newly hired TTI employees, your initial elections should be carefully considered since they will be in place for the remainder of the calendar year.

FALL 2018 OPEN ENROLLMENT DATES FOR 2019 ELECTIONS

Open Enrollment dates for current TTI employees will be October 29, 2018 to November 12, 2018. No Open Enrollment elections can be made after November 12, 2018.

Newly hired employees should contact their Human Resources Department for enrollment instructions and deadlines.

SUMMARY OF BENEFITS OFFERED

The following chart shows the benefits that are included in the 2019 TTI Benefits Program.

Medical Plan	<ul style="list-style-type: none"> ● Six Medical Plan Options ● Plan 1 - \$500 Deductible—"Smoking Free/Tobacco Free" and "Standard" versions ● Plan 2 - \$1,000 Deductible—"Smoking Free/Tobacco Free" and "Standard" versions ● Plan 3 - \$1,350 Deductible—including an optional Health Savings Account—"Smoking Free/Tobacco Free" and "Standard" versions ● All Plans administered by Anthem/Blue Cross Blue Shield ● All Plans with prescription drug coverage administered by Express Scripts
Dental Plan	<ul style="list-style-type: none"> ● One Dental Plan Option administered by Delta Dental
Vision Plan	<ul style="list-style-type: none"> ● One Vision Plan Option insured by VSP
Flexible Spending Accounts	<ul style="list-style-type: none"> ● Two Flexible Spending Accounts (FSA) ● Health FSA—Includes Automatic Medical Claims Substantiation ● Dependent Day Care FSA ● Both administered by HealthEquity, a new administrator for 2019
Health Savings Account	<ul style="list-style-type: none"> ● Only available with enrollment in Medical Plan 3 ● Bank account set up in your name at HealthEquity ● 2019 pre-tax contributions up to \$3,500 single/\$7,000 family. \$1,000 more if age 55 or older
Life Insurance	<ul style="list-style-type: none"> ● Company paid life insurance ● Supplemental life insurance you can purchase for you and your eligible dependents ● Insured by Liberty Mutual
Disability Insurance	<ul style="list-style-type: none"> ● Short Term Disability (STD) paid by the Company and reviewed by Liberty Mutual ● Long Term Disability (LTD) coverage insured by Liberty Mutual
Employee Assistance Program	<ul style="list-style-type: none"> ● EAP administered by Anthem/Blue Cross Blue Shield ● Free, confidential resources
401(k) Plan	<ul style="list-style-type: none"> ● Allows you to contribute 1% to 75% of your pay, up to IRS maximums (\$18,500 in 2018) ● Allows catch up contributions if you are age 50 and older, up to IRS maximums (\$6,000 in 2018)—2019 maximums may be higher ● Company match of 50% on the first 8% saved ● 100% immediate vesting on Company match ● Administered by T. Rowe Price ● Wide range of investment options ● Automatic enrollment for newly hired employees at 5% of pay

IMPORTANT REMINDERS!

If you take no action during Open Enrollment from October 29, 2018 to November 12, 2018, your 2018 benefit elections for Medical, Dental, Vision and Life Insurance coverage will remain the same for 2019 with the applicable 2019 contribution rates. **In order to participate in Flexible Spending Accounts (FSA) in 2019, you must make an election during Open Enrollment—FSA elections do not roll over from one year to the next.**

If you elect to participate in Plan 3, you can participate in the Dependent Care Spending Account but you are NOT eligible to participate in the Health Flexible Spending Account in 2019.

Important Medical Plan Information: Smoking & Tobacco Use Medical Contributions

If you certified your tobacco use and smoking status during a prior Open Enrollment or at time of hire and your status has not changed, you **DO NOT** need to recertify this Open Enrollment period. You only need to recertify if your status has changed. The amount you contribute through payroll deductions towards the Medical Plan will be based on whether you and your enrolled family members use any form of tobacco (smoking or smokeless) or smoke anything (legal or illegal). Use of e-cigarettes is considered smoking, regardless of what kind of substance is inside. Please carefully review the Important Information below:

- To elect the lower cost “Smoking Free/Tobacco Free” versions of the Medical Plan, you and all family members you cover under the Medical Plan must have been smoking free and tobacco free for 6 full calendar months as of January 1, 2018. If only one covered family member smokes or uses tobacco, then the entire family is ineligible to enroll in the “Smoking Free/Tobacco Free” version of the Medical Plan.
- If you or any of your covered family members cannot satisfy the 6 month rule, you must elect the “Standard” version of the Medical Plan.
- This election operates on the honor system, there is no testing, and TTI trusts that all employees will be truthful. Making an election is submitting information to the Company for approval, no different than any other Company record. Submitting false information is a violation of Company policy and doing so will result in discipline, up to and including termination of employment.
- If you and your covered family members have not been smoking free and tobacco free for 6 continuous calendar months and you elect the “Standard” version of the Medical Plan, but at a subsequent date you and your covered family members all achieve 6 continuous months of being smoking free and tobacco free, you should contact Human Resources and they will advise you how to switch to the lower cost “Smoking Free/Tobacco Free” version of the Medical Plan.
- If you are enrolled in the “Smoking Free/Tobacco Free” version of the Medical Plan and you or a covered family member smokes or uses tobacco, you must notify Human Resources so they can switch you to the higher cost “Standard” version of the Medical Plan. Failing to notify Human Resources of this change is considered maintaining false information in Company records, a violation of Company policy and doing so will result in discipline, up to and including termination of employment.
- Any use of tobacco and any smoking, no matter how infrequent, is considered use of tobacco and smoking and you cannot elect the “Smoking Free/Tobacco Free” versions of the Medical Plan. The following examples are provided for illustration.



- John smokes 1-2 cigars occasionally (once a month) on the weekends but otherwise does not smoke or use tobacco. This is considered Tobacco Use and Smoking and John cannot elect the “Smoking Free/Tobacco Free” versions of the Medical Plan.
- Susan smokes 1-2 cigarettes occasionally (once a month) on the weekend when she goes to a bar with friends. This is considered Tobacco Use and Smoking and Susan cannot elect the “Smoking Free/Tobacco Free” versions of the Medical Plan.
- David plays on a spring and fall softball team and during the games will join the other guys on the team in using some chewing tobacco. This is considered Tobacco Use and Smoking and David cannot elect the “Smoking Free/Tobacco Free” versions of the Medical Plan.
- Karen used to smoke tobacco cigarettes but now uses e-cigarettes. This is considered Tobacco Use and Smoking and Karen cannot elect the “Smoking Free/Tobacco Free” versions of the Medical Plan.

Your health plan is committed to helping you achieve your best health. Lower rates for non-tobacco use are available to all employees. If you think you might be unable to meet a standard for lower rates under this program, you might qualify for an opportunity to earn lower rates by different means. Contact us at **443-391-1204** and we will work with you (and, if you wish, with your doctor) to find a program that is right for you in light of your health status.

TTI’s goal is simple: we want all TTI employees and their family members to be tobacco free and smoking free to lead a healthier lifestyle, and lower Medical Plan costs for everyone.

ENROLLMENT INSTRUCTIONS

Enroll online at <https://online.adp.com/portal/login.html>. Call the ADP Benefits Center at **844-884-2363** with any questions.

IMPORTANT NEWS FOR OPEN ENROLLMENT 2019

Special One-Time Optional Life Insurance Increase Option:

During the 2019 Open Enrollment period, you will have a one-time opportunity to increase your Optional Life Insurance up to 1X, 2X, 3X or 4X your basic annual earnings, regardless of your current level of coverage, as long as the total coverage does not exceed \$750,000 and you have not previously been denied an increase by completing an Evidence of Insurability (EOI) Application with Liberty Mutual.

If you were previously denied coverage after completing an EOI Application, you can still apply for an increase in coverage but you will need to complete another EOI form.

New FSA Administrator for 2019

We will be changing FSA administrators (both Health and Dependent Daycare) on 1/1/2019 to **HealthEquity**; the same administrator that we currently use for the HSA program. **HealthEquity** offers all of the same familiar features along with a few new ones. See page 32 for important information about this change.

MAKING YOUR 2019 BENEFIT PROGRAM ELECTIONS

To make the correct benefit election for you and your family, you should thoroughly read this Guide as well as the other benefit plan materials that have been provided to you. To help you understand your benefit program we will:

- Assist you to better understand your benefit plan options
- Clarify and explain anything that you do not understand
- Give you access to resources to help you evaluate your benefit options
- Provide educational opportunities for you to learn about your benefit options
- Explain your cost to participate in each benefit option

The one thing we cannot do for you is to make or recommend your benefit elections. Only you can make the final decision on your benefit program elections that are right for you.



OPEN ENROLLMENT CHECKLIST

Open Enrollment for current TTI employees starts October 29, 2018 and ends November 12, 2018. Here is a Checklist of the actions you should take to help you make your elections for 2019.

