October 2021 Important Benefits Information

Tenneco is legally required to distribute the following notices. These notices are for informational purposes only.

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 its 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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid: Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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, 2021, 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

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 enroll yourself and your dependents in a Tenneco medical/prescription drug option if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). **However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).**

In addition, if you have a new dependent as 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 31 days after the marriage, birth, adoption, or placement for adoption.** To request special enrollment or obtain more information, contact the Tenneco U.S. Benefits Center at **1-877-436-3409.**

Important Notice About Your Summary of Benefits and Coverage (SBC)

The Summary of Benefits and Coverage (SBC) is the document that provides – in a format prescribed by Federal regulations – a brief, standard summary of the benefits and coverage available under each medical plan option sponsored by Tenneco.

Tenneco is required to provide this information to you during each annual enrollment period.

A copy of the SBC for each medical plan option for which you are eligible is available on the DRiV™ Benefits Center website at www.myDRiVbenefits.com. Once logged in, please click on the Resources tab, then Plan Documents. The SBCs will be available for download or print.

Or, you may contact your Local HR representative to request a paper copy of any SBC.

Your Rights Following a Mastectomy (Women's Health and Cancer Rights Act Notice)

As required by the Women's Health and Cancer Rights Act of 1998, Tenneco's medical plan options provide benefits for mastectomy-related services including all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to achieve symmetry between the breasts, prostheses, and treatment of physical complications resulting from a mastectomy, including lymphedema. Contact Tenneco U.S. Benefits Center at **1-877-436-3409** for more information.

Mothers and Newborns

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

Continuing Coverage Under COBRA

If you lose your eligibility for group health care coverage (such as medical, dental, vision, Health Care FSA and EAP) because of certain qualifying events, then for a period of time you can continue your health care coverage in the Company's group health plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Alternatively, you can choose another health coverage (of the same type) that may be available to you through the Health Insurance Marketplace. However, if you elect COBRA and you are enrolled in a CDHP, the Company will no longer make contributions to your HSA.

This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse (if applicable), and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Tenneco, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

You must provide this notice to:

Tenneco U.S. Benefits Service Center
1-877-436-3409
Available Monday through Friday between 8 am and 8 pm ET

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The plan requires that you submit your disability award letter from the Social Security Administration within 60 days of the date on which the disability determination is issued and within your 18-month COBRA period.

This notice should be provided to:

Tenneco U.S. Benefits Service Center
1-877-436-3409
Available Monday through Friday between 8 am and 8 pm ET

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

This notice must be provided to:
Tenneco U.S. Benefits Service Center
1-877-436-3409
Available Monday through Friday between 8 am and 8 pm ET

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retiree Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit **www.healthcare.gov**.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Tenneco U.S. Benefits Service Center
1-877-436-3409
Available Monday through Friday between 8 am and 8 pm ET

TENNECO INC. GROUP HEALTH PLANS
NOTICE OF PRIVACY PRACTICES

THE TENNECO INC. ("COMPANY") GROUP HEALTH PLANS ARE REQUIRED BY LAW TO SEND YOU THIS NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

GENERAL INFORMATION ABOUT THIS NOTICE

This document relates to the use and disclosure of your medical information by the group health plans ("Plans") maintained by Tenneco Inc. ("Company"). For these purposes, "Plans" means the following plans sponsored by the Company: DRiV Automotive Inc. Master Health and Welfare Plan (including its component medical, dental, vision, health care FSA and limited purpose FSA programs), the Tenneco Welfare Benefit Plan (including its component medical, dental, vision, health care FSA and limited purpose FSA programs), the Tenneco Inc. Retiree Health Reimbursement Account Plan, the Federal Mogul LLC Retiree Health Reimbursement Arrangement Plan, the Federal Mogul LLC Champion Retiree Health Reimbursement Arrangement Plan, and all other Company retiree health programs available to former employees.

Please note that, depending on the circumstances, the term "Plans" as used in this Notice may mean multiple Plans or a single Plan.

The Plans continue their commitment to maintaining the confidentiality of your medical information for purposes of your Plan coverage. This Notice describes the Plans' legal duties and privacy practices with respect to that information. This Notice also describes your rights and the Plans' obligations regarding the use and disclosure of your medical information. You are entitled to a copy of this Notice.

This Notice applies to:

1. The group health plans sponsored by Company;
2. Any Company employee or other individuals acting on behalf of the Plans, and
3. Third parties performing services for the Plans.

The Plans are required by law to:

1. Make sure that medical information that identifies you is kept private;
2. Give this Notice of the Plans' legal duties and privacy practices with respect to medical information about you;
3. Follow the terms of the Notice that is currently in effect; and
4. Notify you if a reportable breach of your unsecured protected health information occurs.

