Textron Short-Term Disability Benefits

Administered by MetLife

Summary Plan Description

For the following eligible employees:

Textron Bargained and Non-Bargained Employees

Effective April 1, 2018

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Introduction

This Summary Plan Description (SPD) is a summary of the short term disability benefits administered by MetLife under a group welfare plan that is part of the Textron Bargained Welfare Benefits Plan 523 and the Textron Non-Bargained Welfare Benefits Plan 524 (the "Plan") for certain employees of Textron Inc., its divisions and subsidiaries (the "Company"). This SPD applies to you if you are an eligible employee (as described in the ***Eligibility*** section and the applicable ***Supplement*** to this SPD) on or after the applicable effective date listed in this SPD.

This summary is incorporated in a more formal Plan document, and summarizes the Textron Short Term Disability Plan major provisions. Your benefits are described as clearly as possible. If there is a conflict between this summary and the formal Plan document, the formal Plan document will control. Likewise, if any oral or written representations made by any Textron representative conflict with this summary the Plan document will control and takes the place of any prior oral or written communication on the subject of the benefit. It is important for you to read this summary to understand what is covered under the Plan, when you are entitled to this benefit and the extent of your coverage. If you have difficulty in understanding this benefit description in English, we will provide you with translation assistance. If you need assistance, please ask your supervisor or call the Textron Human Resources Service Center at 1-866-MY-TXT-HR (1-866-698-9847).

This SPD is not intended to create a contractual right to employment by Textron. All employment is "at will."

The information presented is not intended to be construed to create a contract between Textron Inc. and you as a Textron Inc. employee or former employee. In the event that the content of this document or any oral or written representations made by any person regarding the plan conflict with or are inconsistent with the provisions of the plan document, the provisions of the plan document control. Textron Inc. reserves the right to amend, modify, suspend, replace or terminate any of its plans, policies or programs, in whole or in part, including any level or form of coverage by appropriate company action, without your consent or concurrence. Notwithstanding the foregoing, Textron will comply with the requirements of a specific bargaining agreement or regulation, if applicable.

If you have any questions regarding eligibility, enrollment or contribution rates for this Plan, please contact the Textron Human Resources Service Center at 1-866-MY-TXT-HR (1-866-698-9847). If you have questions regarding benefit coverage or claims under this Plan, please contact the Claims Administrator. This SPD describes the Plan in effect on January 1, 2017 and applies to you only if you are an eligible employee on or after this date.

Eligibility

Who Is Eligible

Eligibility criteria, including definition of eligible Employee (as applicable) are contained in the applicable ***Supplement*** to this SPD.

Who Is Not Eligible

Even if you meet the above requirements, you are not eligible to participate in the Plan if:

- You are a leased employee of one of the Textron companies;
- You are classified by Textron as an independent contractor or other non-employee (even if you are later classified by Textron, the IRS or other government agency or a court as a common-law employee of one of the Textron companies);
- Your basic compensation for services is not paid directly by one of the Textron companies;
- You were retained by one of the Textron companies under a contract that states that you are not eligible to participate in the Plan;
- You are a seasonal, temporary or introductory employee of one of the Textron companies;
- You are student hired through a program that is designed to supplement classroom education, such as an internship program, a co-op program or a special program for at-risk students;
- You are a non-resident alien and you receive no earned income from any of the Textron entities that constitutes income from sources within the United States under the Internal Revenue Code;
- You are a self-employed individual, as defined in the Internal Revenue Code;
- You are an individual engaged as a consultant or advisor on a retainer or fee basis, as determined by the Plan Administrator; or
- You are a member of Textron's Board of Directors who is not otherwise eligible to participate in the Plan.

Note: *If you are employed by a Textron organization that supplies services to other Textron units, benefits will be received from the Company that employs and pays you.*

When Benefits Eligibility Begins

Your Benefits Eligibility Date (i.e., the effective date of your Short Term Disability (STD) coverage) is your date of hire or the date you satisfied any waiting period (if applicable) as noted in the applicable ***Supplement*** to this SPD.

If you are not Actively at Work as an employee on your Benefits Eligibility Date, your STD coverage will take effect on the date you return to Active Work as an employee.

No enrollment is necessary.

When Benefits Eligibility Ends

Your eligibility for STD coverage ends on the date of whichever of the following occurs first:

- Your employment ends. Your employment ends when you cease Active Work as an employee. However, for the purpose of benefits, Textron may deem your employment to continue for certain absences. See ***Conditions for Which Your Active Work Status May Continue***;
- The Plan is terminated; or
- The date you cease to be eligible for coverage.

Importance of Current Address

Because benefit-related information is mailed to you, you must update your information if you have access to PeopleSoft; or, you must notify the HR Service Center if your address changes, otherwise, you may not receive important information about your benefits.

If you provided your email address, you will also need to update your email address.

If you terminate employment and are entitled to benefits under the Textron Benefits Program, you must keep the Textron Human Resources Service Center informed of your current mailing address. You may do this be contacting 1-866-MY-TXT-HR (1-866-698-9847). If not, your benefits information may not reach you.

The Company has no obligation or duty to locate a plan participant, beneficiary or dependent.

