BENEFITS GUIDE

OPEN ENROLLMENT 2016

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TTI 2016 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 2016 TTI Benefits Program. Whether you are a current TTI employee reviewing your benefit elections during Open Enrollment in the fall of 2015, or a newly hired employee in 2016 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.

OPEN ENROLLMENT DATES

Open Enrollment dates for current TTI employees will be November 2, 2015 to November 16, 2015. No Open Enrollment elections can be made after November 16, 2015.

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 2016 TTI Benefits Program.

Medical Plan	● Four 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 ● All Plans administered by Anthem/Blue Cross Blue Shield ● All Plans with prescription drug coverage administered by Express Scripts
Dental Plan	● One Dental Plan Option administered by Delta Dental
Vision Plan	● One Vision Plan Option insured by VSP
Flexible Spending Accounts	● Two Flexible Spending Accounts (FSA) ● Health FSA—Includes Automatic Medical Claims Substantiation—New Feature for 2016 ● Dependent Day Care FSA ● Both administered by Anthem Flexible Benefits Services—New Vendor for 2016
Life Insurance	● Company paid life insurance ● Supplemental life insurance you can purchase for you and your eligible dependents ● Insured by Liberty Mutual
Disability Insurance	● 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	● EAP administered by Anthem/Blue Cross Blue Shield ● Free, confidential resources
401(k) Plan	● Allows you to contribute 1% to 50% of your pay, up to IRS maximums ($18,000 in 2015) ● Allows catch up contributions if you are age 50 and older, up to IRS maximums ($6,000 in 2015)—2016 maximums may be higher ● Company match of 50% on the first 8% saved ● 100% immediate vesting on Company match ● Administered by Transamerica ● 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 November 2 to November 16, 2015, your 2015 benefit elections for Medical, Dental, Vision and Life Insurance coverage will remain the same for 2016 with the applicable 2016 contribution rates. **In order to participate in Flexible Spending Accounts (FSA) in 2016, *you must make an election during Open Enrollment*—FSA elections do not roll over from one year to the next.**

Important Medical Plan Information: Smoking & Tobacco Use Medical Contributions

If you certified your tobacco use and smoking status during last year's 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, 2016. 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.

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 & OPEN ENROLLMENT MEETINGS

Refer to the separate communication titled Enrollment Instructions for information on how to make your benefit plan elections and obtain assistance from Human Resources.

MAKING YOUR 2016 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.

OPEN ENROLLMENT CHECKLIST

Open Enrollment for current TTI employees starts November 2, 2015 and ends November 16, 2015. Here is a Checklist of the actions you should take to help you make your elections for 2016.

- ☐ Review this 2016 TTI Employee Benefits Guide
- ☐ Review other TTI Benefit Program materials
- ☐ Attend an Open Enrollment meeting (if offered at your site)
- ☐ Ask Human Resources to help explain and clarify what you do not understand

- ☐ **Medical/Prescription Plan:** Four Options
  - 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

  Plan Options Include:
  - 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:
  - Continue coverage with same covered dependents—**No Action Necessary**
  - Add dependents
  - Drop dependents

- ☐ **Dental Plan:** One Option
  - TTI Dental Plan

  Plan Options Include:
  - 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:
  - Continue coverage with same covered dependents—**No Action Necessary**
  - Add dependents
  - Drop dependents

- ☐ **Vision Plan:** One Option
  - TTI Vision Plan

  Plan Options Include:
  - 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:
  - Continue coverage with same covered dependents—**No Action Necessary**
  - Add dependents
  - Drop dependents

- ☐ **Flexible Spending Accounts:**
  - New vendor for 2016—Anthem Flexible Benefits Services
  - New feature—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.
  - Make an election for the Health FSA and/or Dependent Day Care FSA during Open Enrollment to participate in 2016. Consider any unused 2015 funds, up to $500 eligible for carryover—when making a 2016 election.
  - 2015 elections do not renew for 2016 so if you want to participate you must make an election.
  - If you do not want to participate in the FSAs in 2016—**No Action Necessary**
  - **If you participated in Flexible Spending Accounts in 2015, carefully understand the one-time transition period and blackout period**

- ☐ **Supplemental Life Insurance**
  - Evaluate your needs and adjust coverage during Open Enrollment
  - Keep your current level of supplemental life insurance—**No Action Necessary**

- ☐ **Make all Open Enrollment elections by November 16, 2015**

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 40 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, 2016 through December 31, 2016. For newly hired employees, the elections you make during your initial election period will be effective from your date of hire until December 31, 2016.