Plans' Use and Disclosure of your Medical Information: The Plans are required by law to maintain the privacy of your protected health information ("PHI"). PHI is the information that is created or received by or on behalf of the Plans and includes:

1. Information that relates to your past, present, or future physical or mental health or condition;
2. The provision of health care to you;
3. The past, present, or future payment for the provision of health care to you; and
4. The information that either identifies you or with respect to which there is a reasonable basis to believe the information can be used to identify you.

This information may be maintained or transmitted either electronically or in any other form or medium. If the Plans need to amend this Notice due to changes in their operation, then this Notice will be amended, and an updated privacy Notice will be made available to you.

The Plans need to use your PHI in certain ways that are described below in more detail.

Use or Disclosure for Payment: The Plans may use and disclose your PHI so that the Plans can make proper payment for the services provided to you. For example, the Plans may use your PHI to determine your benefit eligibility or coverage level, to pay a health care provider for your medical treatment, or to reimburse you for your direct payment to a health care provider.

Use or Disclosure for Health Care Operations: The Plans may use and disclose your PHI to the extent necessary to administer and maintain the Plans. For example, the Plans may use your PHI in the process of negotiating contracts with third party carriers, such as HMOs and provider networks, or for internal audits. The Plans may also use or disclose your PHI in order to contact you to provide information or reminders about health-related benefits or services. For example, the Plans may send you information regarding disease management. If the Plans use or disclose your PHI for underwriting purposes, however, the Plans are prohibited from using or disclosing your genetic information for such purposes.

Disclosure to Tenneco Inc.: With respect to your Plan coverage, the Plans may use and disclose your PHI to Company as permitted or required by the Plan documents or as required by law. Certain employees of Company who perform administrative functions for the Plans may use or disclose your PHI for Plan administration purposes. This will include the personnel in the Benefits Department and Human Resources Managers/Representatives. Any PHI disclosed to Company by the Plans for other than payment or health care operations will require your written authorization. At no time will PHI be disclosed to Company for employment-related actions or decisions without your written authorization.

Disclosures to Family or Close Friends: Under certain very limited circumstances (e.g., an emergency), the Plans may release your PHI to either a family member or someone who is involved in your health care or payment for your care. Outside of these limited circumstances, the Plans will require an authorization in order to disclose your health information to any other individuals, including your spouse or other family members. If you would like to designate another individual to handle your health information for you, authorization forms will be available for this purpose. To obtain an authorization, you should contact the Claims Administrator listed in your summary plan description or contact the HIPAA Privacy Officer by calling the number listed on the last page of this Notice.

Use by or Disclosure to Consultant: The Plans may release your PHI to a consultant providing administrative services to the employer. Such services include, but are not limited to, monitoring eligibility for the Plans, processing enrollment events, producing COBRA notices, directing billings and payments, and entering data.

Your Written Authorization: Generally, the Plans must have your written authorization to use or disclose your PHI in circumstances not covered by this Notice or the laws that apply to the Plans (including uses and disclosures of psychotherapy notes, if applicable). If you provide the Plans with authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time by written notice to the HIPAA Privacy Officer or other individual designated in the authorization you provided. If you revoke your authorization, the Plans will no longer use or disclose your PHI for the reasons covered by your written authorization. However, you understand that the Plans are unable to take back any disclosures already made based on your prior authorization.

Special Situations: The following are examples of when the Plans may disclose your PHI without your authorization:

1. Required by Law: The Plans may use or disclose your PHI to the extent required by law.

2. Public Health Reasons: The Plans may disclose your PHI for public health reasons. These reasons may include but not limited to the following:

    a. Prevention or control of disease, injury or disability.
    b. To report child abuse or neglect;
    c. To report reactions to medications or problems with products;
    d. To notify individuals of recalls of medication or products they may be using; and
    e. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence: As permitted or required by law, the Plans may disclose your PHI to an appropriate government authority if the Plans reasonably believe you are the victim of abuse, neglect or domestic violence.

4. Health Oversight Activities: As required by law, the Plans may disclose your PHI to health oversight agencies. Such disclosure will occur during audits, investigations, inspections, licensure, and other government monitoring and activities related to health care provision or public benefits or services.

5. Judicial Proceedings, Lawsuits and Disputes: The Plans may disclose your PHI in response to an order of a court or administrative tribunal, provided that the Plans disclose only the PHI expressly authorized by such order.

    If you are involved in a lawsuit or a dispute, the Plans may disclose your PHI when responding to a subpoena, discovery request, or other lawful process where there is no court order or administrative tribunal. Under these circumstances, the Plans will require satisfactory assurance from the party seeking your PHI that such party has made reasonable efforts either to ensure that you have been given notice of the request or to secure a qualified protective order.