Conditions for Which Your Active Work Status May Continue

If you are not actively at work as an Employee because of sickness, injury, a leave of absence or a layoff, Textron Inc. may deem you to be actively at work only for the purpose of continuing your employment—and only for the periods specified below—so that certain benefits under this Plan may be continued.

- *Your Sickness or Injury* – The period determined in accordance with Textron's general practice for an Employee in your job class.
- *Your Leave of Absence or Layoff* – The period determined in accordance with Textron's general practice for an Employee in your job class, or as required by applicable law.

However, in the event the leave qualifies under the Family Medical Leave Act of 1993 (FMLA), the FMLA leave period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

How the STD Plan Works

The Textron STD Plan enables you continue to receive income when you have an illness or injury—away from work—that makes you unable to work.

Once you are deemed eligible, the Company will automatically enroll you for coverage and your coverage will begin as noted in the ***When STD Coverage Begins*** section of this SPD. Textron pays the full cost of this important benefit.

The amount of benefits you receive depends on your basic annual (or weekly) earnings when you were disabled, and any other disability benefits you receive for the same illness or injury. Your benefits usually continue (up to the maximum benefit duration) as long as you are under a physician’s care and are unable to return to work.

Plan Features

When Short-Term Disability (STD) Coverage Begins

Your STD benefit will begin when you have met the criteria for full disability (as defined in this summary plan description) and have satisfied any applicable waiting period, as noted in the applicable ***Supplement*** to this SPD.

The waiting period begins on the day you become disabled and is a period of continuous disability which must be satisfied before you begin receiving STD benefit payments.

Unless you sustain an accidental injury, you must fulfill a waiting period (as noted in the applicable ***Supplement*** to this SPD) before your STD benefit begins. The waiting period begins on the day you become disabled. The waiting period is defined as the number of consecutive days of full disability before STD benefits become payable under the Plan.

If your disability is a result of a hospitalization or outpatient surgery, payment of the STD benefit begins immediately. If your disability is a result of illness, pregnancy or injury, STD benefit payments will begin after meeting the waiting period, or as outlined in the *Supplement* to this SPD

When You Are Considered Disabled

You are considered "Fully Disabled" when, due to an injury or sickness, you are:

- Unable to perform any of the material duties of your regular job, and
- Under the regular care and attendance of a physician.

Your STD Pregnancy Coverage

Your STD benefit is payable for time taken due to your pregnancy and the related childbirth. These benefits are determined on the same basis as the benefits due to a sickness.

Payment of Your STD Benefit

When the Claims Administrator receives proof that you are fully disabled, you will be paid a weekly benefit—calculated from your basic annual/weekly earnings—as described in the ***Amount of Benefit*** section of the applicable ***Supplement*** to this SPD.

The weekly benefit will be paid to you after you complete the waiting period, until you recover or meet the maximum period of coverage (also listed in applicable ***Supplement*** to this SPD). Payment of your full weekly benefit depends on:

- The impact of other disability income,
- The receipt of lump-sum payments associated with other income benefits, and
- The effect of cost-of-living increases on your benefit.

Note: *If Full Disability benefits are due for a period of less than a week, they will be paid at a daily rate of 1/7th of the weekly benefit.*

STD Benefits and Other Income Benefits

If you are eligible for short-term disability, you may also be eligible to receive benefits from Other Income Benefits. If so, the STD Plan benefit may be reduced according to the amount you receive from the Other Income Benefits. Other income benefits include, but are not limited to, benefits listed below which apply to you, your spouse, and your child(ren) as indicated:

- Any amount you receive or for which you are eligible under:
  - The amount earned while on Partial Disability,
  - Workers' or Workmen's Compensation law,
  - Occupational disease law, and
  - Any other act or law of like intent;
- Any amount you receive or are estimated to receive under any Compulsory Benefit act or law (i.e., state disability plans);
- Any amount of any disability income benefit for which you are eligible under:
  - Any other group insurance plan of Textron,
  - Any governmental retirement system as a result of your job with Textron, or
  - Any individual disability policies sponsored by Textron;
- Any amount of benefits you receive under Textron's Retirement Plan as a disability benefit or retirement benefit; or
- Any amount of benefits you receive from Social Security Disability Insurance.
- Recovery amounts that you receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings.

Note: *The above amounts are benefits resulting from the same disability for which a weekly benefit is payable under the Plan.*

Cost of Living Increases

Your weekly benefit will *not* be reduced by cost-of-living increases that:

- Are payable under Other Income Benefits, or
- Occur after the initial determination of reduction due to Other Income Benefits.

Lump-Sum Payments

If any of your Other Income Benefits are paid in a lump sum, the sum will be spread on a weekly basis over the period stated in the calculation of such sum. If no period of time is stated, the sum will be spread on a weekly basis over your life expectancy, using appropriate actuarial tables.

Overpayment and Reimbursement of Benefits

If you receive other income benefits (as previously described in this SPD) in addition to STD benefits received from Textron, an overpayment may result. As a condition of receiving STD benefits, Textron has the right to recover the excess amount from you. If needed, Textron may recover this excess amount by reducing or offsetting any future benefits payable to you.

