TRANSDIGM GROUP INC.

2025 Employee Benefits

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We all work together to make TransDigm Group, Inc. a success, and our teamwork extends to your benefits. Your health and well-being are important to us, so we provide benefit options to make you and your family's lives better. Together, let's invest in you. Please review this guide in its entirety to understand all benefit offerings for the 2025 calendar year.

See **page 32** for important information concerning Medicare Part D coverage.

In this guide, we use the term company to refer to TransDigm Group, Inc. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Important Contacts

TRANSDIGM HEALTH & WELFARE BENEFITS SERVICE CENTER
833-874-1592
www.transdigmbenefits.com

MEDICAL AND PRESCRIPTION
Anthem/CarelonRx
844-879-5704 (Medical)
833-280-3280 (Pharmacy)
www.anthem.com

MEDICAL AND PRESCRIPTION
(Certain Areas of Northern and Southern CA)
Kaiser
800-464-4000
www.kp.org

SURGERY BENEFIT
Lantern (Formerly SurgeryPlus)
833-814-5699
https://my.lanterncare.com

SUPPLEMENTAL HEALTH BENEFITS
(Accident, Critical Illness, Hospital Indemnity)
Aflac
800-433-3036
www.aflacgroupinsurance.com

DENTAL
Cigna
800-244-6224
www.mycigna.com

VISION
VSP
800-877-7195
www.vsp.com

HEALTH SAVINGS ACCOUNT & FLEXIBLE SPENDING ACCOUNT(S)
HSABank
800-357-6246
www.hsabank.com

LIFE AND AD&D INSURANCE
MetLife
800-638-6420
www.metlife.com/mybenefits

DISABILITY INSURANCE
MetLife
833-622-0135
www.metlife.com/mybenefits

LEGAL
MetLife Legal Plans
800-821-6400
www.legalplans.com
Access Code: 9903333

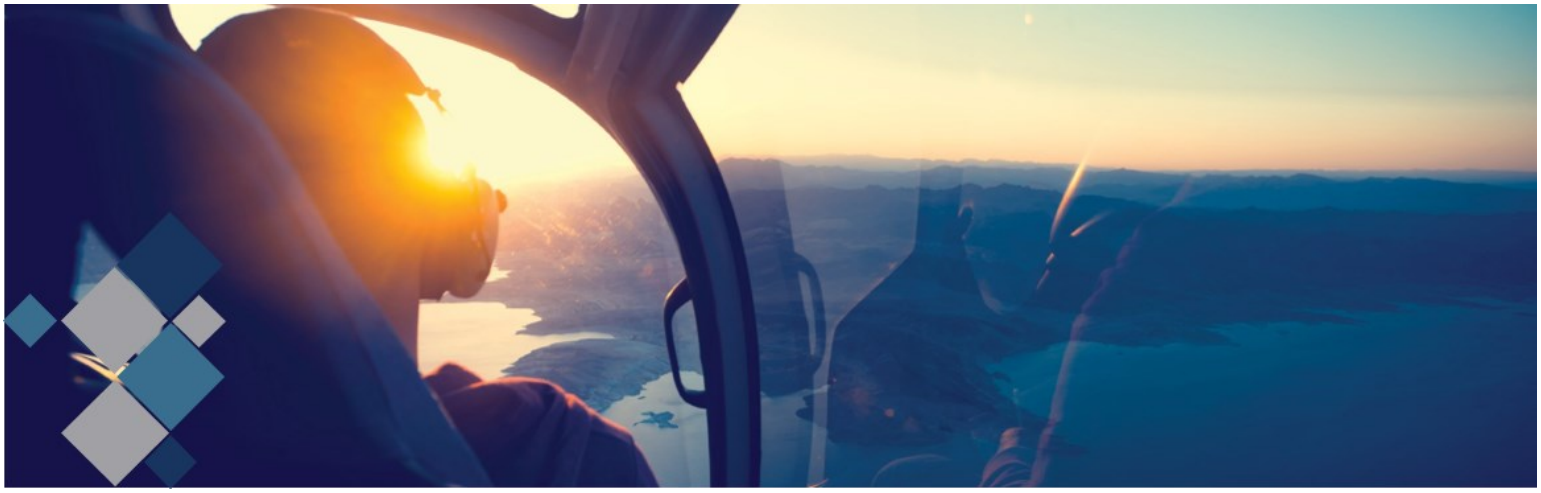
IDENTITY THEFT
Allstate Identity Protection
800-789-2720
https://www.myaip.com/

PET INSURANCE
Nationwide
877-738-7874
www.petinsurance.com/transdigm

AUTO AND HOME
Farmers GroupSelect
800-438-6381
www.myautohome.farmers.com

EMPLOYEE ASSISTANCE PROGRAM
Magellan
800-424-4039
memeber.magellanhealthcare.com

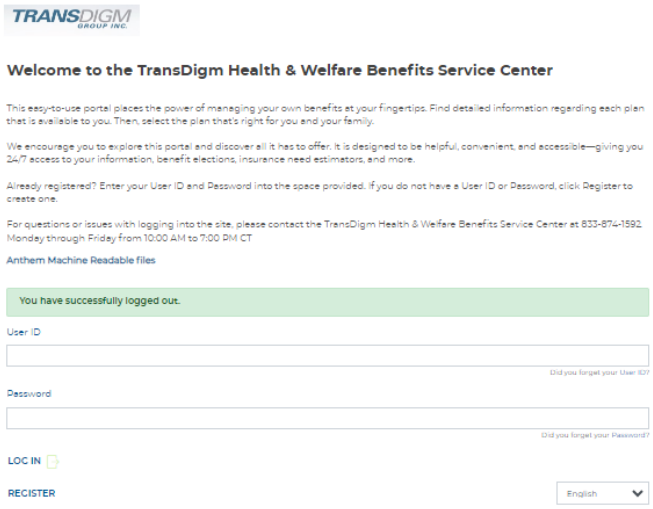
COMMUTER BENEFITS
HSABank
800-357-6246
www.hsabank.com



TransDigm Health & Welfare Benefits Service Center – How to Register

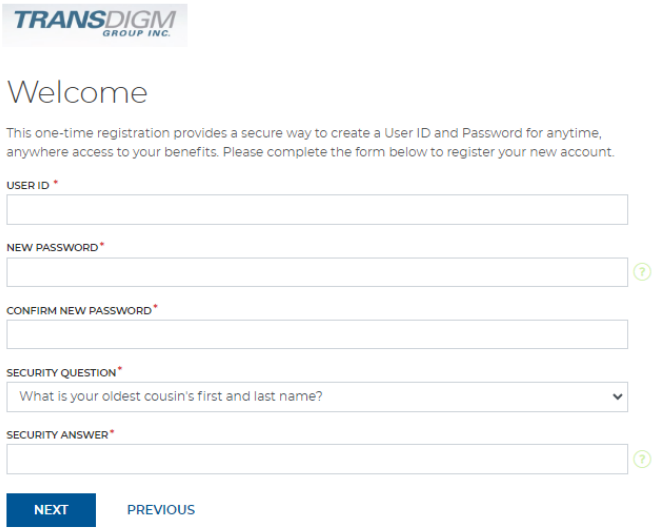
If you have not yet registered in the Benefits Administration System, powered by Empyrean, follow the steps below to Register and create your User ID and password. You will utilize this system to manage your benefits.