6. Law Enforcement: In response to a court order, subpoena, warrant, summons or other legal request, or upon a law enforcement official's request, the Plans may release your PHI to a law enforcement official. The Plans may also release medical information about you to authorized government officials for purposes of public and national security.

7. Coroners, Medical Examiners and Funeral Directors: Upon your death, the Plans may release your PHI to a coroner or medical examiner for purposes of identifying you or determining a cause of death, and to funeral directors as necessary to carry out their duties.

8. National Security and Intelligence Activities: The Plans may release medical information about you to authorized federal officials for intelligence, counterintelligence, and any other national security activities authorized by law.

9. Military and Veterans: If you are or were a member of the armed forces, the Plans may release your PHI as required by military command authorities. The Plans may also release PHI about foreign military personnel to the appropriate authority.

10. Workers' Compensation: The Plans may release your PHI to comply with workers' compensation or similar programs.

Your Rights:

You have a number of rights regarding your PHI maintained by the Plans. PHI maintained by the Plans is primarily maintained by the Claims Administrators. For that reason, if you wish to exercise any of the rights

listed below, you should first contact the Claims Administrator for the applicable program (for example, the dental program to access your PHI relating to the dental plan).

Contact information for the Claims Administrators is located in your summary plan description (benefits booklet). If your rights are not resolved by contacting the Claims Administrator, you should contact the HIPAA Privacy Officer, at the address and phone number listed on the last page of this Notice. When exercising any of the rights listed below, you should follow the particular procedures listed under each of the rights in this Notice.

Your rights regarding your PHI maintained by the Plans are as follows:

1. Right to request restrictions: You have the right to request a restriction or limitation on the Plans' use or disclosure of your PHI for payment or health care operations purposes as set forth above. You also have the right to request a limit on the PHI the Plans disclose about you to someone who is involved in your care or the payment of your care. **In general, the Plans are not required to agree to your request.**

   If the Plans do agree (or are required to), the Plans will comply with your request unless the information is needed to provide you with emergency treatment or to comply with one of the "Special Situations" described earlier in this Notice.

   To request restrictions on the use and disclosure of your PHI, you must make a written request which includes: (1) the information you want to limit; (2) whether you want the Plans to limit the use, disclosure, or both; and (3) to whom you want the restrictions to apply.

   The Plans may terminate their agreement to a restriction by notifying you of the termination.

2. Right to receive confidential communications: You have the right to request the Plans to communicate with you about your PHI in a certain manner or at a certain location. For example, you may request that the Plans contact you only at home and not at work.

   The Plans will accommodate all reasonable written requests if you clearly state that you are requesting the confidential communication because you feel that disclosure could endanger your life. You must make sure your request specifies how or where you wish to be contacted.

3. Right to inspect and copy your PHI: You have the right to inspect and copy your PHI that is contained in records maintained, used, collected or disseminated by the Plans. Usually, this includes the medical and billing records maintained by the Plans but does not include psychotherapy notes, if any, to which the Plans have access. Requests for inspection and copying must be made in writing.

   The Plans may charge you fees for the costs of copying, mailing or other supplies directly associated with your request.

   If the Plans deny your request, you will have an opportunity to have the denial reviewed if the denial was based on a licensed health care professional's opinion that:

   a. The access is reasonably likely to endanger the life or physical safety of you or another individual; or
   b. Your PHI makes references to another person, and the Plans believe that the requested access would likely cause substantial harm to the other person.

   If this occurs, a licensed health care professional chosen by the Plans will review the request and denial. The person conducting the review will not be the person who denied your request. The Plans will comply with the outcome of the review.

If the Plans maintain your PHI electronically in one or more designated record sets, you have the right to get a copy of your PHI in an electronic format.

4. Right to amend your PHI: You have the right to request an amendment to your PHI if you believe the PHI the Plans have about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Plans.

   To request an amendment, you must submit a written request, and must provide the Plans with a reason that supports your request.

   The Plans may deny your request for an amendment in any of the following circumstances:

   a. Your request is not in writing, or it does not include a reason to support the request;
   b. The PHI to which your request refers was not created by the Plans, unless the person or entity that created the PHI is no longer available to make the amendment;
   c. The PHI to which your request refers is not part of the medical information, enrollment, payment, claims adjudication or management records kept by the Plans;
   d. The PHI to which your request refers is not part of the information you would be permitted to inspect or copy; or
   e. The PHI to which your request refers is accurate and complete.