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 Human Resources, 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 and wellness. That is why TTI offers two comprehensive Medical Plan Preferred Provider (PPO) options through Anthem/Blue Cross Blue Shield (BCBS) and Prescription Drug coverage through Express Scripts. 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-pockets 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 99% of the claims were with in-network providers.

Prescription plan benefits are provided through Express Scripts under both 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:

- You can fill the first three (3) prescriptions at a retail pharmacy before mandatory mail order begins.
- 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.

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. Both 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/BLUE CROSS BLUE SHIELD MEDICAL PLAN OPTIONS				
	Plan 1		Plan 2	
	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
Coinsurance ● You Pay ● Plan Pays	 20% 80%	 40% 60%	 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
Annual & Lifetime Maximums	None	None	None	None
Preventive Care	Plan Pays			
● Well Baby Exams ● Well Child Exams ● Well Adult/Woman Exams ● Immunizations ● Lab & X-Rays with above Exams ● Mammograms ● Pap Smears ● Colonoscopy	Paid In Full	60%	Paid In Full	50%
Office Visits	80% No Deductible	60% After Deductible	80% No Deductible	50% After Deductible
Outpatient Services				
● Outpatient Surgery & Related Services	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible
● Physical, Speech & Occupational Therapy	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible

ANTHEM/BLUE CROSS BLUE SHIELD MEDICAL PLAN OPTIONS (continued)				
	Plan 1		Plan 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Plan Pays			
Inpatient Hospital Services	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible
Maternity Services	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible
Emergency Room Services	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
Urgent Care Facility	80% No Deductible	60% After Deductible	80% No Deductible	50% After Deductible
Durable Medical Equipment	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
Skilled Nursing Care	80% After Deductible	60% After Deductible	80% After Deductible	50% After Deductible
Hospice Services	80% After Deductible	80% After Deductible	80% After Deductible	80% After Deductible
Prescription Drug Benefits				
	Plan 1		Plan 2	
Type of Drug	**Retail**	**Mail**	**Retail**	**Mail**
	You Pay			
Generic	$10 Copay	$25 Copay	$10 Copay	$25 Copay
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
Non-Formulary	40% Copay $50 Minimum $125 Maximum	40% Copay $125 Minimum $300 Maximum	40% Copay $50 Minimum $125 Maximum	40% Copay $125 Minimum $300 Maximum
In 2016, 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.				

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° Health℠ 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 gift card.

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 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.

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
- Cardiovascular
- Physical Medicine
- Pediatric Specialties
- Neurology
- Obstetrics/Gynecology
- Gastroenterology
- Medical Oncology
- Rheumatology
- Urology

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 **1-877-Talk-2-RN (1-877-825-5276)**. 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 2016 cards in late December 2015. 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 2016 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.

In 2016, there will be a cost difference of $50 per month for employees who enroll in the Medical Plan 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.

- 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, 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.anthemeap.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 (73,000+ dentist locations nationwide) and their Premier network (148,000+ dentist locations 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	100% No Deductible, Limit 2 Exams Per Year	100% No Deductible, Limit 2 Exams Per Year
Restorative Services— Filings, 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 2016, 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 2015. This new card should be used effective January 1, 2016. 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 2016.

VISION PLAN BENEFITS

For 2016, 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

The chart 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	$120	Up to $70 Reimbursed
Lens (Pair)	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	$160 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 of 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. In 2016, the Supplemental AD&D coverage will have 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.

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 60% of Employee Supplemental for Spouse and 15% for Children; Children Only—Equals 15% of Employee Supplemental	Accidental death

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

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.