1. Go to www.TransDigmBenefits.com and click on "REGISTER" below.

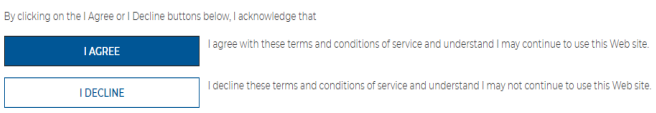


2. Enter your First Name, Last Name, Date of Birth and Social Security Number. Once completed, click "NEXT."

3. If you have a company email address on file, that will populate as your User ID automatically. If you do not have an email on file or do not wish to use your company email address, you can create your own User ID, it must be at least 8 characters long. Then you can create your password and security question. Your password must have one letter, one number and one special character.



4. Lastly, you will be prompted to read the Terms and Conditions of the site. After selecting "I AGREE," you will be taken to the home page of www.TransDigmBenefits.com where you can enroll and manage your benefits.



Eligibility & Enrollment

TransDigm offers a variety of benefits to support you and your family's needs. It is up to you to choose options that cover what's important to your unique lifestyle. Benefits will be effective for the entire 2025 calendar year, unless you experience a qualified life event.

How to Enroll

1. Visit www.TransDigmBenefits.com and log in with your User ID and password. Directions on how to register are outlined on the previous page.
2. Once you log in, you will be prompted to start your enrollment.
3. Start your enrollment process and follow the steps through to the end. Your elections are not recorded until you save and accept. You will know you have completed your enrollment once you come to the confirmation page and receive a confirmation number. Once you are finished, you can print your confirmation statement, or if you have an email on file, you will receive an email confirming that your enrollment choices have been saved.
4. If you have any trouble enrolling online, or wish to enroll over the phone, you can call the TransDigm Health & Welfare Benefits Service Center at 833-874-1592 10:00 a.m. –7:00 p.m. CT, Monday through Friday.

Eligibility

If you are a full-time employee of TransDigm Group, Inc. who is regularly scheduled to work at least 30 hours a week, you are eligible to participate in the medical, pharmacy, dental, vision, life and disability plans along with additional benefits.

When does Coverage Begin?

If you are enrolling in benefits for the first time, all of your elections are effective the first of the month following the day you become a TransDigm benefits eligible employee, with the exception of your Life, Accidental Death & Dismemberment (AD&D), Disability and EAP benefits, which become effective the day you become a benefits eligible TransDigm employee. You won't be able to change your benefits until the next open enrollment period unless you experience a qualifying life event.

If you are a new hire employee, you will have 30 days to enroll in your new hire benefits from your new hire effective date.

Eligible Dependents

Dependents eligible for coverage in the TransDigm Group Inc. benefits plans include:

- Your legal spouse (or common-law spouse where recognized).
- Same and opposite gender Domestic Partners. Imputed income* will be taken from your paycheck if you are covering a Domestic Partner (unless they are a verified tax dependent).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you, your spouse or domestic partner).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.

*Under federal tax law, the portion of your insurance premium that your employer pays for your Domestic Partner's coverage is subject to withholding an payroll taxes and will be reported on your W2. Please refer to a tax accountant for more specific details regarding Imputed Income taxes.

Thoughts & Tips: You cannot change your benefit elections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child.

Qualifying Life Events

What are Qualifying Life Events?

Most people know you can change your benefits when you start a new job or during Open Enrollment each year. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual time.

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Keep in mind your change in coverage must be consistent with your change in status. This is not a complete listing of all eligible Qualified Life Events. For questions about a Qualified Life Event you can contact the TransDigm Health & Welfare Benefits Service Center at 833-874-1592.

Preparing for Enrollment

As a committed partner in your health, your employer absorbs a portion of your benefit costs. Your contributions for medical, dental, vision and spending account benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage.

You may select any combination of medical, dental and/or vision plan coverages. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of TransDigm Group, Inc., must elect coverage for yourself in order to elect any dependent coverage.

Enrollment To-Do List

Review your choices.

Review this guide to make the benefit decisions that best fit your family's needs.

Review your Beneficiaries.

This is a good opportunity to review and update your beneficiaries' information in the benefits administration system.

Make your elections.

During Enrollment, whether it is Open Enrollment or you are newly enrolling during the year, be sure to log in to the benefits administration system, www.TransDigmBenefits.com, and review your elections to ensure you are making the right choices for yourself and your family!

Check to ensure your provider is in-network.

Going in-network often saves you money. Check to ensure the providers you utilize are in the medical, pharmacy, dental and vision networks to control your costs.

Medical Plan Summary - Anthem BlueCross Blue Shield Plans

This chart summarizes the 2025 medical coverage provided by Anthem. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	$400 DEDUCTIBLE		$900 DEDUCTIBLE		$1,850 DEDUCTIBLE		$3,300 DEDUCTIBLE		$4,500 DEDUCTIBLE	
HSA ELIGIBLE	No		No		Yes		Yes		Yes	
HSA FUNDING BY EMPLOYER	No		No		$250 Employee $500 Employee + Spouse $500 Employee + Child(ren) $750 Family		$500 Employee $750 Employee + Spouse $750 Employee + Child(ren) $1,250 Family		No	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE										
INDIVIDUAL	$400	$2,500	$900	$3,000	$1,850	$3,700	$3,300	$6,400	$4,500	$9,000
FAMILY	$800	$5,000	$1,800	$6,000	$3,700	$7,400	$6,400	$12,800	$9,000	$18,000
OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)										
INDIVIDUAL	$2,200	$4,400	$3,000	$6,000	$3,500	$7,000	$5,500	$11,000	$6,550	$13,100
FAMILY	$4,400	$8,800	$6,000	$12,000	$6,500	$13,000	$11,000	$22,000	$13,100	$26,200
PLAN PROVISIONS										
COINSURANCE (YOU PAY)	20%*	40%*	20%*	40%*	20%*	40%*	30%*	50%*	30%*	50%*
PREVENTIVE CARE (YOU PAY)	$0	40%*	$0	40%*	$0	40%*	$0	50%*	$0	50%*
PRIMARY CARE	$20 copay	40%*	$40 copay	40%*	20%*	40%*	30%*	50%*	30%*	50%*
SPECIALIST	$40 copay	40%*	$80 copay	40%*	20%*	40%*	30%*	50%*	30%*	50%*
INPATIENT/ OUTPATIENT HOSPITAL	20%*	40%*	20%*	40%*	20%*	40%*	30%*	50%*	30%*	50%*
EMERGENCY ROOM	$150 then 20%*	$0	20%*	20%*	20%*	20%*	30%*	30%*	30%*	30%*
RETAIL PRESCRIPTIONS (30 DAY SUPPLY)										
GENERIC	$10 copay	$10 copay	$10 copay	$10 copay	20%*	20%*	30%*	30%*	30%*	30%*
PREFERRED	$30 copay	$30 copay	30% ($25 min, $50 max)	30% (25 min, $50 max)	20%*	20%*	30%*	30%*	30%*	30%*
NON-PREFERRED	$60 copay	$60 copay	45% ($40 min, $80 max)	45% ($40min, $80 max)	20%*	20%*	30%*	30%*	30%*	30%*
MAIL ORDER PRESCRIPTIONS (90 DAY SUPPLY)										
GENERIC	$25 copay	Not covered	$25 copay	Not covered	20%*	Not covered	30%*	Not covered	30%*	Not covered
PREFERRED	$75 copay		30% (62.50 min, $125 max)		20%*		30%*		30%*	
NON-PREFERRED	$150 copay		45% ($100 min, $200 max)		20%*		30%*		30%*	

*After Deductible

Helpful Information About Deductibles and Out-of-Pocket-Maximums

Under the $1,850 Deductible Plan, if you cover any family member(s) in addition to yourself:

- The entire Family Deductible must be met before benefits begin to pay out for any family member.
- The entire Family Out-of-Pocket Maximum must be met before the plan pays in full for any family member.