<input type="checkbox"/> Review this 2019 TTI Benefits Guide <input type="checkbox"/> Review other TTI Benefit Program materials <input type="checkbox"/> Attend an Open Enrollment meeting (if offered at your site) <input type="checkbox"/> Ask Human Resources to help explain and clarify what you do not understand <input type="checkbox"/> Email Benefits@ttihq.com with any questions you have	<input type="checkbox"/> Vision Plan: One Option <ul style="list-style-type: none"> ● TTI Vision Plan Plan Options Include: <ul style="list-style-type: none"> ● Keep current Vision Plan coverage—No Action Necessary ● Add Vision Plan coverage if currently not enrolled ● Drop Vision Plan coverage if currently enrolled Coverage Levels Include: <ul style="list-style-type: none"> ● Continue coverage with same covered dependents—No Action Necessary ● Add dependents ● Drop dependents
<input type="checkbox"/> Medical/Prescription Plan: Six Options <ul style="list-style-type: none"> ● TTI Medical Plan 1—\$500 Annual Deductible—“Smoking Free/Tobacco Free” and “Standard” versions ● TTI Medical Plan 2—\$1,000 Annual Deductible—“Smoking Free/Tobacco Free” and “Standard” versions ● TTI Medical Plan 3—\$1,350 Annual Deductible—“Smoking Free/Tobacco Free” and “Standard” versions Plan Options Include: <ul style="list-style-type: none"> ● Keep current Medical Plan Option—No Action Necessary ● Change Medical Plan Option ● Change smoking and tobacco certification ● Add Medical Plan coverage if currently not enrolled ● Drop Medical Plan coverage if currently enrolled Coverage Levels Include: <ul style="list-style-type: none"> ● Continue coverage with same covered dependents—No Action Necessary ● Add dependents ● Drop dependents 	<input type="checkbox"/> Flexible Spending Accounts: <ul style="list-style-type: none"> ● HealthEquity ● Make an election for the Health FSA and/or Dependent Day Care FSA during Open Enrollment to participate in 2019. Consider any unused 2018 funds, up to \$500 eligible for carryover—when making a 2019 election. ● 2018 elections do not renew for 2019 so if you want to participate you must make an election. ● If you do not want to participate in the FSAs in 2019—No Action Necessary
<input type="checkbox"/> Dental Plan: One Option <ul style="list-style-type: none"> ● TTI Dental Plan Plan Options Include: <ul style="list-style-type: none"> ● Keep current Dental Plan coverage—No Action Necessary ● Add Dental Plan coverage if currently not enrolled ● Drop Dental Plan coverage if currently enrolled Coverage Levels Include: <ul style="list-style-type: none"> ● Continue coverage with same covered dependents—No Action Necessary ● Add dependents ● Drop dependents 	<input type="checkbox"/> Health Care Savings Account—Requires Enrollment in Medical Plan 3: <ul style="list-style-type: none"> ● If you currently participate in the Health HSA—No Action Necessary unless you want to change your contribution level ● Make an election for the Health HSA to participate in 2019. ● If you do not want to participate in the HSA in 2019—No Action Necessary <input type="checkbox"/> Supplemental Life Insurance <ul style="list-style-type: none"> ● Evaluate your needs and adjust coverage during Open Enrollment ● Keep your current level of supplemental life insurance—No Action Necessary <input type="checkbox"/> Make all Open Enrollment elections by November 12, 2018

IMPORTANT NOTICES INCLUDED IN THE GUIDE:

- Medicare Part D—Notice of Creditable Coverage
- Women's Health and Cancer Rights Act
- HIPAA Notice of Special Enrollment Rights
- Notice of Availability—Privacy Practices

BENEFIT PROGRAM ELIGIBILITY

Eligibility for Medical, Dental, Vision and Supplemental Life insurance coverage is as follows:

Employees

All active, regular full-time employees working 30 or more hours per week are eligible.

Dependents

Your legal opposite sex or same sex spouse is eligible for coverage under many of the TTI benefit plans.

A domestic partner (same sex as well as opposite sex) can be enrolled as a dependent for Medical, Dental and Vision. To inquire about tax implications to you as a result of covering a domestic partner, as well as enrolling a domestic partner, please contact Human Resources for more information as well as required documentation.

Your dependent children are eligible for coverage until they reach age 26, regardless of the child's marital or student status. Dependent children include:

- Biological children
- Adopted children
- Stepchildren
- Domestic Partner's children (Medical, Dental and Vision only)
- Children for whom you have legal guardianship as long as you are able to provide the necessary documentation—contact Human Resources for more information.



ELECTIONS & LIFE EVENT CHANGES— MAKING MID-YEAR CHANGES

The benefits you elect during Open Enrollment will be effective from January 1, 2019 through December 31, 2019. For newly hired employees, the elections you make during your initial election period will be effective from your date of hire.

Once you have made your elections, you will not be able to change them until the next Open Enrollment period unless you have a qualified life event (see below). We encourage you to review all of your benefits and make your selections wisely.

Any change to your benefits due to a life event change has to be made within 31 days of the life event. You will be required to provide documentation to the ADP Dependent Verification Service, and all changes are subject to approval by the Company. Examples of qualifying life events are:

- Marriage
- Adoption
- Death
- Birth
- Divorce
- Involuntary change in other insurance
- Lose or gain eligibility under Medicare, Medicaid or CHIP (you have 60 days to make a change)

MEDICAL PLAN BENEFITS

Nothing is more important than your good health, wellness and flexibility in choosing a medical plan that fits your needs. That is why TTI offers comprehensive Medical Plan Preferred Provider (PPO) options through Anthem/Blue Cross Blue Shield (BCBS) and Prescription Drug coverage through Express Scripts. You now have three medical plan options from which to choose. Each option uses the same PPO network options and all provide the same covered services. When choosing a Medical Plan option that can best meet your individual and family needs, you should consider...

- Your current use of medical services.
- Your share of the cost (premiums and out-of-pocket costs, such as deductibles, co-payments and co-insurance).
- Your use of in-network versus out-of-network health care providers. It is to your advantage to utilize in-network providers to help minimize your out-of-pocket expenses.

The Anthem/Blue Cross Blue Shield network is very broad and can be viewed at www.anthem.com. A review of actual claims filed by all TTI employees show that over 96% of the claims were with in-network providers.

Prescription plan benefits are provided through Express Scripts under all Medical Plan options. The Express Scripts network contains over 60,000 retail pharmacies which represent virtually every retail pharmacy in the U.S. If you or an eligible dependent uses prescription drugs on an ongoing basis (maintenance medications), you will be required to use Express Scripts mail order service for refills. Express Scripts mail order program offers the convenience of home delivery while saving you money on out-of-pocket expenses. Here's how it works:

- After a maintenance prescription is filled 3 times at a retail pharmacy, you must fill the medication at either a Smart 90 retail pharmacy or Express Scripts Home Delivery for a 90 day supply. If you don't move your prescriptions to a Smart 90 pharmacy or Home Delivery after the 3 courtesy fills you will pay 100% of the cost of the medication and this amount does not accumulate toward the out-of-pocket maximum.
- Before using mail order, ask your physician to write your prescription for a 90-day supply, with three refills.
- After you have submitted your first prescription, you can request refills by telephone or online. Forms can be found online at www.express-scripts.com or contact Human Resources for more information.



IMPORTANT REMINDERS ABOUT PLAN 3

Plan 3 is a **High Deductible Health Plan (HDHP)** that allows you to also enroll for a tax-free savings account known as a **Health Savings Account (HSA)**. Paired together, a **HDHP** and **HSA** provide you with a tax free way to save for current and future health expenses that is not available with traditional medical plans like Plan 1 and Plan 2. You cannot enroll for the **HSA** if you elect Plan 1 or Plan 2 or waive Medical Plan coverage.

What Is Covered—All three Medical Plan Options (Plan 1, Plan 2 and Plan 3) cover the same broad list of services. There is no difference between any of the three Medical Plan options when it comes to covered and excluded services. The difference between the two traditional options (Plan 1 and Plan 2) and the HDHP Plan 3 is **when** the Plan starts to pay for services. Under Plan 1 and Plan 2, when you use in-network providers, most services are paid at 100%, 80% or with various copayments without having to first meet an annual deductible. Under the new HDHP Plan 3, the opposite happens. Except for a limited list of preventive services which are still paid at 100% without any annual deductible, all other services under Plan 3, including prescription drugs, **will not be paid until you have satisfied your annual deductible**.

Why Elect A HDHP—Enrolling for a HDHP is not for everyone. If you prefer to minimize your out of pocket expenses at the time services are received and have no interest in a Health Savings Account, you should stick with either Plan 1 or Plan 2. If you are OK with paying more up front for your health care expenses in order to get the tax advantages of a Health Savings Account, then you may want to consider Plan 3 and also enrolling for the HSA. An HSA may appear to look and work a lot like a Flexible Spending Account, but it is really much different and more advantageous from both a tax and a short and long term savings perspective.