If you receive damages from another party (and/or their insurance carrier) and you are receiving STD benefit payments from Textron, you must reimburse the Plan for the full benefit amount the Plan pays. You must reimburse this amount whether or not you have signed a reimbursement agreement with Textron. A reimbursement agreement is a document that you use to say that you will reimburse the Plan for any benefit payments the Plan makes for the injury or sickness, if you recover money from someone other than Textron.

Note: *If you suffer an injury or sickness caused by someone else, you must contact the Claims Administrator to provide the details. If benefits are paid, but you have not signed a reimbursement agreement, you are still obligated to reimburse the Plan.*

Other Changes That May Occur

Your weekly benefit *may* change if your earnings or class change. Your new weekly benefit amount is effective on the date of your earnings or class change or as a result of changes to your collective bargaining agreement (if applicable) and only applies to full disability benefits that you may be eligible for in the future. The weekly benefit amount that was in effect when you were deemed disabled will continue to apply for the remainder of the existing disability benefit period.

Note: *If you are not Actively at Work on the date of the change, the new weekly benefit amount will take effect on the date you return to active work.*

Successive Periods of Disability

If you recover from your disability and return to work, and then become disabled again, you *may* still be entitled to benefits. Generally, if your current disability is not related to your previous disability, it will be treated as a new claim and you will need to complete another waiting period.

However, if your current disability is due to the same or related cause, it *may* be considered as one continuous period of disability. Successive Periods of Disability will be considered one continuous period of disability if:

- The periods of full disability are due to the same or related causes and are not separated by a specified number of consecutive days of Active Work at your job, as noted in the applicable Supplement to this SPD.
- The periods of full disability are due to different causes and are not separated by one day of Active Work.

What Is Not Covered Under STD

The Plan does not pay benefits if your disability contributed to, results from or is caused by:

- Sickness or accidental injury due to any employment with any employer or self-employment,
- Commission of a felony, or
- Intentionally self-inflicted injury.

In addition, benefits are not payable for any period during which:

- You are not eligible for coverage under the STD Plan, or
- You are not under the care of a doctor.

Your STD Benefit and FMLA

The STD Plan and the Family and Medical Leave Act (FMLA) work independently. While your absence may qualify for FMLA leave for a number of different reasons (see below), your eligibility for STD Plan benefits is based only on your own disability. If you are disabled and receive STD Plan benefits, it is likely that you also will be eligible for an FMLA leave.

Note: *FMLA does not require employers to continue any part of your salary while you are not working. However, Textron voluntarily replaces your income through your STD benefit plan.*

For more information on how STD and FMLA coordinate, contact the Textron Human Resources Service Center at 1-866-698-9847.

How Short-Term and Long-Term Disability Benefits Work Together

Short-term disability benefits are payable for the maximum number of weeks listed in the applicable ***Supplement*** to this SPD. After the maximum STD period ends, you **may be** eligible for long-term disability (LTD) benefits. Each benefit has different eligibility requirements, which are described in the ***Eligibility*** section of this STD SPD and in the LTD Plan's Certificate of Insurance Coverage. Please refer to your Long-Term Disability Plan's Certificate of Insurance Coverage to determine your eligibility for and details on long-term disability.

Other Plan Information

Assignment of Benefits

Your benefits may not be assigned before a loss occurs.

Medical Examinations

The Claims Administrator, at our expense, has the right to have you examined by physicians of our choice when and as often as we consider necessary, at any point during your claim or your request for benefits.

Right to Withhold Taxes

Neither Textron nor the Claims Administrator can provide legal or tax advice to you. However, the Claims Administrator can and will interpret application regulations that may require mandatory withholding from your benefit payments.

Additional Provisions

The benefits under this Plan do not at any time provide paid-up insurance, or loan or cash values.

No agent has the authority to:

- Accept or to waive the required notice or proof of a claim; nor
- Extend the time within which a notice or a proof must be given to the Claims Administrator.

Claims Payment and Appeals Process

Filing and Submitting a Claim

You must file, with the Claims Administrator, notice of a claim for short-term disability benefits within twenty (20) calendar days from your last day worked after the start of the Full Disability.

To file a claim with the claims administrator, you must call the MetLife Customer Response Center at 1-877-597-7918, Monday through Friday, 8:00 am – 8:00 pm (ET), or have a representative file a claim on your behalf either by phone or electronically.

All employees must provide MetLife a signed medical Release of Information form immediately if possible, and no later than 15 calendar days of filing for benefits. Failure to provide this Release of Information form will result in the immediate temporary suspension of benefits until a signed MetLife Release of Information form is received. Once MetLife Release of Information form is received by MetLife any unpaid benefits will be paid.

If there is any question about a claim payment, you may request information from your Human Resources Department or the Claims Administrator.

Payment of Benefits

The Claims Administrator will review your claim and reach a decision within a reasonable period of time. You generally will receive notice of the decision no later than 45 days from the date the Claims Administrator receives your claim. If the Claims Administrator concludes that special circumstances require more time to review your claim (not more than 30 days), the Claims Administrator will notify you of the extension of time within the original 45-day period. The Claims Administrator may again notify you during the 30-day extension that it needs to extend the review period again (not more than another 30 days).