For all other plans, if you cover any family member(s) in addition to yourself:

- Once one family member meets the Individual Deductible, benefits begin to be paid for that individual.
- Once one family member meets the Individual Out-of-Pocket Maximum, the plan pays covered benefits in full for that individual.

Medical Plan Summary - Kaiser Permanente Plans

This chart summarizes the 2025 medical coverage provided by Kaiser Permanente. You are only eligible for this coverage if you live in certain areas of Northern and Southern California.

	HMO MEDIUM PLAN	$3,300 DEDUCTIBLE	$4,500 DEDUCTIBLE
HSA ELIGIBLE	No	Yes	Yes
HSA FUNDING BY EMPLOYER	No	$500 Employee $750 Employee + Spouse $750 Employee + Child(ren) $1,250 Family	No
	IN-NETWORK	IN-NETWORK	IN-NETWORK
DEDUCTIBLE			
INDIVIDUAL	$500	$3,300	$4,500
FAMILY	$1,000	$6,400	$9,000
OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)			
INDIVIDUAL	$1,500	$5,500	$6,550
FAMILY	$3,000	$11,000	$13,100
PLAN PROVISIONS			
COINSURANCE (YOU PAY)	10%	30%	30%
PREVENTIVE CARE (YOU PAY)	$0	$0	$0
PRIMARY CARE	$25 copay	30%*	30%*
SPECIALIST	$40 copay	30%*	30%*
INPATIENT HOSPITAL	10%*	30%*	30%*
OUTPATIENT HOSPITAL	$250 copay*	30%*	30%*
EMERGENCY ROOM	$150 copay	30%*	30%*
RETAIL PRESCRIPTIONS (30 DAY SUPPLY)			
GENERIC	$10 copay	30%* up to a $50 max	30%* up to a $50 max
PREFERRED / NON-PREFERRED	$30 copay	30%* up to a $100 max	30%* up to a $100 max
SPECIALTY	$30 copay	30%* up to a $100 max	30%* up to a $100 max
MAIL ORDER PRESCRIPTIONS (90 DAY SUPPLY)			
GENERIC	$20 copay	30%* up to a $50 max	30%* up to a $50 max
PREFERRED / NON-PREFERRED	$60 copay	30%* up to a $100 max	30%* up to a $100 max
SPECIALTY	Not Covered	Not Covered	Not Covered

*After Deductible

Helpful Information About Deductibles and Out-of-Pocket-Maximums

If you cover any family member(s) in addition to yourself:

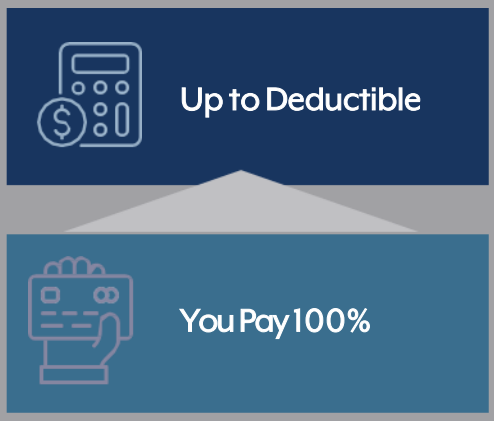
- Once one family member meets the Individual Deductible within Family Deductible, benefits begin to be paid for that individual.
- Once one family member meets the Individual Out-of-Pocket Maximum within Family Out-of-Pocket Maximum, the plan pays covered benefits in full for that individual.

Know Before You Go: Paying for Services

It is important to understand the features of your medical plans. The below chart helps explain key terms and provisions that apply to all of the medical plans offered by your employer.

Deductible

The amount you must pay for covered services before your insurance starts paying its portion.



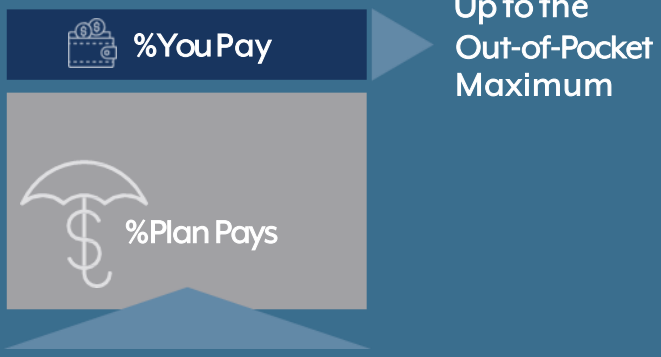
Copay

The fixed amount you pay for healthcare services at the time you receive them.

(on applicable plans)

Coinsurance

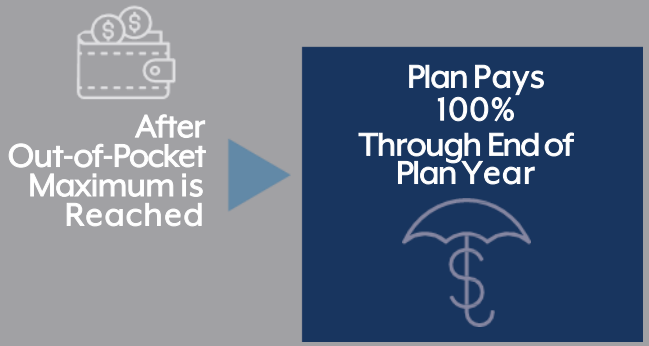
Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.



After Deductible is reached

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount, for both medical and prescription drug benefits. All copays, deductibles and coinsurance you pay during the calendar year contribute to the out-of-pocket maximum.



The examples and descriptions above refer to In-Network benefits; please note that Out-of-Network Benefits may vary.

How to Pick a Plan

Which plan is right for you? When deciding, consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does a PPO (Preferred Provider Organization) or HMO (Health Maintenance Organization) work?

You'll pay more in premiums out of your paycheck, but perhaps less at the time of service.

You're able to choose from a network of providers who offer a fixed copay for services.

If you expect to need more medical care this year or you have a chronic illness, a PPO may be the right choice for you to ensure your healthcare needs are covered.

How does a HDHP (High Deductible Health Plan) work?

You'll pay less in premiums. (Think less money from your paycheck.)

You'll pay for the full cost of most medical services until you reach your deductible.

You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.

If you expect to mostly use preventive care (which is covered at 100%), this plan could be for you.

Lantern—A Surgery Benefit That Saves You Money!