Plan 3 Design—The design of Plan 3, specifically the amount of the annual deductible, is controlled by the IRS. In exchange for allowing someone to have a Health Savings Account, the IRS has set various rules and guidelines that must be followed. These include the minimum levels for annual deductibles and out of pocket maximums. Each year the IRS adjusts the minimum levels and TTI will need to adjust our plan levels to comply for future years.

Other Restrictions With Plan 3/HDHP & HSA—There are other restrictions with enrolling for a HDHP and an HSA.

- Neither the employee nor any other covered family members may be enrolled for any other health insurance, including Medicare, Medicaid, VA, TRI-CARE or any other non-HSA compliant secondary coverage.



- You cannot switch between Plan 3 and Plan 1 or 2 mid-year.
- If you enroll for Plan 3, you (or your spouse) cannot sign up for the Health FSA at TTI or your spouses' employer.

HSAs Explained—An HSA has some enrollment, payroll and operating features that are similar to a Flexible Spending Account. See the comparisons in the chart below:

Account Feature	HSA	FSA
Annual election required	Yes	Yes
Deductions from paycheck before-tax	Yes	Yes
Debit card	Yes	Yes
Use-it or lose-it feature	No	Yes
Actual bank account	Yes	No
Can be used for future years expenses	Yes	No
Account earns interest	Yes	No

HSAs provide three types of tax savings. The funds are deducted from your paycheck before tax. Once funds are in your account they can earn interest or be invested tax free. And when funds are used for qualified health, Rx, dental and vision care expenses, the funds come out of the account tax free. Unlike an FSA where you can use funds you have pledged each year before they are actually deducted from your payroll check, with an HSA you can **only** use funds after they are deducted and deposited to your HSA account.

When you elect to participate in the HSA, a real bank account is opened in your name with HealthEquity, the health account administrator we have selected to administer the TTI HSA accounts. Each payroll period the amount deducted from your paycheck for the HSA is deposited into this bank account. The account is linked to a debit card in your name. Funds in your account earn interest and once you build up a balance you can move funds into various Vanguard mutual funds. The money that you deposit into your HSA can be used tax-free when paying for qualified expenses. Your HSA and the money in it belongs to you—not the company. Also, should you ever leave the company, you can take your HSA account with you. You never lose or forfeit money you deposit into your HSA.

Some people use an HSA to save for future health care expenses including health care expenses in retirement. Even if you contribute the maximum amount allowed to your HSA, there is no requirement that you use your saved HSA dollars to pay for current medical expenses. You can decide to pay those expenses from your regular checking account and save as much as you can year after year in your HSA for future health care needs.

In 2019, you can deposit as much as \$3,500 to your HSA if you enroll for Employee-Only and up to \$7,000 if you enroll for Two-Party or Family coverage in Plan 3. If you are 55 or older, you can contribute an additional \$1,000 per year.

If your HSA money is not used for qualified medical expenses, you will have to pay income tax and a penalty on your withdrawal.

If you enroll for Plan 3, even if you do not sign up for the HSA, an HSA bank account will be opened up in your name by HealthEquity. You will receive information in the mail on how to activate your account should you ever decide to use it.

What You Need To Know About Your Flexible Spending Account

If you enroll in Plan 3, **you can no longer contribute to the Flexible Spending Account for health expenses.** You can still sign up for the Dependent Daycare portion of the FSA. Additionally, any amount of FSA health funds that are not used by 12/31/2018 will NOT be rolled over to 2019. You will still have until March 31, 2019 to file claims for expenses incurred in 2018. Any medical expenses incurred in 2019 can be reimbursed to you out of your HSA account, if elected.



MEDICAL PLAN BENEFITS SUMMARY

The chart below provides a summary of benefits under the TTI Medical Plan. For a complete description of benefits, please refer to the TTI Medical Plan Summary Plan Description. All Medical Plan options cover the same services, use the same network of providers, cover preventive services in full, and limit your financial exposure with an out-of-pocket maximum.

ANTHEM/BLEU CROSS BLUE SHIELD MEDICAL PLAN OPTIONS						
	Plan 1		Plan 2		Plan 3	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible ● Individual ● Family Maximum	\$500 \$1,000	\$1,000 \$2,000	\$1,000 \$2,000	\$2,000 \$4,000	\$1,350 \$2,700	\$2,700 \$5,400
Coinsurance ● You Pay ● Plan Pays	20% 80%	40% 60%	20% 80%	50% 50%	20% 80%	50% 50%
Annual Out-of-Pocket Maximum (Deductible plus Coinsurance) ● Individual ● Family Maximum	\$2,500 \$5,000	\$5,000 \$10,000	\$3,500 \$7,000	\$7,000 \$14,000	\$4,500 \$6,650	\$9,400 \$18,900
Annual & Lifetime Maximums	None	None	None	None	None	None
Preventive Care	Plan Pays					
● Well Baby Exams	Paid In Full	60%	Paid In Full	50%	Paid In Full	50%
● Well Child Exams						
● Well Adult/Woman Exams						
● Immunizations						
● Lab & X-Rays with above Exams						
● Mammograms						
● Pap Smears						
● Colonoscopy						
Office Visits	80%; No Deductible	60% After Deductible	80%; No Deductible	50% After Deductible	80% After Deductible	50% After Deductible

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ANTHEM/BLEU CROSS BLUE SHIELD MEDICAL PLAN OPTIONS (CONTINUED)

	Plan 1		Plan 2		Plan 3	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Services	Plan Pays					
● Outpatient Surgery & Related Services	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible	80% After Deductible	50% After Deductible
● Physical, Speech & Occupational Therapy	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible	80% After Deductible	50% After Deductible
Inpatient Hospital Services	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible	80% After Deductible	50% After Deductible
Maternity Services	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible	80% After Deductible	50% After Deductible
Emergency Room Services	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible
Ambulance Services	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible	80% After Deductible	50% After Deductible
Urgent Care Facility	80%; No Deductible	60% After Deductible	80%; No Deductible	50% After Deductible	80% After Deductible	50% After Deductible
Durable Medical Equipment	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible
Mental Health Office Visits	80%; No Deductible	60% After Deductible	80%; No Deductible	50% After Deductible	80% After Deductible	50% After Deductible
Skilled Nursing Care	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible	80% After Deductible	50% After Deductible
Hospice Services	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible

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ANTHEM/BLEU CROSS BLUE SHIELD MEDICAL PLAN OPTIONS (CONTINUED)

	Plan 1		Plan 2		Plan 3	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drug Benefits	Plan 1		Plan 2		Plan 3	
Type of Drug	Retail	Mail	Retail	Mail	Retail	Mail
Generic	\$10 Copay	\$25 Copay	\$10 Copay	\$25 Copay	\$10 Copay After Deductible	\$25 Copay After Deductible
Preferred Brand	25% Copay \$30 Minimum \$75 Maximum	25% Copay \$75 Minimum \$150 Maximum	25% Copay \$30 Minimum \$75 Maximum	25% Copay \$75 Minimum \$150 Maximum	25% Copay After Deductible \$30 Minimum \$75 Maximum	25% Copay After Deductible \$75 Minimum \$150 Maximum
Non-Preferred Brand	40% Copay \$50 Minimum \$125 Maximum	40% Copay \$125 Minimum \$300 Maximum	40% Copay \$50 Minimum \$125 Maximum	40% Copay \$125 Minimum \$300 Maximum	40% Copay After Deductible \$50 Minimum \$125 Maximum	40% Copay After Deductible \$125 Minimum \$300 Maximum
Specialty	20% Copay 1-31 Days— \$100 Max; 32-60 Days— \$200 Max; 61-90 Days— \$250 Max	20% Copay 1-31 Days— \$100 Max; 32-60 Days— \$200 Max; 61-90 Days— \$250 Max	20% Copay 1-31 Days— \$100 Max; 32-60 Days— \$200 Max; 61-90 Days— \$250 Max	20% Copay 1-31 Days— \$100 Max; 32-60 Days— \$200 Max; 61-90 Days— \$250 Max	20% Copay After Deductible 1-31 Days— \$100 Max; 32-60 Days— \$200 Max; 61-90 Days— \$250 Max	20% Copay After Deductible 1-31 Days— \$100 Max; 32-60 Days— \$200 Max; 61-90 Days— \$250 Max

In 2019, for Plan 1 and Plan 2, the Prescription Drug Program will have an Out-of-Pocket Maximum. This maximum will apply to all prescription drugs obtained at retail and mail. The annual Prescription Drug Annual Out-of-Pocket Maximum will be \$3,000 per person and \$6,000 for all covered family members combined. This is a separate Out-of-Pocket Maximum from the Medical Plan and the two maximums do not combine. This maximum will provide a potential cost savings to a participant with significant prescription drug needs.