In each case, the extension notice will explain the circumstances requiring an extension and the date by which the Claims Administrator expects to reach a decision. The notice will also describe the standards on which disability is based under the Plan, the unresolved issues that prevent a decision on your claim, and any additional information that is required to allow the Claims Administrator to reach a decision. If the notice requires you to provide additional information, you will have at least 45 days to provide the information. The deadline for the Claims Administrator's decision will not include any time between the date the Claims Administrator notifies you that it needs additional information from you and the date when you provide the information.

Manner and Content of Notification of Claims Decision

If your request is denied, you will be provided with a written explanation as to why the request was denied. The explanation will include reference to the Plan provisions on which the denial is based, a description of any additional material or information you must provide in order to support your claim and an explanation of why the additional material or information is necessary, an explanation of the Plan's claims review procedures and time limits, and a description of your right to file a lawsuit under ERISA if your claim is denied again on review.

In addition, the notice of denial will include the following information:

- The specific rule, guideline, protocol, standard or other similar criterion of the Plan that the Claims Administrator relied upon in denying your claim, or for claims filed after April 1, 2018, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

- If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- For claims for disability benefits filed after April 1, 2018, the notice of denial will include the following additional information:

    - A discussion of the decision, including, if applicable, an explanation of the reasons for disagreeing with or not following:

        - The views which you provide to the Claims Administrator of any health care professionals who are treating you or any vocational professionals who have evaluated you;
        - The views of any medical or vocational experts who, upon request by the Claims Administrator, give advice regarding your claim; and
        - A disability determination by the Social Security Administration that you present to the Claims Administrator.

    - A statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Note: *While a claim is pending, the Claims Administrator, at its expense, has the right to have you examined by doctors of its choice when and as often as it reasonably chooses.*

If Your Claim Is Denied

If a claim for benefits is denied in part or in whole, you may discuss, on an informal basis, your questions regarding the determination by calling the Claims Administrator at 1-888-240-6414.

If the Claims Administrator cannot resolve your questions to your satisfaction via phone, you may file an appeal as described below.

First Level Appeal: If you wish to appeal a denied claim, you (or your authorized representative) must submit your appeal in writing within 180 days after receiving the denial. You must submit your appeal to the Claims Administrator. Your written appeal must include:

- Your name (the employee),
- The name of the Plan,
- Reference to the initial decision, and
- An explanation of why you are appealing the initial determination.

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim. Your written letter of appeal should be mailed to your Claims Administrator at:

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590
Phone: (877) 597-7918
Fax: (800) 230-9531

The Claims Administrator will conduct a full and fair review of your appeal after it receives your request to appeal the initial determination. The review on appeal will take into account all comments, documents, records, and other information that you submit in relation to your claim, without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted in the initial determination.

Once the review is complete, the Claims Administrator will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after

receipt of your written appeal. This timing assumes that all required appeal documentation has been submitted.

Under special circumstances, the Claims Administrator may have up to an additional 45 days to provide written notification of the final decision. If such extension is required, the Claims Administrator will notify you prior to the expiration of the initial 45-day period, stating the reason(s) why such an extension is needed and informing you when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from the Claims Administrator's notice to you of the need for an extension to when it receives the requested information will not count towards the time that the Claims Administrator is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from the Claims Administrator.

For claims for disability benefits filed after April 1, 2018, if the claim is not approved, the Claims Administrator will provide the following information to you (if applicable): (i) any new or additional evidence considered, relied upon, or generated by or at the direction of the Claims Administrator or its designee, and (ii) any new or additional rationale upon which an adverse decision is based. This information will be provided to you free of charge and with sufficient time to provide you with a reasonable opportunity to respond.

If the Claims Administrator denies the claim on appeal, it will send you a final written decision that states the reason(s) why the claim you appealed is being denied; references the Plan provision(s) on which the denial is based; and includes a statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

In addition, the notice of denial will include the following information:

- The specific rule, guideline, protocol, standard or other similar criterion of the Plan that the Claims Administrator relied upon in denying your appeal, or, for claims filed after April 1, 2018, a statement that such rules, protocols, guidelines, standards or other similar criteria do not exist.

- If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice of denial will include either an explanation of the scientific or clinical judgment, applying the terms of the Plan to your medical circumstances, or a statement that you will be provided such an explanation free of charge upon request.

- For claims for disability benefits filed after April 1, 2018, the notice of denial will include the following additional information:

    - A discussion of the decision, including, if applicable, an explanation of the reasons for disagreeing with or not following:

- The views which you provide to the Claims Administrator of any health care professionals who are treating you or any vocational professionals who have evaluated you;
- The views of any medical or vocational experts who, upon request by the Claims Administrator, give advice regarding your claim; and
- A disability determination by the Social Security Administration that you present to the Claims Administrator.

Second Level Appeal: You may appeal the Claims Administrator's decision on appeal to Textron Inc. within 180 days after you receive the Claims Administrator's final written decision. If you have not received a decision on your claim by the end of the review period (including any extensions), you may consider your claim denied and file a Second Level appeal with Textron within 180 days after the end of the review period.