Lantern is a supplemental benefit offering available to TransDigm members enrolled in an Anthem medical plan at no additional cost. Lantern offers high-quality surgeons at a lower cost for non-emergency, pre-planned surgical procedures. Lantern has rigorously screened the area's top-quality surgeons for the best possible care.

	OTHER NETWORK	LANTERN
BOARD CERTIFICATION	Optional	☑
SPECIALTY TRAINING REQUIREMENT	Optional	☑
PROCEDURE VOLUME REQUIREMENTS	☐	☑
STATE SANCTIONS CHECK	☐	☑
MEDICAL MALPRACTICE CLAIMS REVIEW	☐	☑
CRIMINAL BACKGROUND CHECKS	☐	☑
CMS QUALITY REQUIREMENTS (HOSPITAL ONLY)	☐	☑
MONTHLY NETWORK MONITORING	☐	☑

You have a pre-planned surgery and choose to utilize Lantern, **TransDigm will waive your coinsurance, meaning you will only be responsible for the amount up to your plan deductible.** A dedicated Care Advocate will manage the entire procedure process for you, including scheduling appointments, transferring medical records and arranging all logistics. To get in touch with Lantern, you can call 833-814-5699 or visit https://my.lanterncare.com/.

	$3,300 PLAN		LANTERN COST		LANTERN SAVINGS
EXAMPLE: KNEE REPLACEMENT SURGERY COST	$40,000		$20,000		$20,000
EMPLOYEE COSTS					
DEDUCTIBLE	$3,300		$3,300		$0
COINSURANCE	$2,200		Waived		$2,200
TOTAL EMPLOYEE COSTS	$5,500		$3,300		$2,200

Saved By You!

Preventive Care

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

- Wellness visits, physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes
- Pediatric screenings for hearing, vision, obesity and developmental disorders
- Anemia screenings, breastfeeding support and pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Where to Go for Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

PRIMARY CARE DOCTOR

When would I use this?

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

What are the costs and time considerations?**

- Requires a copay and/or coinsurance based on what plan you are enrolled in
- Normally requires an appointment
- Usually little wait time with scheduled appointment

TELEMEDICINE

When would I use this?

You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*

- Behavioral health
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?**

- If you are enrolled in a PPO plan you will pay the same copay you do for an office visit to your primary care physician.
- If you are enrolled in a HDHP plan, you will pay the full cost of the visit until you reach your deductible, then applicable coinsurance will apply.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

URGENT CARE CENTER

When would I use this?

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

What are the costs and time considerations?**

- Often requires a copay and/or coinsurance that is usually higher than an office visit.
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first.

EMERGENCY ROOM

What are the costs and time considerations?**

- Often requires a much higher copay and/or coinsurance.
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

When would I use this?

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment

Finding a Provider

How to Find an Anthem Provider

If you are not yet registered on the Anthem site, here is how to find a provider in-network, on your computer.

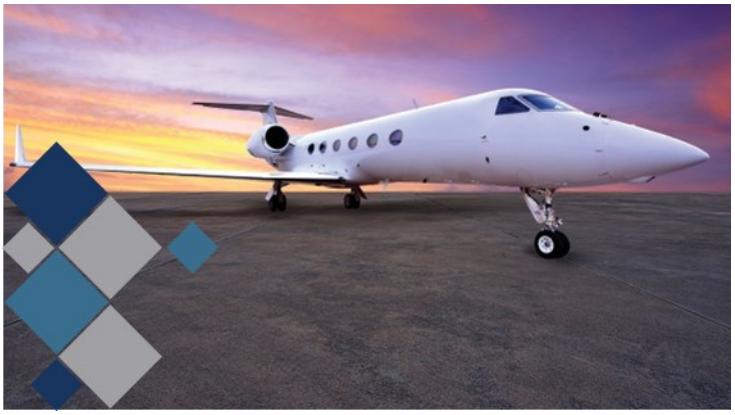
1. Go to www.Anthem.com and select "Find Care" at the top of the page.
2. Under the section titled "Use Member ID for Basic Search," enter **XTU** in the ID search box.
3. Enter the provider type and your location.
4. Results will be displayed below on that same page.

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through CarelonRx, an Anthem owned company. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.anthem.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred or Non-Preferred.

Generic Drugs

Looking to save money on medication costs? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov, or talk to your doctor to see if there is a generic option that might work for you.



Note: Apps such as GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. If you use these tools, make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. As a result, if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay may not count toward your deductible or out-of-pocket maximum under the benefit plan.

Telemedicine

When you're sick, the last thing you want to do is leave the cozy comfort of your home. Or sometimes you're just too on the go to pop in for a visit. Telemedicine is a convenient and easy way to talk to a doctor fast.

Anthem Members

LiveHealth Online

For those enrolled in an Anthem medical plan, there is a telemedicine benefit through LiveHealth Online for you and your eligible dependents. LiveHealth Online through Anthem offers on-demand access to board-certified doctors and behavioral health specialists through online video. You and your family can be treated for general health issues at home. If you are enrolled in the $400 or $900 Plan, you will pay your normal office visit copay. If you are enrolled in the $1,850, $3,300, or $4,500 plan, you will pay the full cost of the visit* until you reach your deductible, then applicable coinsurance will apply. Telemedicine is useful for after-hours non-emergency care, when your primary care doctor is unavailable, if you need prescriptions or refills or if you're traveling. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit www.livehealthonline.com.

*$80 for general medical visits and $85-$185 for behavioral health visits, depending on the type of provider chosen.

Through LiveHealth Online, you can see a board-certified doctor or a licensed therapist, for many medical conditions (but not limited to):

- Cold & flu
- Behavioral health issues
- Fever
- Respiratory infection
- Sinus problems
- Stress/anxiety
- Depression
- Grief

How to Access Virtual Visits

Make sure to register before using LiveHealth Online. To register:

- Visit www.livehealthonline.com or download the LiveHealth Online app.
- Choose Sign Up and enter your information.
- Enter your First and Last Name.
- Confirm your email and password and accept the Terms of Agreement.
- For the question "Do you have insurance?" select Yes (if you are enrolled in a TransDigm Anthem plan). Have your ID card ready to complete your insurance information.
- Select Anthem in the Health Plan drop down box.
- For Subscriber ID, enter your identification number, which is found on your Anthem member ID card. Select Yes if you are the primary subscriber or No if you are not the primary subscriber.
- Select the Finish button.

Kaiser Members

Kaiser plan members have access to telehealth services through Kaiser—anytime, anywhere. You can get the care you need by phone, email or video. To schedule an appointment:

- Call 800-464-4000
- Visit kp.org
- Go to the top left corner and Choose Your Region

Supplemental Health Benefits

TransDigm offers several ways for you to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and it offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Aflac, provides benefits for you and your covered family members if you have expenses related to an accident that occurs at work or outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

BRIEF SUMMARY OF BENEFITS*	
HOSPITAL CONFINEMENT	$1,000 + $250 per day ($500 per day for ICU)
DISLOCATIONS AND FRACTURES	Up to $8,000
AMBULANCE	Ground: $400 / Air: $1,200
EMERGENCY VISIT - PHYSICIAN, URGENT CARE, OR EMERGENCY ROOM	$250
X-RAY	$100
FOLLOW-UP OFFICE VISIT	$50
BURNS	Up to $20,000
BRAIN INJURY DIAGNOSIS (CONCUSSION)	$500
CT OR MRI	$200
COMA	$10,000
OPEN ABDOMINAL OR THORACIC SURGERY	Up to $750
TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY WITH REPAIR, RUPTURED DISC	Up to $750
BLOOD AND PLASMA	$200
PHYSICAL THERAPY	$35
APPLIANCE	Up to $100

*This is a summary. Refer to plan documents for details.