For Plan 3, there is not a separate Out-of-Pocket Maximum for prescription drugs. The Out-of-Pocket Maximums are combined for medical and pharmacy.

This summary does not cover all plan details. Further information can be found in the Medical Plan Summary Plan Description. That document provides a thorough explanation of the Medical Plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the Summary Plan Description, then the Summary Plan Description shall govern.

ADDITIONAL MEDICAL RESOURCES

360° HealthSM Programs to help you improve, manage and maintain your health

No matter what your healthcare needs, you have access to programs and services to help you achieve and maintain your highest potential for good health—at no additional charge. 360° Health is a group of programs that surround you with personalized support. From preventive care to managing complex conditions, Anthem is there to meet your needs with programs such as Future Moms and 24/7 NurseLine.

Future Moms

The Future Moms program is designed to manage the three stages of pregnancy: preconception, pregnancy and parenting. Women considering pregnancy are provided information to prevent potentially detrimental conditions. Expectant mothers are identified and proactively managed to reduce the risk of premature birth or other serious maternal issues. New parents are provided actionable materials about parenting skills to assist with baby's progress. To encourage member participation, this program provides a participation incentive of a \$100 Amazon gift card if you register for this program in your first trimester.

Best Doctors

Facing any medical situation can be stressful enough without worrying if you or a family member is getting the right diagnosis and the most effective treatment. That is why TTI offers this program. Best Doctors offers you peace of mind by giving you access to advice from the world's leading physicians. It's for everything from minor surgery to serious issues like cancer and heart disease. With Best Doctors, you can have an expert physician review your diagnosis and treatment plan, ask basic medical questions, and even get help finding a local physician who is right for you.



Best Doctors consultation is 100% free and confidential. It is also not mandatory to use Best Doctors. Benefits under the TTI Medical Plan are the same regardless of whether you use Best Doctors or not. It is included in your benefits package and available at no cost to you and any of your dependents enrolled in the TTI Medical Plan. Neither TTI nor our TTI Medical Plan administrators will ever be made aware of your call. Any charges for actual physician visits are processed under the medical plan and deductible or coinsurance may apply.

25 years ago, Best Doctors was founded by Harvard-trained physicians with an extraordinary vision—to share the medical expertise of the best physicians in the world with patients who are facing medical uncertainty, no matter where they live. Since then, Best Doctors has grown into a global health care leader. They now provide medical expertise to millions of members through second opinions and medical advice from renowned expert physicians. The experts are affiliated with world-leading hospitals, medical practices and research institutions, and they have been selected as the best in their specialties by fellow doctors. These renowned specialists don't replace your doctor—they simply provide second opinions and advice for you to consider and share with your doctor if you wish.

Common Specialties for Expert Second Opinions

- | | | |
|-------------------------|-------------------------|----------------|
| ● Orthopedic Surgery | ● Neurology | ● Rheumatology |
| ● Cardiovascular | ● Obstetrics/Gynecology | ● Urology |
| ● Physical Medicine | ● Gastroenterology | |
| ● Pediatric Specialties | ● Medical Oncology | |

Ask The Expert™

Sometimes, a quick visit with your doctor just isn't enough time to get all of your questions answered. If you still have questions about a medical condition or treatment plan, the Ask the Expert service can help. When you contact Best Doctors, you will receive written guidance from an expert who specializes in your unique condition. As a result, Ask the Expert answers are always tailored to your specific medical needs.

When to call

- You have any general or specific medical question and don't want to rely on the Internet for information.
- You have heard about a new treatment option or medical procedure and wonder if it's right for you.
- You are uncertain if medications you're now taking are the best options for you.



Find a Best Doctor™

Need an oncologist? Want the best surgeon in your area? Looking for a world-class medical specialist? Just contact Best Doctors for help locating the in-network doctor who is right for you.

When to call

- You just moved to a new area and are looking for a doctor.
- You believe you need to consult with a specialist.
- You would like additional providers you can see about your condition.

Critical Care Support

Best Doctors helps ensure that you have the right diagnosis and treatment when it matters the most—after an acute or catastrophic medical event. Renowned emergency medical experts can provide early intervention along with your treating medical team for some of the most serious cases, significantly improving outcomes while reducing unnecessary expense.

When to call

- You have experienced a medical emergency and have been admitted to a hospital or acute care facility.
- You are experiencing a multi-trauma event, spinal cord injuries, traumatic brain injuries, severe burns or sepsis.
- You need any type of urgent medical decision-making support.

Medical Records eSummary

Be proactive when it comes to your health. Even if you're not facing an immediate medical need, Best Doctors can collect and organize all your medical records and provide them to you on an easy-to-access USB drive. Also included is a personal health summary from an expert physician.

When to call

- You want all of your medical information on a convenient, secure USB drive.
- You are planning on moving, changing doctors or are traveling overseas for extended periods.

LiveHealth Online

LiveHealth Online is a convenient way for you to interact with a doctor via live, two-way video on a computer or mobile device to address a medical situation and in some cases receive a prescription (in most states). You just need to be enrolled in the TTI Medical Plan and have the LiveHealth Online smartphone app or a computer with a webcam for access to live consultations—anytime, anywhere. LiveHealth Online is part of the TTI Medical Plan so LiveHealth Online will only collect from you the appropriate coinsurance and bill the balance through the TTI Medical plan.

LiveHealth Online:

- Is available anywhere you have an internet connection (at home, the office or on the go)
- Is available 24 hours a day/7 days a week/365 days a year (only while you are in the U.S.)
- Provides access to in-network, U.S. board-certified doctors
- Offers help at the same price as (or less than) a regular doctor visit
- Doctors can ePrescribe to local pharmacies (where applicable)
- Takes member payments via Visa, MasterCard and Discover
- Is secure, convenient and easy-to-use

Sign up by going to www.livehealthonline.com on your computer and register using your personal information and your Anthem ID card. Once registered, load the app on your smart phone or tablet and link each device to your online account.

24/7 NurseLine

Receive immediate assistance from a registered nurse, toll-free, 24-hours, 7-days-a-week. Simply call **1-800-700-9184**. If you need advice on comforting a baby in the middle of the night or need to locate a doctor, Anthem will be there. Call Anthem to:

- Assess and understand your symptoms
- Find additional help to make informed healthcare decisions
- Locate a doctor, hospital or other practitioner
- Get information about an illness, medication or prescription
- Find information about a personal health issue such as diet, exercise or high blood pressure
- Answer questions on pregnancy
- Get assistance with discharge from a hospital
- Help you decide if a medical situation requires emergency treatment
- You can also access an easy-to-use audio library. You'll hear advice and news delivered in English and Spanish on more than 330 topics—from colds and sore throats to diabetes and cancer

24/7 NurseLine is not for emergencies, so please do not call if you believe you or a family member:

- Is having a heart attack or stroke
- Is severely injured
- Is unable to breathe

- May have ingested poisonous or toxic substances
- Is unconscious

In these cases, call 911 or your local emergency service as soon as possible.

PHARMACY MANAGEMENT PROGRAMS

Our pharmacy benefit includes programs to help you get the right prescription at the right cost

- Pre-certification requirements keep you safe and help you and your provider consider medicines that are safe, effective and reasonably priced
- Step therapy requirements allow you to take certain medications only after a less-expensive option has not been effective
- Prescriptions are monitored to uncover drug-to-drug interactions or potential misuse

MEDICAL & PHARMACY ID CARDS

ID Cards are issued by Anthem/Blue Cross Blue Shield. All employees and covered dependents will receive new 2019 cards in late December 2018. This card will be used for both medical and pharmacy. For newly hired employees, cards will arrive at the address on file within 2 to 3 weeks from the date elections are made. Temporary ID cards can be found at www.anthem.com.



MEDICAL PLAN 2019 TOBACCO & SMOKING

The use of tobacco (smoking and smokeless) as well as smoking of tobacco or any other substance (legal or illegal) is bad for your health and adds unnecessary costs to the Medical Plan that have to be shared by all Medical Plan participants. On average, only about 20% of the population smokes or uses tobacco, yet 100% have to pay the medical insurance costs resulting from these lifestyle habits.

Continuing in 2019, there will be a cost difference of \$50 per month for employees who enroll in the Medical Plan (any option) if the employee or any covered eligible dependents use any form of tobacco or smokes. Use of e-cigarettes is also considered smoking. If you currently smoke or use tobacco, there are resources to stop smoking or using any form of tobacco.

Your health plan is committed to helping you achieve your best health. Lower rates for non-tobacco use are available to all employees. If you think you might be unable to meet a standard for lower rates under this program, you might qualify for an opportunity to earn lower rates by different means. Contact us at **443-391-1205** and we will work with you (and, if you wish, with your doctor) to find a program that is right for you in light of your health status.