Your appeal must be in writing, and must explain why you think your claim should be granted in spite of the reasons the Claims Administrator gave for denying your claim. Please mail or fax your appeal to this address:

Textron Inc.
40 Westminster Street
Providence, RI 02903
Attn: Benefit Strategy & Compliance
Fax: (401) 457-2593

As part of the appeal process, you or your authorized representative may submit comments, documents, records, and other relevant information in writing. Textron will consider this information even if it was not provided to the Claims Administrator as part of your original claim. Also, you or your authorized representative will be allowed (free of charge) to see and copy all Plan documents and records that affect your appeal. You may, upon request and free of charge, obtain the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the Claims Administrator's denial of your claim for benefits, without regard to whether the Claims Administrator relied on the expert's advice in deciding your claim.

Your appeal will be decided by someone other than the person who decided your original claim. In deciding the appeal of a determination that is based partly or entirely on a medical judgment, Textron will consult with a health care professional who has appropriate training and experience, and who was not consulted in the initial review.

Textron generally will reach a decision within 45 days after it receives your written appeal, unless it notifies you within the original 45-day period that special circumstances require an extension of the review period (not more than another 45 days). The notice will explain the special circumstances that require an extension of time to process your appeal and will tell you when you can expect a decision. If the

notice requires you to provide additional information, you will have at least 45 days to provide the information. The deadline for Textron's decision will not include any time between the date Textron notifies you that it needs additional information from you and the date when you provide the information.

In addition, before issuing an adverse decision on appeal of any claim for disability benefits filed after April 1, 2018, Textron will provide the following information to you (if applicable): (i) any new or additional evidence considered, relied upon, or generated by or at the direction of Textron or its designee, and (ii) any new or additional rationale upon which the adverse determination on appeal is based. This information will be provided free of charge and sufficiently in advance of the deadline for decision so that you have a reasonable opportunity to respond.

Textron will communicate the reason for its decision to you in writing in a clear and understandable manner. If your second-level appeal is denied, the explanation will include reference to the Plan provisions on which the denial is based, a statement of your right to review, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claims for benefits, and a statement of your right to bring a lawsuit under section 502(a) of ERISA. You may not bring a lawsuit under Section 502(a) of ERISA unless your second-level appeal has been denied or your claim or appeal is not resolved in a timely fashion.

In addition, the notice of denial will include the following information:

- The specific rule, guideline, protocol, standard or other similar criterion of the Plan that Textron relied upon in deciding your appeal, or, for claims filed after April 1, 2018, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

- If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the written notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- For claims for disability benefits filed after April 1, 2018, the notice of denial will include the following additional information:

    - A discussion of the decision, including, if applicable, an explanation of the reasons for disagreeing with or not following:

        - The views which you provide to Textron of any health care professionals who are treating you or any vocational professionals who have evaluated you;
        - The views of any medical or vocational experts who, upon request by Textron, give advice regarding your claim; and
        - A disability determination by the Social Security Administration that you present to Textron.

    - Any applicable contractual limitations period for bringing a lawsuit, including a specific date on which the contractual limitations period will end.

Textron's decision on the appeal will be final. If you are not satisfied with the decision, you or your authorized representative may file a lawsuit in court under ERISA. You and the Plan might have voluntary alternative dispute resolution options, such as mediation. One way to find out what might be available is to contact your local US Department of Labor Office.

Notice of Privacy Practices

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

"We" refers to the Textron Non-Bargained Welfare Benefits Plan, Textron Bargained Welfare Benefits Plan, Textron Non-Bargained Medical Plan, Textron Bargained Medical Plan, the Textron Flexible Spending Account Plan, and the Textron Retiree Benefits Plan, which are referred to collectively and individually in this Notice of Privacy Practices as the "Plan." "You" or "yours" refers to the individual participants in the Plan. If you are covered by an insured health option under the Plan you will receive a separate notice from the insurer or Health Maintenance Organization (HMO.)

Use and Disclosure of Protected Health Information

We are required by federal law to protect the privacy of your personal health information (referred to in this notice as Protected Health Information or (PHI)). We are also required to provide you with this notice regarding our legal duties, privacy practices, policies, and procedures regarding your Protected Health Information (PHI), and to abide by the terms of this notice, as it may be updated from time to time.

Under applicable law, we are permitted to make certain types of uses and disclosures of your PHI, without your authorization, for treatment, payment, and healthcare operations purposes.

The Plan's Rights

For treatment purposes, such use and disclosure may take place in providing, coordinating or managing healthcare and its related services by one or more of your providers, such as when your primary care physician consults with a specialist regarding your condition.

For payment purposes, such use and disclosure may take place to determine responsibility for coverage and benefits, such as when we confer with other health plans to resolve a coordination of benefits issue. We also may use your PHI for other payment-related purposes, such as to assist in making Plan eligibility and coverage determinations, or for utilization review activities.

For healthcare operations purposes, such use and disclosure may take place in a number of ways involving Plan administration, including for quality assessment and improvement, vendor review, and underwriting activities. Your information could be used, for example, to assist in the evaluation of one or more vendors who support us, or we may contact you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Plan.

We may disclose your PHI to the Plan Sponsor in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose PHI to the Plan Sponsor in connection with payment, treatment, or healthcare operations.