WELLNESS BENEFIT: A $50 annual Wellness Benefit is payable for each covered family member who completes certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy or stress test.

MONTHLY CONTRIBUTIONS	
EMPLOYEE ONLY	$8.87
EMPLOYEE + SPOUSE	$14.45
EMPLOYEE + CHILD(REN)	$20.02
EMPLOYEE + FAMILY	$25.60

Hospital Indemnity Coverage

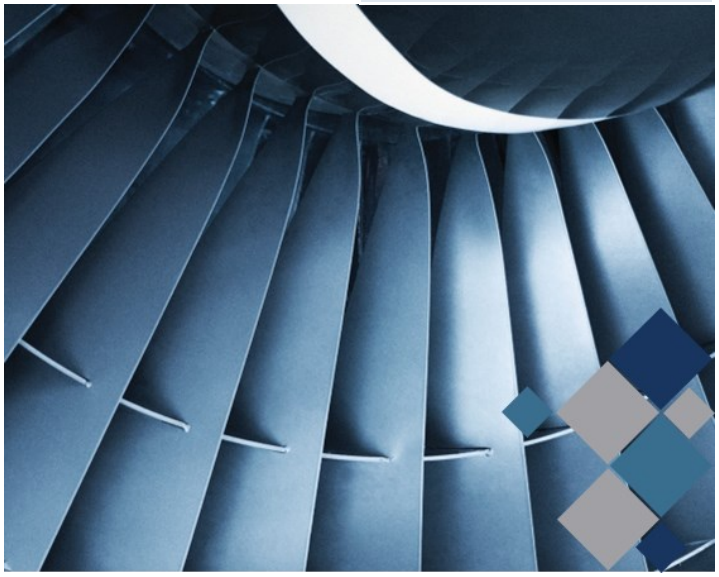
Hospital Indemnity Coverage through Aflac pays cash benefits directly to you if you have a covered stay in a hospital or intensive care unit. You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

Coverage is guaranteed; no medical questions.

SUMMARY OF BENEFITS*	
FIRST DAY HOSPITAL CONFINEMENT BENEFIT	$1,250 (once per covered sickness or accident per calendar year)
DAILY HOSPITAL CONFINEMENT BENEFIT	$200 per day (max 180 days per covered sickness or accident)
DAILY HOSPITAL INTENSIVE CARE UNIT BENEFIT	$200 per day (max 30 days per covered sickness or covered accident)

*This is a summary. Refer to plan documents for details.

MONTHLY CONTRIBUTIONS	
EMPLOYEE ONLY	$11.76
EMPLOYEE + SPOUSE	$23.66
EMPLOYEE + CHILD(REN)	$18.78
EMPLOYEE + FAMILY	$30.68



Critical Illness Benefit

Critical Illness coverage through Aflac pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, child-care, travel, home health care costs or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions), pre-existing limitations can apply
  - Employee: Choose either $15,000 or $30,000
  - Spouse: Can choose to elect up to 100% of Employee-elected coverage amount
  - Child(ren): Can choose to elect up to 50% of Employee-elected coverage amount, at no additional cost
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis, illnesses or occurrences prior to the effective date of coverage will not be payable events.
- $50 annual Wellness Benefit is payable for each enrolled Employee and Spouse for completing certain wellness screenings such as a pap test. cholesterol test, mammogram, colonoscopy or stress test.

CRITICAL ILLNESS SAMPLE BENEFIT AND MONTHLY PREMIUM ILLUSTRATION

$15,000 Benefit

EMPLOYEE AGE	EMPLOYEE ONLY OR EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE OR EMPLOYEE + FAMILY
Age 30	$7.16	$13.67
Age 35	$8.24	$15.82
Age 40	$10.42	$20.18
Age 45	$12.28	$23.91

$30,000 Benefit

EMPLOYEE AGE	EMPLOYEE ONLY OR EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE OR EMPLOYEE + FAMILY
Age 30	$12.80	$24.29
Age 35	$14.95	$28.59
Age 40	$19.31	$37.32
Age 45	$23.04	$44.77

Premiums for this plan are dependent on your age and the benefit amount elected. They will be illustrated in the enrollment system.

COVERED CONDITIONS

Enrolled employees and spouses receive 100% of the below benefit amount when a diagnosis or event occurs after your plan is effective.

Enrolled Children will receive 50% of the Employee's elected amount, according to the benefit schedule below.

	AMOUNT PAYABLE
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKINSON'S DISEASE	25%
AMYOTROPHIC LATERAL SCLEROSIS (ALS)	100%
BENIGN BRAIN TUMOR	100%
BONE MARROW TRANSPLANT (STEM CELL TRANSPLANT)	100%
CANCER (INTERNAL OR INVASIVE)	100%
CANCER (NON-INVASIVE)	25%
CANCER (SKIN CANCER)	$500 per calendar year
COMA	100%
CORONARY ARTERY BYPASS SURGERY	100%
HEART ATTACK	100%
KIDNEY FAILURE (END STAGE RENAL FAILURE)	100%
LOSS OF HEARING	100%
LOSS OF SIGHT	100%
LOSS OF SPEECH	100%
MAJOR ORGAN TRANSPLANT	100%
MULTIPLE SCLEROSIS (MS)	100%
PARALYSIS	100%
SEVERE BURNS	100%
STROKE (ISCHEMIC OR HEMORRHAGIC)	100%
SUDDEN CARDIAC ARREST	100%
CHILDHOOD CONDITIONS	
CYSTIC FIBROSIS, CEREBRAL PALSY, CLEFT LIP OR CLEFT PALATE, DOWN SYNDROME, PHENYLALANINE HYDROXYLASE DEFICIENCY DISEASE (PKU), SPINA BIFIDA, TYPE I DIABETES	50% of Employee Benefit

This is a summary. Refer to plan document for details including definitions, plan exclusions and limitations.

Dental Benefits

TransDigm offers three Dental plan options through Cigna.

Dental Plan Summary

This chart summarizes the Cigna Dental plan options and applicable monthly contributions. Your plan and tier election will determine the applicable monthly contribution.

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). The services outlined in the chart below are not guarantees of coverage; refer to the Summary Plan Document to confirm covered services.