- Employee Assistance Program—Call the EAP and they will assign you a tobacco cessation coach. Through the EAP and your coach you will have access to a plan with goals, unlimited follow up sessions, follow up calls and emails from your coach, plus a personalized web portal that will contain interactive radio programs, MP3 downloads, articles, and a goal journal.
- If you are covered under the Medical Plan, you will have access to prescription drugs prescribed by your doctor that may help you kick the habit. These drugs include Zyban and Chantix. The Medical Plan will also provide reimbursement for nicotine replacement patches, gum and lozenges.

EMPLOYEE ASSISTANCE PROGRAM

All TTI employees, whether they are enrolled for the Medical Plan or waive Medical Plan coverage, are eligible for the Employee Assistance Program (EAP).

The EAP, administered by Anthem/Blue Cross Blue Shield, provides telephone and online assistance and referrals for:

- Work Life Services: Child care, parenting, special needs, senior care, legal, financial, identity theft.
- Personal Services: Stress, depression, substance abuse, marital difficulties, plus other mental health issues.

To access the EAP you can call Anthem/Blue Cross Blue Shield at **1-800-999-7222** or sign into your account at the Anthem web site at **www.anthemead.com**. Under the EAP, you will receive up to three visits paid in full to see a counselor for any of the items listed in Personal Services. Beyond these initial three visits, if you are enrolled in the Medical Plan, benefits will be provided as an office visit, subject to applicable deductibles and coinsurance.

DENTAL PLAN BENEFITS

TTI offers a comprehensive Dental Plan administered by Delta Dental. The TTI Dental Plan covers a wide range of services including diagnostic and preventive care, restorative services, major procedures and orthodontia.

With Delta Dental you have access to their PPO network (104,000+ dentists nationwide) and their Premier network (152,000+ dentists nationwide). Your lowest out-of-pocket costs will come from seeing a Delta Dental PPO dentist, but you will also enjoy cost advantages if you see a Premier dentist. This means savings on out-of-pocket costs and better choice. To find a Delta Dental participating dentist near you visit www.deltadentalwi.com or call **1-800-236-3712**.

	In-Network	Out-of-Network
Annual Maximum Per Person	\$1,500	
Annual Deductible	\$50 Individual \$150 Family	\$50 Individual \$150 Family
Diagnostic & Preventive—Exams, Cleanings, X-Rays, Sealants, Fluoride	100% No Deductible, Limit 2 Exams Per Year	100% No Deductible, Limit 2 Exams Per Year
Restorative Services—Fillings, Periodontics, Endodontics, Simple Extractions	80% After Deductible	80% After Deductible
Major Services—Crowns, Bridges, Implants	50% After Deductible	50% After Deductible
Child Orthodontia	\$1,500 Lifetime Maximum, Age 26 Limit 100% After Deductible	

Note: In-Network and Out-of-Network benefits combine.

Delta Dental encourages you to be informed about your dental care. Before you have any dental work done, please call **1-800-236-3712** to ensure coverage. Also, before scheduling an appointment for extensive dental care, you should ask your dentist to send your treatment plan to Delta Dental. The plan will be reviewed and a Predetermination of Benefits form will be returned to you and your dentist. You and your dentist can then discuss the treatment and your out-of-pocket costs.

This summary does not cover all plan details. Further information can be found in the Dental Plan Summary Plan Description. That document provides a thorough explanation of the Dental Plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the Summary Plan Description, then the Summary Plan Description shall govern.

DENTAL ID CARDS

For 2019, Delta Dental will only issue a new ID card to you if you make a change to your dental coverage. Unlike medical, the dental card only shows the employee's name and not the names of your covered dependents. Cards will arrive at your home address during the last week in December 2017. This new card should be used effective January 1, 2018. For newly hired employees, cards will arrive at the address on file within 2 to 3 weeks from the date elections are made. Please present the card to your dental provider during your first appointment in 2018.

VISION PLAN BENEFITS

For 2019, vision coverage will continue to be through VSP.

VSP offers:

- An average of 25% savings on lens options such as progressives, scratch-resistant and anti-reflective coatings
- 20% off additional glasses and sunglasses, including lens options
- 15% off the cost of a contact lens exam (fitting and evaluation)
- Average of 15% off the regular price of laser correction surgery or 5% off the promotional price from contracted facilities

Frame Allowance is \$160

The chart on the following page outlines the benefits provided by VSP.



VSP		
Vision Benefits	In-Network Coverage	Out-of-Network Coverage
Copay	\$10 Per Exam	N/A
Annual Maximum	None	
Exam Coverage	100% Less Copay	Up to \$50 Reimbursed
Frame Coverage—every 2 years	\$175	Up to \$70 Reimbursed
Lens (Pair)—annually	Glass or Plastic	
● Single Vision	100%	Up to \$50 Reimbursed
● Bifocal	100%	Up to \$75 Reimbursed
● Trifocal	100%	Up to \$100 Reimbursed
● Polycarbonate	100%	\$0
Contact Lenses	\$175 Allowance	
● Elective	Contact lens allowance applies	
● Diagnostic, Fitting & Evaluation		
Additional Options/Costs		
● Standard Progressive Lenses	Contact VSP Customer Service at 800-877-7195 to discuss pricing questions	
● Scratch Resistant Coating	Controlled pricing, varies by service	
● Tints	Up to 15% discount	
● Other Add On Items		
● Lasik/Laser Surgery Discount		
Provider Network	Most independent vision care providers	N/A
Frequency of Benefits		
● Vision Exam	Every 12 Months	
● Frame	Every 24 Months	
● Lenses or Contacts	Every 12 Months	

VSP does not issue ID cards. You can print your ID card at www.vsp.com. Check with your vision provider to ensure they participate with VSP.



LIFE INSURANCE PLAN

Whether you're single or married, buying your first home or preparing for retirement, raising children or sending them off to college, life insurance should be part of your financial plan. TTI's Basic and Supplemental Life Insurance plans are insured through Liberty Mutual. Be sure to keep your life insurance beneficiaries up to date.

Basic Life Insurance — TTI provides you with Company paid Basic Life Insurance coverage equal to 2 times your basic annual earnings rounded to the next higher \$1,000, with a minimum of \$50,000 to a maximum of \$400,000. You are automatically enrolled in this coverage effective your date of hire or benefit eligibility date.

Basic Accidental Death & Dismemberment (AD&D) Insurance — TTI provides you with Company paid Basic AD&D Insurance coverage equal to 2 times your basic annual earnings rounded to the next higher \$1,000, with a minimum of \$50,000 to a maximum of \$400,000. You are automatically enrolled in this coverage effective your date of hire or benefit eligibility date.

Supplemental Employee Life Insurance — You can buy additional life insurance equal to 1 time to 4 times your basic annual earnings, to a maximum of \$750,000. Medical underwriting is waived for amounts up to \$500,000 (guarantee issue) for new employees. Employees currently with coverage are allowed to purchase an additional 1 time annual earnings without medical underwriting (up to the \$500,000) during Open Enrollment. Amounts exceeding the guarantee issue would be subject to medical underwriting and requires completion of evidence of insurability (EOI) and is subject to approval by Liberty Mutual. Any coverage amount elected by employees that have waived coverage in the past is subject to medical underwriting and requires completion of EOI and is subject to approval by Liberty Mutual during Open Enrollment.

Supplemental Spouse Life Insurance — You can buy supplemental life insurance for your spouse. The amounts range from \$10,000 to \$200,000. Medical underwriting is waived for amounts up to \$50,000 (guarantee issue) for new spouses. Spouses currently with coverage are allowed to purchase an additional increment without medical underwriting (\$50,000). Amounts exceeding the guarantee issue would be subject to medical underwriting. Any coverage amount elected by spouses that have waived coverage in the past is subject to medical underwriting and requires completion of EOI and is subject to approval by Liberty Mutual.

Supplemental Child Life Insurance — You can buy supplemental life insurance for your children. The amount available is \$10,000 per child. No EOI is required.

Supplemental AD&D Insurance — Provides coverage in the case of accidental death or dismemberment. You can buy Voluntary AD&D Insurance to cover yourself, your spouse and children. The Supplemental

AD&D coverage has a minimum of \$25,000 and be available in increasing increments of \$25,000 to a maximum of \$300,000

The chart below details all coverage available.