	Basic Life Insurance	Supplemental Life Insurance
How much coverage do I have?	● 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.	● 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.	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. Newly hired employees can enroll at any level, subject to EOI for any amount over $500,000.
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.

BUSINESS TRAVEL ACCIDENT INSURANCE

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—NEW VENDOR FOR 2016

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 2016, to be eligible for reimbursement the covered out of pocket expense must occur between January 1, 2016, and December 31, 2016.

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.

- The FSA Plan will change plan administration from PayFlex to Anthem Flexible Benefits Services effective January 1, 2016.
- New feature—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.

Please read below for important information regarding the transition to the new administrator.

For employees with 2015 FSA Accounts:

1. For claims incurred in 2015, file any claims with PayFlex as soon as possible. Do not hold your receipts until the end of the year. This includes both health care and dependent care claims.
2. PayFlex will process claims received in their office *on or before November 30, 2015*. PayFlex will deny all claims received after November 30, 2015. PayFlex will then finalize account activity. Once accounts are finalized, all remaining 2015 balance information will be provided to Anthem. Anthem will then process remaining 2015 claims in early 2016.
3. There will be a “black out period” for accounts while Anthem loads the 2015 account information into their system. (A “black out period” is a period of time during which claims cannot be filed or processed.) The “black out period” is targeted to be over by December 31, 2015. Any delay beyond December 31, 2015 will be communicated. Claims should NOT be filed with Anthem until the “black out period” is over.
4. PayFlex Debit Cards will be de-activated on November 30, 2015. You may destroy your PayFlex Debit Card after this date. Just keep track of receipts for out-of-pocket medical costs incurred in December and submit them to Anthem in January.

- For 2016, 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 2015 and have leftover unused dollars, up to $500 dollars will carryover into 2016. Any unused dollars above $500 will be forfeited.
- If you elect the Health FSA in 2016 and at the end of 2016 have leftover unused dollars, up to $500 dollars will carryover into 2017. Any unused dollars above $500 will be forfeited.
- Carryover dollars from 2015 will not be available for use until April 1, 2016.
- The $500 in carryover dollars does not count towards the $2,550 annual Health FSA limit, so if you elect $2,550 in Health FSA for 2016 and you have $500 in Carryover dollars from 2015, you will have a total of $3,050 in Health FSA dollars in 2016.
- You do not need to do anything if you have unused 2015 Health FSA dollars. The Health FSA administrator PayFlex will automatically move up to $500 in unused 2015 Health FSA dollars into your 2016 Health FSA account at Anthem.
- Dependent Day Care FSA is not eligible for the new carryover feature so any unused Dependent Day Care FSA dollars will be forfeited.

During Open Enrollment, you must make an election to participate in an FSA. Elections from 2015 do not roll over into 2016.

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 2016 calendar year and any unused Health FSA dollars above $500 and all unused Dependent Day Care FSA dollars are forfeited.

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 $2,550. 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 you will be issued an Anthem FSA Debit Card. The card will arrive at your home prior to January 1, 2016. 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 Anthem 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 Anthem 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 Anthem to comply with IRS regulations. Your Anthem FSA Debit Card has an expiration date on it.

Important Note: If you do not use your Anthem 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 2016 calendar year must be submitted to Anthem for reimbursement no later than March 31, 2017. 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 (if married) 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
- Summer day camp
- Preschool
- Before and after school programs
- Adult day care

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 complete an STD application and submit it along with supporting documentation 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. Coverage becomes effective 30 days after the date you become a full-time employee.

Long Term Disability (LTD)

After 26 weeks/180 days of absence, if you are still unable to work due to an accident, illness or injury, protection for your paycheck is provided under LTD. 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. You will be required to complete an LTD application and submit it along with supporting documentation to Liberty Mutual. 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

Starting January 1, 2016, TTI will offer the MetLife Auto & Home Insurance Program. This new program will allow employees to secure auto and home insurance and pay for it thru convenient payroll deductions. Please note that 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 in any claims that may be filed. TTI’s only involvement is to deduct premiums from paychecks and send it to MetLife.