	BASIC PLUS PLAN	ENHANCED PLAN WITH ORTHODONTIA	DHMO PLAN
MONTHLY EMPLOYEE CONTRIBUTIONS			
EMPLOYEE ONLY	$11.09	$21.77	$9.49
EMPLOYEE + SPOUSE	$21.09	$41.39	$12.29
EMPLOYEE + CHILD(REN)	$22.66	$45.74	$15.58
EMPLOYEE + FAMILY	$33.29	$65.34	$24.36
	BASIC PLUS PLAN	ENHANCED PLAN WITH ORTHODONTIA	DHMO PLAN
	IN-NETWORK		
ANNUAL MAXIMUM BENEFIT	$1,250/Individual	$2,000/Individual	None
INDIVIDUAL DEDUCTIBLE	$50	$50	$0
FAMILY DEDUCTIBLE	$150	$150	$0
PREVENTIVE SERVICES (YOU PAY)	$0	$0	Copays vary by service
BASIC SERVICES (YOU PAY)	30%*	20%*	Copays vary by service
MAJOR SERVICES (YOU PAY)	50%*	50%*	Copays vary by service
ORTHODONTIA SERVICES (YOU PAY)	Not covered	50%*	Copays vary by service
ORTHODONTIA LIFETIME MAXIMUM	Not covered	$1,500	Copays vary by service
ORTHODONTIA ELIGIBILITY	Not covered	Eligible children to age 19	Eligible children and adults

*After Deductible

How to Find a Provider

If you are not yet registered on myCigna.com, here is how to find a Dentist in your network:

- To find a network dentist, go to https://hcpdirectory.cigna.com.
- Enter your ZIP code, then select Dentist under "Doctor by Type."
- Select Continue, then confirm your ZIP Code.
- Under Dental you will select the network based on what plan you are enrolled in.
  - If you are enrolled in the DHMO Plan, select the Cigna Dental Care Access Plus Network.
  - If you are enrolled in either the Basic Plus Plan or Enhanced Plan, select the Total Cigna DPPO Network.

Vision Benefits

Don't wear glasses? Even you shouldn't skip an annual eye exam! TransDigm provides you and your family access to quality vision care with a comprehensive vision benefit through VSP.

Vision Plan Summary

This chart summarizes MetLife Vision Plan provided through Vision Service Plan (VSP). Please refer to the Summary Plan Description for further details. To find a provider, go to www.VSP.com and click on "Find a Doctor," where you can then search by your location.

	STANDARD VISION PLAN		
MONTHLY EMPLOYEE CONTRIBUTIONS			
EMPLOYEE ONLY	$6.19		
EMPLOYEE + SPOUSE	$12.58		
EMPLOYEE + CHILD(REN)	$13.47		
EMPLOYEE + FAMILY	$20.02		
	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
EXAMS			
VISION EXAM	$10 copay	$45 allowance	Once every 12 months
ELECTIVE CONTACT LENS FITTING	Up to $60 copay	$150 allowance	
FRAMES			
FRAMES	$150 allowance; 20% savings over allowance	$70 allowance	Once every 24 months
FEATURED BRAND FRAMES	$150 allowance; 20% savings over allowance	$70 allowance	
LENSES			
SINGLE VISION	$25 copay	$30 allowance	Once every 12 months
LINED BIFOCALS	$25 copay	$50 allowance	
LINED TRIFOCALS	$25 copay	$65 allowance	
POLYCARBONATE LENSES FOR CHILD(REN)	$25 copay	N/A	
STANDARD PROGRESSIVE LENSES	$55 copay	$50 allowance	
PREMIUM PROGRESSIVE LENSES	$95 - $105 copay	$50 allowance	
CUSTOM PROGRESSIVE LENSES	$150 - $175 copay	$50 allowance	
CONTACTS			
ELECTIVE CONTACT LENSES	$150 allowance	$105 allowance	Once every 12 months
NECESSARY CONTACT LENSES	$25 copay	$210 allowance	
OTHER SERVICES			
RETINAL SCREENING	No more than $39 copay on routine retinal screening as an enhancement to a vision exam.		
LASER VISION CORRECTION	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

Health Savings Account

A Health Savings Account or HSA can be a fantastic savings vehicle if you are enrolled in a qualified high deductible health plan.

Health Savings Account (HSA)

If you are enrolled in the $1,850 Deductible Plan, $3,300 Deductible Plan and the $4,500 Deductible Plan, you can open and contribute to a Health Savings Account with HSABank to help pay for eligible medical expenses, including prescription drugs, dental and vision expenses. **If you enroll in the $1,850 Deductible Plan or the $3,300 Deductible Plan, TransDigm will also contribute towards your HSA.**

$1,850 DEDUCTIBLE PLAN TRANSDIGM CONTRIBUTIONS		$3,300 DEDUCTIBLE PLAN TRANSDIGM CONTRIBUTIONS	
EMPLOYEE ONLY	$250	EMPLOYEE ONLY	$500
EMPLOYEE + SPOUSE	$500	EMPLOYEE + SPOUSE	$750
EMPLOYEE + CHILD(REN)	$500	EMPLOYEE + CHILD(REN)	$750
EMPLOYEE + FAMILY	$750	EMPLOYEE + FAMILY	$1,250

An HSA is a tax-advantaged account that you can use to pay for out-of-pocket medical costs with pre-tax dollars for Federal income tax purposes. Your money goes into the account before it is taxed, grows tax free and can be withdrawn tax free when used to pay for qualified medical expenses. IRS publication 502 provides a complete list of eligible expenses; visit www.irs.gov for details.

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in one of the high deductible health plan(s) and do not have any other healthcare coverage that reimburses expenses for covered services (other than preventive services) before reaching a high deductible (as defined by Federal rules).
- You and/or your dependents are not covered by your spouse/domestic partner's health plan or reimbursement account. Reimbursement accounts include Healthcare Reimbursement Accounts or Healthcare Flexible Spending Accounts that reimburse expenses for covered services before meeting your deductible (other than a Limited Use Flexible Spending Account).
- You are not eligible to be claimed as a dependent on someone else's Federal income tax return. You are not enrolled in Medicare, Medicaid or TRICARE. This includes Medicare Part A, which is typically provided at no cost to people who are Medicare eligible or acquiring Social Security benefits.
- You do not receive Veterans Administration Benefits, have not used a Veterans Administration hospital and have not received Veterans Administration Benefits for 3 months prior to opening an HSA.

Individually Owned Account

- You own and administer your Health Savings Account. You determine how much you will contribute to the account, subject to IRS annual limits, when to use the money to pay for qualified medical expenses and when to reimburse yourself.
- HSAs allow you to save and automatically roll over money from year to year if you do not spend it in the calendar year. The money in this account is portable, even if you change plans or jobs. There are no vesting requirements or forfeiture provisions.
- The account grows tax free for Federal income tax purposes, including any interest.

Each year the IRS places maximums on how much money can be contributed towards an HSA. The limits shown below are inclusive of the money that TransDigm contributes on your behalf if you are enrolled in the $1,850 or $3,300 Plan.

HSA FUNDING LIMITS	
EMPLOYEE ONLY	$4,300
EMPLOYEE + DEPENDENTS	$8,550
CATCH-UP CONTRIBUTIONS (AGE55+)	$1,000

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for various out-of-pocket expenses. TransDigm offers three different Flexible Spending Account Options through HSABank—Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account, and Dependent Care Flexible Spending Account.

Health Care Flexible Spending Account

You can contribute up to $3,200 for qualified medical expenses with pre-tax dollars. You cannot participate in this if you have a Health Savings Account (HSA) with HSABank, or anywhere else. The Health Care Flexible Spending Account helps you pay for out-of-pocket expenses incurred on plans where you do not have an HSA. Each year you will have to re-elect the amount you would like to have in this account; it does not roll over. Examples of eligible expenses include:

- Copays
- Eye exams, eye glasses and contact lenses
- LASIK surgery
- Hearing exams and hearing aids
- Lab fees
- Dental and orthodontia work

Limited Purpose Flexible Spending Account

This spending account is designed to complement an HSA. It allows for reimbursement of eligible dental **and** vision expenses. Medical expenses are only eligible for reimbursement after your annual deductible has been met for you and your eligible dependents. You can contribute up to $3,200 annually to this account through HSABank. Each year you will have to re-elect the amount you would like to have in this account; it does not roll over.