In addition, we may use or disclose your PHI without your authorization under conditions specified in federal regulations, including:

- As required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
- For public health activities;
- Disclosures to an appropriate government authority regarding victims of abuse, neglect or domestic violence;
- To a health oversight agency for oversight activities authorized by law;
- In connection with judicial and administrative proceedings;
- To a law enforcement official for law enforcement purposes;
- To a coroner or medical examiner;
- To cadaveric organ, eye or tissue donation programs;
- For research purposes, as long as certain privacy-related standards are satisfied;
- To avert a serious threat to health or safety;
- For specialized government functions (e.g., military and veteran activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations); and
- For Workers' Compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

We may disclose to one of your family members, to a relative, to a close personal friend or to any other person identified by you PHI that is directly relevant to the person's involvement with your care, or payment related to your care. In addition, we may use or disclose the PHI to notify a member of your family, your personal representative, another person responsible for your care or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, if there is an emergency, or if you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and we will disclose only the information that is directly relevant to the person's involvement with your healthcare.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

Your authorization is required for (1) uses and disclosures of PHI for marketing purposes, (2) disclosures that constitute a sale of PHI, and (3) most uses and disclosures of psychotherapy notes (which the Plan rarely, if ever, receives). You may revoke your authorization in writing for these uses and disclosures at any time, but the revocation will not affect any disclosure made prior to the receipt of the revocation.

YOUR RIGHTS

Uses and disclosures for purposes other than those described above in the section entitled "The Plan's Rights" will be made only with your written authorization, and you may revoke your authorization in writing at any time, except to the extent that we have taken action in reliance on your authorization.

You may ask us to restrict uses and disclosures of your PHI to carry out treatment, payment, or healthcare operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request. You may exercise this right by contacting the individual or office identified at the end of this notice. They will provide you with additional information.

You have the right to request the following with respect to your Protected Health Information:

- Inspection and copying;
- Amendment or correction;
- An accounting of certain disclosures of this information by us (you are not entitled to an accounting of disclosures made for payment, treatment or healthcare operations, or disclosures made pursuant to your written authorization);
- A paper copy of this notice upon request, even if you agreed to receive the notice electronically; and
- To receive your PHI by alternative means or at an alternative location if you indicate that disclosure by the regular means could pose a danger to you and you specify a reasonable alternative address or method of contact.

You have the right to receive notification following a breach of your unsecured PHI.

PROHIBITED USES AND DISCLOSURES

We are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Right to Change Terms of the Notice

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI we maintain. If we change this notice you will be notified, and the updated notice will be posted on the Company intranet and NetBenefits.com. You may also obtain a copy by calling the Textron Human Resources Service Center at 1-866-698-9847 and follow the prompts to reach the Service Center, Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 A.M. and 8:30 P.M. Eastern time.

Contacting the Plan

If you believe that your privacy rights have been violated, you may complain to us in writing at the location described below or to:

Secretary of the Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

You will not be retaliated against for filing a complaint.

You may exercise the rights described in this notice by contacting the office identified below. They will provide you with additional information. The contact is:

Benefits Strategy and Compliance Center of Excellence
(BS&C CoE) Textron Inc.
40 Westminster Street
Providence, RI 02903
Attn: HIPAA Privacy Officer
(401) 421-2800

Limitations on Disclosure to the Company of Protected Health Information

The Protected Health Information (PHI) created or received by a Group Health Plan in connection with your provided benefit coverage is protected by the HIPAA Privacy Regulations. However, there are instances where the Plan must disclose your health information. The following gives you information regarding the Plan's rights.

General Disclosures

1. **Summary Information.** Under the HIPAA Privacy Regulations, a group health plan (or a health insurance issuer or health maintenance organization providing coverage under a group health plan) may disclose summary health information to the Company if such information is requested by the Company in order to obtain premium bids from health plans for providing coverage

under the group health plan or to modify, amend or terminate the group health plan.

2. **Enrollment Information.** A group health plan (or a health insurance issuer or health maintenance organization providing coverage under a group health plan) may also disclose to the Company information about whether an individual is participating in the group health plan or is enrolled or has disenrolled from a health insurance issuer or health maintenance organization offered by the group health plan.

3. **Authorized Disclosures**. A group health plan (or a health insurance issuer or health maintenance organization providing coverage under a group health plan) may disclose PHI to the Company if the individual who is the subject of the information authorized the disclosure in writing. The individual generally may revoke his or her authorization at any time by providing a written notice to the Plan; but the revocation will not apply to any information that the group health plan has already disclosed.

Otherwise, pursuant to the HIPAA Privacy Regulations, a group health plan may disclose your PHI to the Company (or allow a health insurance issuer or health maintenance organization to disclose PHI to the Company) only under the circumstances described in the next section.

RESTRICTED DISCLOSURES

The Plan may disclose PHI to the Company, and the Company may use or further disclose the PHI it receives from the Plan, as necessary to permit the Company to perform plan administration functions on behalf of the group health plan. **For example:**

- The Company may receive and disclose PHI to arrange with a health maintenance organization or similar provider to provide services under the Plan;

- The Company may receive and disclose PHI to a reinsurer for purposes of obtaining a reinsurance contract or seeking reimbursement under such contract; and

- The Company (or its delegate) may receive and review PHI when deciding claims for benefits under the Plan in accordance with the Plan's claims procedures.