5. Right to receive an accounting of disclosures of PHI: You have the right to request a list of the disclosures of the PHI the Plans have made about you, subject to certain exceptions (including, but not limited to, disclosures made for treatment, payment, or health care operations). Effective on such date as the Secretary of Health and Human Services designates, if the Plans maintain your PHI in an electronic record of health related information created, gathered, maintained, or consulted by authorized health care clinicians and staff ("Electronic Health Records"), you may request an accounting of disclosures made from those Electronic Health Records for treatment, payment, or health care operations.

   Your request must include (1) the time period for the accounting which may not be longer than the six (6) years (or three (3) years, in the case of an accounting from an Electronic Health Record) prior to the date on which the accounting is requested; and (2) the form (i.e., electronic, paper) in which you would like the accounting.

   Your first request within a 12-month period will be free. The Plans may charge you for costs associated with providing you additional lists. The Plans will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any costs.

6. Right to receive a paper copy of this Notice: If you have received this Notice electronically, you have the right to also receive a paper copy of this Notice.

   In order to receive a paper copy, you must submit a written request to the HIPAA Privacy Officer at the address listed on the last page of this Notice. You may receive a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

Filing a complaint against the Plans: If you believe your privacy rights have been violated, or if you become aware of a security incident that affects your PHI or the PHI of other Plan participants, you may file a complaint with the Plans. The complaint should contain a brief description of how you believe your rights have been violated. You should attach any documents or evidence that support your belief, along with the Plans' privacy Notice provided to you, or the date of such Notice. The Plans take complaints very seriously. You will not be retaliated against for filing such a complaint. Please send all complaints to the HIPAA Privacy Officer at the address listed on the last page of this Notice.

You may also file complaints with the United States Department of Health and Human Services. Visit www.hhs.gov for more information.

ADDITIONAL INFORMATION ABOUT THIS NOTICE

Changes to this Notice: The Plans reserve the right to change their privacy practices as described in this Notice. These changes may affect the use and disclosure of your PHI already maintained by the Plans, as well as any of your PHI that the Plans may receive or create in the future. The Plans will provide a copy of the current Notice to individuals currently covered under the Plans and to new Plan enrollees at the time of enrollment.

A copy of the current Notice is also available during normal business hours upon request to the HIPAA Privacy Officer at the address listed below, and on the Company intranet. Additionally, if material changes are made to this Notice, the change or a revised Notice will be posted on the Company intranet by the effective date of the material change to this Notice, and the Plans will provide you with the revised Notice (or information about the material change and how to obtain the revised Notice) in the Plans' next annual mailing to you.

No Guarantee of Employment: Nothing contained in this Notice shall be construed as a contract of employment between Company and any employee, nor as a right of any employee to be continued in the employment of Company, nor as a limitation of the right of Company to discharge any of its employees, with or without cause.

No Change to Plans: Except for the privacy rights described in this Notice, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Plans. You should refer to the Plan documents for complete information regarding any rights or obligations you may have under the Plans.

Compliance with State Law: If a use or disclosure for any purpose described in this Notice is prohibited or materially limited by applicable state privacy law, the Plans will comply with that law.

Contact Information: If you have any questions regarding this document, please contact:

For Employees of Clean Air and Powertrain or Retirees of legacy Federal-Mogul:	
Benefits Service Center Information Line:	1-888-242-0800
Mailing Address:	Tenneco Attn: Benefits – HIPAA Privacy Officer 27300 West 11 Mile Road Southfield, MI 48034
Email Address:	PrivacyOffice@Tenneco.com

For Employees of Performance Solutions and Motorparts or Retirees of legacy Tenneco	
Benefits Service Center Information Line:	1-877-436-3409
Mailing Address:	Tenneco Attn: Benefits – HIPAA Privacy Officer 27300 West 11 Mile Road Southfield, MI 48034
Email Address:	PrivacyOffice@DRiV.com

Important Notice 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 Tenneco and about your options under Medicare's prescription drug coverage.

> ***Note: the 2020 Notice for Motor Parts/Performance Solutions aligned team members erroneously stated that the Plan coordinated with Medicare coverage. This error has been corrected within this 2021 Notice containing the correct language below.***

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. Tenneco has determined that the prescription drug coverage offered by the Tenneco Health and Welfare 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 through 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-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 enroll in a Medicare drug plan, be aware that by doing so, you are foregoing your Tenneco prescription drug coverage and that you may not be able to re-enroll for this coverage at a later date.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan? You should also know if you drop or lose your current coverage with Tenneco and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (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 19 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 Tenneco Benefits Center at **1-877-436-3409** for further information. 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 Tenneco 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).

Date: October 14, 2021

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).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

Definition of Balance Billing (also known as Surprise Billing)

When you see a physician or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **balance billing**. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency Services: If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center: When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you should contact your **Claims Administrator** to review your claim. You can also contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

For more information about your rights under federal law, visit **DOL.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act**