Dependent Care Flexible Spending Account

In addition to the Health Care and Limited Purpose FSA's, you can choose to contribute to a Dependent Care Flexible Spending Account. This allows you to set aside pre-tax dollars to help pay for expenses associated with caring for elder or child dependents. You can contribute up to $5,000 annually if you are married and filing a joint return or if you are a single parent. If you are married and filing separately you can contribute up to $2,500.

Life and Accidental Death and Dismemberment Insurance

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Life Insurance provides financial protection and security in the event of an absence or unexpected event. Securing Life Insurance now ensures your family will be protected for the future.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

TransDigm provides employees with Basic Life and AD&D Insurance as part of your basic coverage through MetLife, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

If you are a full-time employee, you automatically receive Life and AD&D Insurance even if you elect to waive other coverage.

Your Basic Life and AD&D Insurance benefit is 2x your annual base salary up to $1,000,000. If your benefit is over $50,000, you may select $50,000 to avoid imputed income tax. In the future, if you want to change your election from $50,000 to 2x your annual salary, you will have to go through Evidence of Insurability.

Newly hired employees earning more than $50,000 will be defaulted to the 2x your annual base salary up to the $1,000,000 coverage level if no enrollment action is taken.

Supplemental Life Insurance

You can also elect additional Life Insurance for yourself and your eligible spouse/children in the amounts shown below.

Employee: Increments of $10,000 up to the lesser of 5x your Base Salary or $500,000

Spouse: Increments of $10,000 up to the lesser of $250,000 or 50% of the employee's benefit amount

Child(ren): Increments of $5,000 up to $20,000; $1,000 maximum if at least 14 days but under age 6 months

Supplemental AD&D Insurance

Beyond what TransDigm provides for AD&D Insurance, you can purchase additional coverage for yourself and your family. You must elect Supplemental AD&D Insurance for yourself for it to be available to your eligible spouse/children.

Employee: Increments of $10,000 up to the lesser of 5x your Base Salary or $500,000

Family AD&D Benefit:

- Spouse Only: 50% of Employee's Coverage up to $250,000
- Child(ren) Only Coverage: 15% of Employee's Coverage up to $75,000
- Spouse and Child(ren): 40% of the Employee's Coverage up to $200,000 if the claim is for the Spouse, or 10% of the Employee's coverage up to $50,000 if the claim is for the child

Make Sure to Designate a Beneficiary

Your beneficiary is the person you designate to receive your Life Insurance benefits in the event of your death. This includes any Life Insurance benefits provided by TransDigm or additional Life Insurance benefits that you elect to have.

Name a primary and contingent beneficiary to make your intentions clear. Make sure to indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches majority age at 18. To name your beneficiaries, go to www.TransDigmBenefits.com

Reminder: You can update your beneficiary throughout the year.

Life and Accidental Death and Dismemberment Insurance

Supplemental Life and AD&D Insurance

Life and AD&D benefits are an important part of your family's financial security. The basic benefits provided to you by TransDigm may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible employees may purchase additional Supplemental Life and AD&D Insurance. Premiums are paid through payroll deductions. Please note that Life and AD&D benefits are subject to age reduction rules. Please see your Summary Plan Description for more details.

SUPPLEMENTAL EMPLOYEE LIFE AND AD&D	
COVERAGE AMOUNT	Increments of $10,000 up to the lesser of 5x your Base Salary or $500,000
WHO PAYS	Employee
MAXIMUM BENEFIT	The lesser of $500,000 or 5x Base Salary
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Newly Eligible: If you are enrolling in the plan for the first time, you will be able to elect up to $200,000 without going through Evidence of Insurability. After your initial eligibility, any requested increase in coverage will require Evidence of Insurability.
SUPPLEMENTAL SPOUSE LIFE	
COVERAGE AMOUNT	Increments of $10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	The lesser of $250,000 or 50% of the Employee's Amount
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Newly Eligible: If you are enrolling in the plan for the first time, you will be able to elect up to $50,000 without going through Evidence of Insurability. After your initial eligibility, any requested increase in coverage will require Evidence of Insurability.
SUPPLEMENTAL CHILD LIFE	
COVERAGE AMOUNT	Increments of $5,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$20,000. For children up to 6 months old, the maximum is $1,000.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
SUPPLEMENTAL FAMILY AD&D	
COVERAGE AMOUNT/MAXIMUM BENEFIT	• Spouse Only Coverage: 50% of Employee's Coverage up to $250,000 • Child(ren) Only Coverage: 15% of Employee's Coverage up to $75,000 • Spouse and Child(ren): 40% of the Employee's coverage up to $200,000 if the claim is for the Spouse or 10% of the Employee's coverage up to $50,000 if the claim is for the Child Employee must be enrolled in Supplemental Employee AD&D for Spouse and Child(ren) to be eligible for this benefit
WHO PAYS	Employee
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

Life and Accidental Death and Dismemberment Insurance

SUPPLEMENTAL LIFE INSURANCE (EMPLOYEE AND SPOUSE)			
MONTHLY RATE / $1,000			
EMPLOYEE AGE	EMPLOYEE RATE	SPOUSE AGE	SPOUSE RATE
Under 24	$0.045	Under 24	$0.058
25-29	$0.058	25-29	$0.065
30-34	$0.072	30-34	$0.086
35-39	$0.081	35-39	$0.108
40-44	$0.094	40-44	$0.144
45-49	$0.137	45-49	$0.202
50-54	$0.209	50-54	$0.310
55-59	$0.387	55-59	$0.547
60-64	$0.594	60-64	$0.792
65-69	$1.143	65-69	$1.584
70-74	$1.854	70-74	$2.534
75+	$1.854	75+	$2.534

CHILD LIFE INSURANCE	
MONTHLY RATES / $1,000	
CHILD	$0.11

SUPPLEMENTAL AD&D INSURANCE	
MONTHLY RATES / $1,000	
EMPLOYEE ONLY	$0.040
EMPLOYEE & FAMILY	$0.053

Life and AD&D Benefits are subject to age reduction rules. When you or your spouse reaches a certain age, the benefits will reduce as follows:

AGE	BASIC LIFE AND AD&D REDUCTION AMOUNT TO
AGES 70-74	67% of the original amount
AGES 75 AND UP	50% of the original amount

AGE	SUPPLEMENTAL LIFE AND AD&D REDUCTION AMOUNT TO
AGES 65-69	65% of the original amount
AGES 70 AND UP	50% of the original amount

Please use the age as of January 1, 2025 to calculate the cost of the benefit per month. Use your spouse/domestic partner's age when calculating the applicable rate for their benefit.

TO CALCULATE HOW MUCH YOUR SUPPLEMENTAL LIFE COVERAGE WILL COST:					
$	÷ 1,000 =	$	x Age Based Rate =	$	
Benefit Elected				Monthly Premium	

Disability Insurance

Maintaining your quality of life counts on your income. TransDigm Group, Inc. offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or until you reach retirement age.