The Plan may also disclose PHI to the Company, and the Company may use or further disclose the PHI it receives from the Plan, as necessary to permit the Company to assist the Plan with payment functions, such as resolving an issue involving the coordination of benefits with another health plan.

When the Plan discloses PHI to the Company for plan administrative purposes or payment purposes, as described in this section, the Company's use and further disclosure of the PHI is subject to the following restrictions:

- The Company shall not use or disclose PHI except as permitted or required by this document or as required by law.

- The Company shall ensure that any agent or subcontractor to whom the Company provides PHI agrees to the same restrictions and conditions that apply to the Company with respect to such information.

- Without specific authorization from the individual who is the subject of the information, the Company shall not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan, except as required by law.

- The Company shall report to the relevant group health plan any use or disclosure of PHI that is inconsistent with the limitations mentioned here.

- With respect to the PHI about an individual contained in a designated record set, the Company shall:

    - Make the PHI available to the individual for access to inspect or shall provide a copy of such information, as provided in 45 C.F.R. § 164.524;

    - Incorporate any amendment to inaccurate or incomplete PHI, as provided in 45 C.F.R. § 164.526; and

    - Make available the information required to provide the individual an accounting of certain types of disclosures of such information (if any), as provided in 45 C.F.R. § 164.528.

Further information relating to the procedures for the activities set forth in this paragraph can be found in the Group Health Plan's Notice of Privacy Practices.

- The Company shall make its internal practices and records that relate to use and disclosure of PHI available to the US Department of Health and Human Services, for purposes of determining the group health plan's compliance with the HIPAA Privacy Regulations.

- The Company shall return or destroy all PHI and copies thereof when such information is no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Company shall not use or disclose the retained PHI unless such use or disclosure is necessary for the reason that makes the return or destruction of the information infeasible.

- The Company shall ensure that only the following classes of employees of the Company shall have access to PHI:

    - Medical professionals who are providing healthcare or treatment to the individual who is the subject of the PHI;

- The employees who are directly involved in administering the Plan (including employees who receive PHI in order to make or approve payments on behalf of the Plan and employees who receive PHI in order to assist the Plan in carrying out its healthcare operations);

- The person(s) who must administer Workers' Compensation benefits or comply with those laws; and

- The person(s) who must comply with OSHA laws.

- The Company shall ensure that the employees listed above shall have access to, and may use or disclose, PHI only for purposes of performing plan administration functions on behalf of the group health plan.

- The Company shall provide a process for resolving any issues of noncompliance with the foregoing restrictions and conditions. That process is as follows:

  - Any individual who believes that the Company has not complied with the restrictions and conditions above with respect to his or her PHI may file a claim using the same procedures that apply under the Plan to a post-service claim for benefits.

  - If the Company determines that an employee has violated the foregoing restrictions and conditions, the employee may be subject to disciplinary action including, but not limited to, required attendance at a HIPAA compliance training session and/or the imposition of any penalty that might apply for noncompliance with a Company policy.

- The Company shall certify to the group health plan that the Plan documents have been amended as provided in this SPD and that the Company agrees to the limitations set forth in this SPD.

DEFINITIONS APPLICABLE TO THIS NOTICE OF PRIVACY RIGHTS

The following definitions apply to the use of your PHI and to the Notice of Privacy Rights:

Company–Textron Inc. and any operation, plant, subsidiary or division of Textron Inc. or any predecessor or successor operation, plant, subsidiary or division.

Designated Record Set–The definition assigned to that term in 45 C.F.R. § 164.501. The term "Designated Record Set" includes the enrollment, payment, claims adjudication, and case or medical management record systems maintained by Group Health Plan or by Company on behalf of group health plan, or any group of records used (in whole or in part) by Group Health Plan or by the Company on behalf of Group Health Plan, to make decisions about an individual.

Group Health Plan–A benefit option that constitutes a "Group Health Plan" within the meaning of 45 C.F.R. § 160.103. A Group Health Plan includes a benefit option

designated as a "Group Health Plan" for purposes of HIPAA by the Company in the Plan Details chart, by the US Department of Health and Human Services in official guidance or a binding ruling, or by a court.

HIPAA Privacy Regulations–The Standards for Privacy of Individually Identifiable Health Information promulgated by the US Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, which are codified at 45 C.F.R. Parts 160, 164.

Notice of Privacy Practices–The notice, provided by the Group Health Plan pursuant to 45 C.F.R. § 164.520, describing, among other things, the Group Health Plan's uses and disclosures of PHI, an individual's rights under the HIPAA Privacy Regulations, and the Group Health Plan's duties under the HIPAA Privacy Regulations.

Privacy Officer–The Privacy Officer is responsible for developing, implementing and maintaining the privacy policies and procedures regarding the privacy of PHI and making sure Textron Inc. is compliant with the HIPAA Privacy Rule.

Protected Health Information (PHI)–The definition assigned to that term at 45 C.F.R. § 164.501. "Protected Health Information" includes any health information about an individual (including demographic information) that:

- Identifies or can be used to identify the individual;
- Is created or received by a healthcare provider, health plan, or employer; and
- Relates to:
    - Past, present, or future physical or mental health or condition of an individual;
    - The provision of healthcare to the individual; or
    - The past, present or future payment for the provision of healthcare to the individual.