During Open Enrollment, you have the option of enrolling in the Supplemental Life Insurance plan without medical underwriting as follows:

Life & AD&D Insurance Coverage			
Type of Coverage	Cost	Amount of Coverage	When Paid
Basic Life Insurance	Company Paid	2 Times Basic Annual Earnings, \$50,000 Minimum, \$400,000 Maximum	Any death
Basic AD&D Insurance	Company Paid	2 Times Basic Annual Earnings, \$50,000 Minimum, \$400,000 Maximum	Accidental death
Supplemental Employee Life Insurance	Employee Paid	1 Time to 4 Times Basic Annual Earnings, \$750,000 Maximum	Any death
Supplemental Spouse Life Insurance	Employee Paid	Options: \$10,000; \$25,000; \$50,000; \$100,000; \$150,000; \$200,000	Any death
Supplemental Child Life Insurance	Employee Paid	\$10,000 Per Child	Any death
Supplemental Employee AD&D Insurance	Employee Paid	\$25,000 increments ranging from \$25,000 to \$300,000; Not to exceed 10 times Basic Annual Earnings	Accidental death
Supplemental Spouse & Child AD&D Insurance	Employee Paid	Spouse Only—Equals 100% of Employee Supplemental; Spouse & Children—Equals 100% of Employee Supplemental for Spouse and 15% for Children; Children Only—Equals 15% of Employee Supplemental	Accidental death

Employee — If coverage is currently in place, increase current coverage an additional 1 time basic annual earnings without EOI. However, if as a result of this increase the employees' life insurance exceeds \$500,000 then any amount in excess of \$500,000 requires completion of EOI and is subject to approval by Liberty Mutual.

Spouse — If coverage is currently in place, an increase of one increment can occur without EOI. However, if as a result of this increase the spouse life insurance exceeds \$50,000 then any amount in excess of \$50,000 requires completion of EOI and is subject to approval by Liberty Mutual

Child — There is no EOI required for the \$10,000 child benefit, even if you waived coverage in the past.

A newly hired employee may enroll for coverage at any level, subject to guaranteed issue limitations. If the amount elected exceeds the guaranteed issue limit, EOI will be required.

BUSINESS TRAVEL ACCIDENT INSURANCE

	Basic Life Insurance	Supplemental Life Insurance
How much coverage do I have?	<ul style="list-style-type: none"> You are provided with basic life insurance equal to 2 times your basic annual earnings—rounded to the next higher \$1,000—from a minimum of \$50,000 to a maximum of \$400,000. Coverage is automatically reduced to 65% at age 70 and 50% at age 75. 	<ul style="list-style-type: none"> Supplemental Life insurance coverage is optional If you choose to enroll, you can purchase Supplemental Life Insurance in an amount equal to 1, 2, 3 or 4 times your annual earnings to a maximum of \$750,000. Your coverage amount is rounded up to the next higher \$1,000. Coverage is automatically reduced to 65% at age 70 and 50% at age 75.
Am I eligible?	You are eligible if you are an active full-time employee who works at least 40 hours per week on a regularly scheduled basis.	
When is coverage effective?	Coverage is effective on the date you became a full-time employee. You must be actively at work to be eligible. Supplemental coverage requiring EOI will become effective when approved by Liberty Mutual.	
What is the cost?	The Company pays the full cost.	You pay the full cost. Refer to the rate chart for costs.
How do I enroll?	You are automatically enrolled.	<p>If you are currently enrolled in the Supplemental Life plan, during Open Enrollment you can elect to add coverage equal to an additional 1 time your basic annual earnings without EOI (up to \$500,000). If not currently enrolled, any amounts elected will be subject to EOI.</p> <p>Newly hired employees can enroll at any level, subject to EOI for any amount over \$500,000.</p>
Is coverage available for a spouse?	No. Basic Life Insurance is NOT available for a spouse.	Yes. You may choose to enroll a spouse for increments ranging from \$10,000 to \$200,000, subject to EOI for any amount over \$50,000
Is coverage available for children?	No. Basic Life Insurance is NOT available for children.	Yes. You may choose to enroll children for \$10,000 of coverage.

When you are traveling on Company business (excludes commuting to and from work), the TTI Business Travel Accident Plan will provide you with additional life insurance. If you die from an accident while traveling on Company business, your beneficiaries will receive a \$250,000 benefit. This coverage is in addition to all other TTI Benefit Program life insurance coverage you may have.

FLEXIBLE SPENDING ACCOUNT PLANS

TTI provides you with the opportunity to pay for out-of-pocket medical, dental, vision and dependent day care expenses with pre-tax dollars through Flexible Spending Accounts, or FSAs. If you choose to participate in an FSA plan for 2019, to be eligible for reimbursement the covered out of pocket expense must occur between January 1, 2019, and December 31, 2019.

Contributions to your FSA offered through Anthem Flexible Benefits Services are deducted before any taxes are taken out of your paycheck, which means that you never pay taxes (Federal, Social Security, State and Local) on contributions to your FSA.

IMPORTANT: If you enrolled in the Health FSA in 2018 and elect Plan 3, the \$500 carryover of your Health FSA dollars does **NOT** apply. You can only be reimbursed for expenses incurred in 2018. You will have until March 31, 2019 to submit for 2018 claims but you cannot submit for any claims incurred in 2019 for your 2018 Health FSA account.

- Automatic Medical Claims Substantiation. When you use the FSA debit card for an expense covered by the TTI Medical Plan for a covered family member, Anthem will automatically approve your FSA claim by matching your Medical Plan claim to the Debit Card transaction. This means minimal paperwork for you.
- Continuing in 2019, the TTI FSA Plan has a carryover feature. With this feature, you will be able to carryover up to \$500 of unused Health FSA dollars from one year into the next year. If you participate in the Health FSA in 2019 and have leftover unused dollars, up to \$500 dollars will carry over into 2020. Any unused dollars above \$500 will be forfeited as of March 31, 2020.
- If you carry over dollars from 2018 to 2019, those funds will **NOT** be available for your use until April 1, 2019.
- The \$500 in carryover dollars does not count towards the 2019 \$2,650 annual Health FSA limit, so if you elect \$2,650 in Health FSA for 2019 and you have \$500 in Carryover dollars from 2018, you will have a total of \$3,150 in Health FSA dollars in 2019. Be sure to account for this possibility when calculating your 2019 FSA elections.
- You do not need to do anything if you have unused 2018 Health FSA dollars. The Health FSA administrator Anthem Benefits Services will automatically move up to \$500 in unused 2018 Health FSA dollars into your 2019 Health FSA account.
- Dependent Day Care FSA is not eligible for the carryover feature so any unused 2018 Dependent Day Care FSA dollars will be forfeited as of December 31, 2018.
- You cannot enroll in the Health FSA for 2019 if you enroll for Plan 3 and elect a Health Savings Account.

During Open Enrollment, you must make an election to participate in either or both the Health and Dependent Care FSA Plan. Elections from 2018 do **NOT** roll over into 2019.

It is very important that you calculate your contribution amount carefully. Remember you can only get reimbursed for eligible out-of-pocket expenses incurred in the 2019 calendar year. Any unused Health FSA dollars above \$500 and all unused Dependent Day Care FSA dollars are forfeited. Remember, the Dependent Day Care FSA is used to pay for child day care or expenses related to elder care. This account is **NOT** to pay for your kids' health care—you use the Health Care FSA for those expenses.



Health Care FSA

A health care FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. The maximum that you can contribute to the Health Care Flexible Spending account is \$2650. You can be reimbursed for the full amount of your annual Health FSA at any time during the year, even if you do not currently have that much money in your Health FSA. Eligible health care expenses include:

- Deductibles
- Vision expenses
- Co-insurance
- Dental expenses
- Prescription drugs
- Limited over-the-counter items

FSA Debit Card

When you enroll in the Health Care FSA for the first time, you will be issued a **HealthEquity** FSA Debit Card. The card will arrive at your home prior to January 1, 2019. If you already received a debit card when you enrolled for 2018, you will not receive a new card from **HealthEquity**. This card is similar to a debit card because it electronically accesses your Health Care FSA to pay for eligible expenses. There are four key benefits to using your **HealthEquity** FSA Debit Card:

1. Approved expenses are paid immediately from your Health Care FSA.
2. Using the card increases your personal cash flow.
3. You don't have to file claims due to the point-of-sale approval process.
4. Makes it easy to use your pre-tax funds.

To use the **HealthEquity** FSA Debit Card, simply present it for payment at the cash register. The retailer's system will validate that your coverage is active and that you have available funds to cover the transaction. When you use the card at qualified merchants, you must select "credit" when purchasing FSA-approved items.

Even though you don't have to file claims, it is important that you keep all itemized receipts and Explanation of Benefits in the event the information is requested by **HealthEquity** to comply with IRS regulations. Your **HealthEquity** FSA Debit Card has an expiration date on it.

Using your FSA debit card eliminates the need for you to wait for a reimbursement from your FSA account. By using your FSA debit card properly, your FSA balance is already available for you when you have an eligible expense. You simply swipe the debit card to pay for that expense. That's it, no need to wait for reimbursement.

Here are some helpful hints on how to get the most out of your FSA debit card:

1. Most pharmacies and grocery stores are “**IIAS certified**.” You don’t need to remember that but if your card is swiped at an IIAS merchant, your claim is automatically approved or denied right at the point of sale.
2. If a card transaction is approved at a service provider who is NOT “**IIAS certified**” (ex. doctors’ offices or hospitals), your card swipe amount is compared to previous amounts spent at that provider. If it matches a previously approved amount, the card swipe will approve. You may submit manual claims for any eligible expenses not purchased at an IIAS provider.
3. If neither step 1 or 2 work, after 90 days you will be sent a request for substantiation of your charge. These transactions are summarized in your monthly card activity statement.