Why MetLife Auto & Home?

- Average savings of $500[1] per year
- Discounts not available to the general public
- Claims may be reported 24 hours a day, 7 days a week, 365 days a year, via desktop, mobile app, or call center
- One easy-to-remember phone number—**800-GET-MET8 (800-438-6838)**
- Portable coverage.
- MetLife has over 90 years of experience in the group benefits business, and 140 years in the insurance and retirement business.
- Claims service that consistently achieves outstanding NPS results[2]

[1] Savings are based on an annualized average savings for a group auto policy where the customer provided his/her prior premium and prior carrier at the time of the original quote (between 01/13-12/13) and where the MetLife Auto & Home written auto premium amount resulted in a price less than the disclosed prior carrier's premium.

[2] Surveys conducted by Customer Contact Solutions, LLC., with customers who experienced an auto or home claim reported from December 2012 through October 2013

More information will be sent to employees about to how to obtain a quote in late December.

BENEFIT PLAN PROVIDER CONTACTS

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	Anthem	877-233-7040	www.anthem.com
EAP	Anthem	800-999-7222	www.anthemeap.com
401(k)	Transamerica	800-755-5801	www.ttiretirement.com
Auto & Home Insurance	MetLife	800-438-6838	www.metlife.com/2minutes

REQUIRED ANNUAL NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free **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 July 31, 2015. You should contact your State for further information on eligibility.

ALABAMA—Medicaid
Website: www.myalhipp.com
Phone: 1-855-692-5447
ALASKA—Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529
COLORADO—Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943
FLORIDA—Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268
GEORGIA—Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507
INDIANA—Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949
IOWA—Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562
KANSAS—Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884
KENTUCKY—Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570
LOUISIANA—Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE—Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741
MASSACHUSETTS—Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120
MISSOURI—Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005
MINNESOTA—Medicaid
Website: http://www.dhs.state.mn.us/id_006254
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629
MONTANA—Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084
NEBRASKA—Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
NEVADA—Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE—Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218
NEW JERSEY—Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK—Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831
NORTH CAROLINA—Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100
NORTH DAKOTA—Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604
OKLAHOMA—Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON—Medicaid and CHIP
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075
PENNSYLVANIA—Medicaid
Website: http://www.dhs.state.pa.us/hipp
Phone: 1-800-692-7462
RHODE ISLAND—Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300
SOUTH CAROLINA—Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059
TEXAS—Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH—Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-866-435-7414
VERMONT- Medicaid
Website: http://www.greenmountaincare.org/
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: 1-866-873-2647
WASHINGTON—Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx
Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA—Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN—Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002
WYOMING—Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can 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

NOTICE OF AVAILABILITY
TTI MEDICAL PLAN NOTICE OF PRIVACY PRACTICES

TTI's Medical Plan (the "Plan") provides health benefits to eligible employees of TTI (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. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information.

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, AultCare, Delta Dental, Express Scripts nc., VSP, PayFlex (collectively the "Plan").

Effective: January 1, 2014

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. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. 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.

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.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

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

Health Care Operations: The Plan may use 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.

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

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

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company) and any insurers and/or HMOs with respect to those plans, health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information, which shall not be used) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

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).

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). 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. 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.

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 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 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 for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

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

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

COMPLAINTS

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the 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

HIPAA Special Enrollment Notice

If you are declining enrollment 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.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 31 day period applies to most special enrollments. As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage may eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other

coverage is in effect, you may not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraphs above, however, regarding enrollment in the event of marriage, birth, adoption, placement for adoption, loss of eligibility for Medicaid or a state CHIP, and gaining eligibility for a state premium assistance subsidy through Medicaid or a state CHIP.)

To request special enrollment or obtain more information, contact Human Resources, Milwaukee Electric Tool, 13135 West Lisbon Road, Brookfield, WI 53005.

CMS MODEL MEDICARE PART D NOTICE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

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 . 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).


TTI
Milwaukee
Empire
RIDGID
RYOBI
Homelite
Dirt Devil
HOOVER
ORECK