Short Term Disability (STD) Insurance

STD coverage is available at no cost to you, provided by TransDigm through MetLife. STD coverage replaces up to 60% of your income, up to a maximum of $2,000 per week. Certain exclusions may apply. See your plan documents for details. **Locations that currently do not receive STD Through TransDigm due to their own sick and vacation time policies will continue with their specified program, instead of the STD plan.**

WEEKLY MAXIMUM BENEFIT	$2,000
ELIMINATION PERIOD	7 days
MAXIMUM BENEFIT PERIOD	Earlier of the 25th week or the end of your disability

Employees who reside in California or New Jersey are not eligible for this benefit, as STD benefits are received through the applicable state.

Long Term Disability (LTD) Insurance

LTD coverage is available to you at no cost, provided by TransDigm through MetLife. LTD replaces 60% of your income (up to a maximum of $12,000 per month) if you become partially or totally disabled for an extended time. Certain exclusions may apply. See your plan documents for details.

MONTHLY MAXIMUM BENEFIT	$12,000
ELIMINATION PERIOD	The end of STD Benefits or 180 days, whichever is greater
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Thoughts & Tips: Nearly 6% of working Americans will experience a short term disability due to illness, injury or pregnancy on average every year.

Additional Benefits

TransDigm Group, Inc. cares about you and wants you to succeed in all aspects of life, so we offer a variety of additional benefits to help make your day-to-day easier.

Employee Assistance Program

We know life is complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional and physical. This benefit comes at no cost to you — whether you're enrolled in a company-sponsored medical plan or not.

Through this program, you have access to mental health assistance, legal and financial help from a number of professionals. You have 24-hour access to helpful resources by phone, and the EAP benefit includes five face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with your employer. You may access information, benefits, educational materials and more either by phone at 800-424-4039 or online at www.magellanascend.com.

The Program provides referrals to help with:

- Emotional health and well-being
- Alcohol or drug dependency
- Marriage or family relationship problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Auto/Home Insurance

Purchasing auto and home insurance through Farmers GroupSelect gives you access to a variety of insurance policies, including automobile, home (not offered in Massachusetts and Florida), landlord's rental dwelling, condo, mobile home, renters, recreational vehicle, boat and personal excess liability. If you want to enroll in Home/Auto Insurance you can do so by visiting www.myautohome.farmers.com or calling 800-438-6381. **Your payment for Home/Auto Insurance will be handled directly with Farmers, not through payroll deductions.**

Legal Plan

The MetLife® Hyatt Legal Assistance Plan offers you and your family access to attorneys for common legal services, such as will preparation, estate planning, family law and more. You and your family will have access to a nationwide network of 15,000 experienced attorneys. If you choose, you also have the flexibility to use a non-plan attorney and get reimbursed for covered services according to a set fee schedule.

Employee & Family: $16.50/month

Identity Theft Protection

Get peace of mind by protecting you and your family against the damage of identity theft. Identity theft protection services from Allstate Identity Protection® monitor your identity, detect fraud and restore your identity in the event of theft. Certified privacy advocates are also available to act as dedicated case managers on your behalf to resolve any identity theft issues.

Employee Only: $7.95/month

Employee & Family: $13.95/month

Pet Insurance

Pet Insurance through Nationwide can make the unexpectedness that comes with pets a little easier. Nationwide policies can cover a multitude of medical problems and conditions related to accidents and illnesses, as well as preventive visits. If you want to enroll in Pet Insurance you can do so by going to www.petinsurance.com/transdigm or calling 855-525-1458. **Your payment for this coverage will be handled directly with Nationwide, not through payroll deductions.**

Commuter Benefits

TransDigm offers the option for you to enroll in a pre-tax benefit account which can be used to cover various modes of mass transit or parking expenses as part of your election. Visit www.hsabank.com or call 800-357-6246 for details.

HIPAA Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by TransDigm Group, Inc. health plans. This information, known as protected health information (PHI), includes almost all individually identifiable health information held by a plan —whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Dental, and Vision. The plans covered by this notice may share health information with each other to carry out treatment, payment, or healthcare operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

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

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

How the Plan may use or disclose your health information

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

- **Treatment** includes providing, coordinating, or managing healthcare by one or more healthcare providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for healthcare. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Healthcare** operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Healthcare operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

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

How the Plan may share your health information with TransDigm Group, Inc.

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to TransDigm Group, Inc. for plan administration purposes. TransDigm Group, Inc. may need your health information to administer benefits under the Plan. TransDigm Group, Inc. agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Finance and Human Resources are the only TransDigm Group, Inc. employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and TransDigm Group, Inc., as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to TransDigm Group, Inc., if requested, for purpose of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to TransDigm Group Inc. information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

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

Other allowable uses or disclosures of your health information

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

WORKERS' COMPENSATION	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
NECESSARY TO PREVENT SERIOUS THREAT TO HEALTH OR SAFETY	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, If made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
PUBLIC HEALTH ACTIVITIES	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
JUDICIAL AND ADMINISTRATIVE PROCEEDINGS	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
LAW ENFORCEMENT PURPOSES	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the plan's premises
DECEDENTS	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
ORGAN, EYE, OR TISSUE DONATION	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
RESEARCH PURPOSES	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
HEALTH OVERSIGHT ACTIVITIES	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the healthcare system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
SPECIALIZED GOVERNMENT FUNCTIONS	Disclosures about individuals who are armed forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS NVESTIGATIONS	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

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

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

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

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

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

The plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

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

Right to receive confidential communications of your health information

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

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

Right to inspect and copy your health information

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

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

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

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

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

Right to amend your health information that is inaccurate or incomplete

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

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

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

Right to receive an accounting of disclosures of your health information

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

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

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

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

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

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

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

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2025. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice by email.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact Human Resources at 216-706-6719.

More Information

For more information of the Plan's privacy policies or your rights under HIPAA, contact Human Resources at 216-706-6719.

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 216-706-6719.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private.

You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 216-706-6719.

HIPAA Special Enrollment Rights

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 later enroll yourself and 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a 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 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 216-706-6719.

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from TransDigm Group 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 TransDigm Group 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. TransDigm Group has determined that the prescription drug coverage offered by the Anthem Choice Fund Open Access Plus, Anthem Open Access Plus OAP3, Anthem Open Access Plus OAP2, Anthem PPO $400 Deductible Plan, Anthem PPO $900 Deductible Plan, Anthem HDHP $1,850 Deductible Plan, Anthem HDHP $3,300 Deductible Plan, Anthem HDHP $4,500 Deductible Plan, Kaiser HMO Plan, Kaiser HDHP $3,300, Kaiser HDHP $4,500 health 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 TransDigm Group coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the TransDigm Group medical plan, **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 TransDigm Group 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 person listed below for further information or call TransDigm HR at 216.340.2003. **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 TransDigm Group changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 4, 2024
Name of Entity/Sender:	TransDigm Group, Inc.
Contact--Position/Office:	TransDigm—Human Resources
Address:	1350 Euclid Ave., Suite 1600, Cleveland, OH 44115
Phone Number:	216.706.6719

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en
US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for- medicaid-health-insurance-premium-payment-program- hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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