If substantiation is requested, you need to provide documentation to show the transaction is FSA-eligible. Explanation of Benefits (“EOB’s”) or itemized statements are the preferred documentation, but any documentation with all of the following 5 pieces of information will work:

1. Provider name
2. Date of service
3. Patient name
4. Description of service and
5. Patient responsibility

Let’s look at a couple of common examples:

Example of Copays (flat \$ amounts): Your Rx plan requires a \$10 co-pay for generic drugs. You use your benefit card at the pharmacy to purchase five prescriptions. Swipe your card for the \$50 purchase. No additional documentation is required because the \$50 total is a multiple of a combination of the co-pays for the particular benefit.

Example for Coinsurance (% of amounts): Assume your health plan requires a 25% co-insurance for doctor visits. You use your FSA debit card to pay \$150 for the visit. Even though the doctor’s office doesn’t have the IIAS system, the transaction may be matched to the Anthem EOB. If the \$150 transaction matches an EOB with patient responsibility of \$150, it will auto-substantiate no action required from you. However, if the amount doesn’t match an EOB’s patient responsibility, you must provide documentation for the entire \$150 transaction.

Important Note: If you do not use your HealthEquity FSA Debit Card and instead pay with cash, check or personal credit card you can submit a claim for reimbursement. Claims for reimbursement of eligible Health and Dependent Day Care expenses incurred during the 2018 calendar year must be submitted to **HealthEquity** for reimbursement no later than March 31, 2019. See FSA Summary Plan Description for details on Filing Claims.

Dependent Day Care FSA

A Dependent Day Care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse are at work. The maximum that you can contribute to the Dependent Day Care FSA is \$5,000 if you are a single employee or married and filing jointly, or \$2,500 if you are married and filing separately. For the Dependent Day Care FSA you must have the money in your account to be reimbursed for an expense. Eligible Dependent Day Care FSA expenses include:

- Day care
- Before and after school programs
- Summer day camp
- Adult day care
- Preschool

Remember, the Dependent Day Care FSA is used to pay for child day care or expenses related to elder care. This account is **NOT** to pay for your kids’ health care—you use the Health Care FSA for those expenses.

NEW FSA ADMINISTRATOR FOR 2019

We will be changing FSA administrators (both Health and Dependent Daycare) on 1/1/2019 to **HealthEquity**; the same administrator that we currently use for the HSA program. **HealthEquity** offers all of the same familiar features along with a few new ones such as:

- A new portal to help you manage your account. You will receive a new member guide with login instructions when you sign up. You can use new widgets to easily navigate to any area.
- Establish an FSA “To Do” list for helpful reminders and alerts to keep you up-to-date with your account. Include important alerts, any open claims that might require payment, unlinked receipts in your Document Library and any unread messages in the Message Center.
- A new mobile app that provides enhanced, easy access to your account wherever you are. You can simply take a photo with your device to initiate claims and payments, send payments and reimbursements, manage debit card transactions and view claim status; all from the convenience of your smart phone.
- You can send payments directly to providers or reimburse yourself for out-of-pocket expenses from your FSA.

Important Transition Information:

Your 2019 FSA election information will be sent directly to **HealthEquity** and you should receive your Welcome Kit and new 2019 Debit Card (separately) in late December.

You should use your new **HealthEquity** Debit Card for all 2019 FSA Health claims beginning January 1, 2019.

Your current 2018 FSA administration will remain with Anthem. You should continue to use the Anthem system through March 31, 2019 for all your 2018 FSA claims. Your Anthem FSA account will be closed as of March 31, 2019.

If you are eligible for a 2018 Rollover (up to \$500), your rollover balance will be transferred to **HealthEquity** after March 31, 2019 and available for your use around the middle of April 2019.

DISABILITY INCOME PROTECTION

When you are unable to work due to an accident, illness or injury, protection for your lost income is as important as your health insurance. TTI provides two levels of income protection for employees (STD and LTD).



Short Term Disability (STD)

During the first 26 weeks of absence, your regular paycheck may be replaced by the STD program. STD benefits are paid through your regular payroll system. Approval for and payment of STD benefits is not automatic. You will be required to report your claim to Liberty Mutual. They will review your submission, request any additional information necessary to make a determination, and advise you and TTI if your disability claim is approved and the length of time your absence from work should last. Once the approval is received, TTI will pay you STD benefits through your regular payroll system. Contact Human Resources for an explanation of your STD benefits.

Long Term Disability (LTD)

After about 17 weeks/120 days of absence, if you are still unable to work due to an accident, illness or injury, Liberty Mutual will contact you to help prepare you for any potential LTD benefits you may be entitled to starting after 26 weeks/180 days. These benefits are provided under a fully insured group policy issued by Liberty Mutual. Since LTD benefits may vary, you should contact your Human Resources department for an explanation of your LTD benefits.

Employees covered by LTD are eligible to receive a monthly benefit equal to 60% of basic earnings. Basic earnings for LTD equal annual base salary plus target bonus (if eligible) divided by 12.

Approval and payment of LTD is not automatic. Liberty Mutual will automatically contact you to start the LTD process. After reviewing your LTD application, Liberty Mutual will advise you if you have been approved for LTD. Approval does not mean that LTD will be paid indefinitely. You will be required to submit ongoing documentation to support your LTD claim. LTD benefits may end at any time if you no longer meet the definition of “disability” as well as other LTD policy limitations and exclusions. Coverage becomes effective the date you become a full-time employee.

Approved Leave of Absence

The maximum period of approved leave of absence as an “employee” is six months. This means that if you transition from STD to LTD, once you start your seventh month of absence, your employment with TTI will end. With the termination of your employment after six months of absence, your other Company benefits will also end, including active employee medical, dental, vision, FSAs and life insurance. You will be given the option to continue medical, dental, vision and Health FSA under COBRA. You will also have the opportunity to continue your life insurance under Liberty Mutual's conversion option.

METLIFE AUTO & HOME INSURANCE PROGRAM

The MetLife Auto & Home Insurance Program allows employees to secure auto and home insurance and pay for it thru convenient payroll deductions. The policies you secure thru this program with MetLife are individual policies and are based on your own driving record and claims experience. TTI has no involvement in whether MetLife chooses to offer any employee coverage, rates charged, whether a policy is renewed or claim filings. TTI's only involvement is to deduct premiums from paychecks on behalf of MetLife.

For more information, contact MetLife at **800-GET-MET8 (800-438-6838)**.

NEW 401(k) ADMINISTRATOR AND ROTH FEATURE COMING

We have great news about the Techtronic Industries 401(k) Retirement Plan. In January 2019, we will switch from Transamerica to T. Rowe Price for recordkeeping services. This change will bring you more choices, more services, and more convenience.

MEET YOUR NEW PLAN SERVICES PROVIDER

Established in 1937, the Baltimore-based investment management firm and its affiliates are recognized leaders in providing retirement plan services.

T. Rowe Price offers a broad range of financial services for your convenience:

- **24/7 account access.** You'll have access to your account and investment transactions by telephone or online anytime, day or night.

- **Direct support.** T. Rowe Price retirement plan specialists will be available to answer your questions every business day from 7 am to 10 pm eastern time.
- **Timely account statements.** Account statements and educational newsletters will be available shortly after the end of each quarter.
- **Ongoing education.** You will receive helpful information about the plan and investing for retirement.
- **New Recordkeeping Services.** Your account balances will be transferred to T. Rowe Price at the end of 2018. There will be a new website, financial planning tools and services, and a new toll-free number to call for managing your account.
- **Roth Feature.** You will now be able to participate in after-tax contributions with a Roth feature. Pay special attention to upcoming educational materials on this feature works to determine if it is appropriate for your financial plans.
- **Lower Administrative Fees.** You will see a decrease in the amount of administrative fees currently assessed against your account.
- **Investment Accounts.** The investment options you have today will remain the same.

IMPORTANT: MORE INFORMATION TO COME

Over the next few weeks, more important information will be sent to you on how this transition will impact you.

From now until the end of the year, ALL of your 401(k)-account support will continue to be provided by Transamerica at the same website and phone number you use today. Please **DO NOT** contact T. Rowe Price until after January 1, 2019

TTI BENEFIT PROGRAM CONTACT INFORMATION

PLAN	PROVIDER	PHONE	WEBSITE
Medical	Anthem	866-862-4862	www.anthem.com
Best Doctors	Best Doctors	866-904-0910	members.bestdoctors.com
Future Moms	Anthem	800-828-5891	www.anthem.com
Pharmacy	Express Scripts	800-711-0917	www.express-scripts.com
Dental	Delta Dental	800-236-3712	www.deltadentalwi.com
Vision	VSP	800-877-7195	www.vsp.com
FSAs	HealthEquity	877-713-7712	www.healthequity.com/TTI
HSA	HealthEquity	877-713-7712	www.healthequity.com/TTI
EAP	Anthem	800-999-7222	www.anthemeap.com
401(k)*	T. Rowe Price*	800-922-9945*	TTIRetire.com *
Auto & Home Insurance	Metlife	800-438-6388	http://choices.metlife.com
Live Health Online	Anthem	888-548-3432	www.livehealthonline.com

**Do not contact until after January 1, 2019*

REQUIRED ANNUAL NOTICES

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment in the TTI Medical Plan (“Plan”) for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also be eligible to enroll in the TTI Medical Plan if you lose coverage under a State Children’s Health Insurance Program (SCHIP) or Medicaid or you become eligible for premium assistance from the State towards coverage in an employer-sponsored plan. See PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM, below.

To request special enrollment or obtain more information, contact the Benefits Manager, Milwaukee Electric Tool, 13135 West Lisbon Road, Brookfield, WI 53005, **443-391-1204**.

WOMEN’S HEALTH AND CANCER RIGHTS ACT

Special Rights Following Mastectomy

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call your plan administrator at Benefits Manager, Milwaukee Electric Tool, 13135 West Lisbon Road, Brookfield, WI 53005, **443-391-1204**.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT NOTICE

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

as they will not have access to any of your information until then.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2018. Contact your State for more

ALABAMA—Medicaid	FLORIDA—Medicaid
Website: http://myalhipp.com/	Website: http://flmedicaidtprecovery.com/hipp/
Phone: 1-855-692-5447	Phone: 1-877-357-3268
ALASKA—Medicaid	GEORGIA—Medicaid
<i>The AK Health Insurance Premium Payment Program</i>	Website: http://dch.georgia.gov/medicaid Click on <i>Health Insurance Premium Payment (HIPP)</i>
Website: http://myakhipp.com/	Phone: 404-656-4507
Phone: 1-866-251-4861	INDIANA—Medicaid
Email: CustomerService@MyAKHIPP.com	<i>Healthy Indiana Plan for low-income adults 19-64</i>
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://www.in.gov/fssa/hip/
ARKANSAS—Medicaid	Phone: 1-877-438-4479
Website: http://myarhipp.com/	<i>All other Medicaid</i>
Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.indianamedicaid.com
COLORADO—Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Phone 1-800-403-0864
Health First Colorado Website: https://www.healthfirstcolorado.com/	IOWA—Medicaid
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus	Phone: 1-888-346-9562
CHP+ Customer Service: 1-800-359-1991/State Relay 711	

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KANSAS—Medicaid	NEW HAMPSHIRE—Medicaid
Website: http://www.kdheks.gov/hcf/	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 1-785-296-3512	Phone: 603-271-5218
KENTUCKY—Medicaid	NEW JERSEY—Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-635-2570	Medicaid Phone: 609-631-2392
LOUISIANA—Medicaid	CHIP Website: http://www.njfamilycare.org/index.html
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	CHIP Phone: 1-800-701-0710
Phone: 1-888-695-2447	NEW YORK—Medicaid
MAINE—Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html	Phone: 1-800-541-2831
Phone: 1-800-442-6003	NORTH CAROLINA—Medicaid
TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/
MASSACHUSETTS—Medicaid and CHIP	Phone: 919-855-4100
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/	NORTH DAKOTA—Medicaid
Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
MINNESOTA—Medicaid	Phone: 1-844-854-4825
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	OKLAHOMA—Medicaid and CHIP
Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org
MISSOURI—Medicaid	Phone: 1-888-365-3742
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	OREGON—Medicaid
Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx
MONTANA—Medicaid	http://www.oregonhealthcare.gov/index-es.html
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	Phone: 1-800-699-9075
Phone: 1-800-694-3084	PENNSYLVANIA—Medicaid
NEBRASKA—Medicaid	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Website: http://www.ACCESSNebraska.ne.gov	Phone: 1-800-692-7462
Phone: (855) 632-7633	RHODE ISLAND—Medicaid
Lincoln: (402) 473-7000	Website: http://www.eohhs.ri.gov/
Omaha: (402) 595-1178	Phone: 855-697-4347
NEVADA—Medicaid	SOUTH CAROLINA—Medicaid
Medicaid Website: https://dwss.nv.gov/	Website: https://www.scdhhs.gov
Medicaid Phone: 1-800-992-0900	Phone: 1-888-549-0820

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SOUTH DAKOTA—Medicaid	WASHINGTON—Medicaid
Website: http://dss.sd.gov	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-888-828-0059	Phone: 1-800-562-3022 ext. 15473
TEXAS—Medicaid	WEST VIRGINIA—Medicaid
Website: http://gethipptexas.com/	Website: http://mywvhipp.com/
Phone: 1-800-440-0493	Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH—Medicaid and CHIP	WISCONSIN—Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
CHIP Website: http://health.utah.gov/chip	Phone: 1-800-362-3002
Phone: 1-877-543-7669	WYOMING—Medicaid
VERMONT—Medicaid	Website: https://wyequalitycare.acs-inc.com/
Website: http://www.greenmountaincare.org/	Phone: 307-777-7531
Phone: 1-800-250-8427	
VIRGINIA—Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm	
Medicaid Phone: 1-800-432-5924	
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm	
CHIP Phone: 1-855-242-8282	

information on eligibility

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or

email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

GROUP HEALTH INSURANCE BENEFIT PLANS PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

HEALTH PLANS COVERED BY THIS NOTICE

This Notice applies to the privacy practices of the health plans listed below. The plans may share with each other your medical information, and the medical information of others they service, for the health care operations of their joint activities: Anthem, Delta Dental, Express Scripts nc., VSP, WageWorks (collectively the “Plan”).

Effective: October 15, 2018

The Plan provides health benefits to eligible employees of Techtronic Industries North America, Inc. and all related entities participating in the Plan (the “Company”) and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words “you” and “your” refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your “Protected Health Information” (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. PHI includes information of a person living or deceased (for a period of fifty years after the death.)

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

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

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and retirees and COBRA qualified beneficiaries, if any. If you require a copy of this Notice, you can get it by requesting it from the contact named at the end of this Notice. Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor’s or other health care provider’s privacy

practices with respect to your PHI that they maintain.

RECEIPT OF YOUR PHI BY THE COMPANY AND BUSINESS ASSOCIATES

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

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

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

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

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

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

HOW THE PLAN MAY USE OR DISCLOSE YOUR PHI

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

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

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

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the

pharmacist's reference in determining whether a new prescription may be harmful to you.

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

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

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

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

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

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

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

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

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

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

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

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

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

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency

medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (for example, a parent acting for a minor child, or a guardian appointed for an incapacitated adult) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: (1) you have been or may be a victim of domestic abuse by your personal representative; (2) recognizing such person as your personal representative may result in harm to you; or (3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

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

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

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

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

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than treatment, payment, or health care operations (and if you did not authorize the disclosure).

Please note, with only limited exceptions, disclosures about spouses and family members will generally be made to the participant employee (when the Plan issues an explanation of benefits, for example). Nevertheless, if a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

AUTHORIZATION TO USE OR DISCLOSE YOUR PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example), you cannot revoke your authorization as it pertains to that

action.

Furthermore, we will not (without an authorization from you): (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited health care operations); (2) sell your confidential information (unless under strict legal restrictions); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

THE PLAN MAY CONTACT YOU

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

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

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for treatment, payment, or health care operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the restrictions to apply (a particular physician, for example). You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Even so, the Plan will comply with a restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full. The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing.

Right to Be Notified of a Breach: You have the right to be notified in the event that the Plan (or a Business

Associate) discovers a breach of unsecured protected health information.

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

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

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

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize or that occurred more than six years prior to the date of the request are not subject to this requirement (three years for electronic health records, as discussed below). To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period (which may not be longer than six years). Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically).

You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years.

The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

COMPLAINTS

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you

to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

The Plan has designated Katie Gavin as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at:

Privacy Officer
Human Resources
13135 West Lisbon Road
Brookfield, WI 53005
262-783-8438

Important Notice from TTI About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with TTI and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. TTI has determined that the prescription drug coverage offered by the TTI Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current TTI Medical Plan coverage may be affected. When you become eligible for Medicare Part D, you can keep this coverage and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current TTI Medical Plan coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with TTI and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact the Benefits Manager, Milwaukee Electric Tool, 13135 West Lisbon Road, Brookfield, WI 53005, (262) 781-3600. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through TTI changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 15, 2018

Name of Entity/Sender: TTI/Milwaukee Electric Tool

Contact—Position/Office: Benefits Manager

Address: Benefits Manager

Milwaukee Electric Tool

13135 West Lisbon Road

Brookfield, WI 53005

Phone Number: (262) 781-3600