Summary Health Information–The definition assigned to that term at 45 C.F.R. § 164.504(a). "Summary Health Information" includes information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the Company has provided health benefits under the Group Health Plan, provided that all identifiers (except zip code) have been removed.

Administrative Information

Textron Inc. provides the benefits described in this SPD and has discretionary authority to determine eligibility for Plan benefits, to construe the terms of the Plan(s) and to decide all questions arising in the administration of the Plan(s).

Plan Sponsor and Administrator

The Plan Administrator has discretionary authority to interpret Plan provisions, construe unclear terms, determine eligibility for benefits and otherwise make all decisions and determinations regarding Plan administration. By participating in the Plan, you (and your dependents or beneficiaries, if any) agree to accept the Plan Administrator's authority. You can contact the Plan Administrator (also known as the Plan Sponsor) as follows:

Textron Inc.
Benefits Strategy & Compliance
40 Westminster Street
Providence, RI 02903
(401) 421-2800

Claims Administrator

For some of the plans, Textron has delegated authority to third party administrators to administer benefit claims. The Claims Administrator for your benefit is stated elsewhere in this document. Subject to Textron's overall authority as Plan Administrator, the Claims Administrator has discretionary authority to interpret Plan provisions and determine benefit claims.

Employer Identification Number

Textron Inc.'s employer identification number, assigned by the IRS, is 05-0315468.

Type of Plan and Plan Number

The Textron Bargained Welfare Benefits Plan 523 and Textron Non-Bargained Welfare Benefits Plan 524 are ERISA plans that provide health and welfare benefits.

Plan Year

The Plan Year is the year by which the Plan's fiscal records are kept. The Plan Year is the calendar year.

Type of Administration

The type of administration associated with this Plan is as listed elsewhere in this document.

Agent for Legal Process

If you wish to file suit, legal papers may be served on your Claims Administrator at the address listed elsewhere in this document or on the Plan Administrator at the address above.

Amendments to the Plan and Termination of Coverage

Textron (including its divisions or subsidiaries) intends to continue this Plan, but it reserves to itself or its designee the right to change or terminate the Plan or any of the Plan benefits at any time to the extent permitted by law. This can occur without the consent of, and without prior notice to, any active or retired person, eligible dependent or beneficiary covered by these benefits. Any amendments or termination will be communicated in writing.

Refund of Overpayments

If the Plan or Claims Administrator pays benefits for expenses incurred by you or your dependent, you (or any other person or organization that was paid) must make a refund to the Plan or Claims Administrator if either of the following applies:

- All or some of the expenses were not paid by you or did not legally have to be paid by you, or
- All or some of the payment the Plan or Claims Administrator made exceeded the allowable benefits under the Plan.

The refund equals the amount the Plan or Claims Administrator paid in excess of the amount they should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan or Claims Administrator obtain the refund when requested.

If you or your dependents do not promptly refund the full amount, the Plan or Claims Administrator may reduce the amount of any future benefits payable under the Plan. The reductions will equal the amount of the required refund. The Plan or Claims Administrator may have other rights in addition to the right to reduce future benefits.

Your Rights Under ERISA

A participant in the Textron benefit plans is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish to each participant a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right, all within certain time schedules, to:

- Know why this was done,

- Obtain copies of documents relating to the decision without charge, and
- Appeal any denial.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance with Your Questions

For questions regarding eligibility, enrollment or contribution rates for this Plan, please contact the Textron Human Resources Service Center. For questions regarding benefit coverage or claims under this Plan, please contact the Claims Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, US Department of Labor as listed in the telephone directory or at the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US 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 1-800-998-7542 or by visiting www.dol.gov/ebsa.

Terms to Know

Actively at Work or Active Work—You are performing all of the material duties of your job with Textron wherever these duties are normally carried out. If you were actively at work on your last scheduled working day, you will be deemed actively at work if you are not disabled on a scheduled non-working day.

Appropriate Medical Care—The appropriate medical services being provided by a "Physician" that are appropriate for diagnosis and in accordance with generally accepted medical standards.

Basic Annual Earnings—Your annual rate of pay from Textron, excluding overtime and other extra pay. Basic annual earnings in effect as of the date of disability will be used to compute your weekly benefit.

Basic Weekly Earnings—1/52 of your basic annual earnings.

Benefits Eligibility Date—The date noted in the applicable Supplement to this SPD.

Claims Administrator—Any organization contracted by Textron to administer disability benefits on its behalf. The current claims administrator is MetLife.

Covered Person—An employee on whose account coverage is in effect under this Plan.

Employee—A person who is employed and paid for services by Textron on a full- or part-time basis.

Full Disability (or "Fully Disabled")—Due to a non-occupational accidental injury or sickness, you:

- Are under the regular care and attendance of a physician; and
- Are unable to perform any of the material duties of your regular job.

Full-time Employee—An employee that is regularly scheduled to work at least 32 paid hours a week for Textron on an ongoing basis, unless otherwise noted in the ***Eligibility*** section of this SPD.

Injury—Accidental bodily injury resulting in hurt, damage or loss sustained to the body, which is a result of an event (other than sickness) that is unforeseen, unintended and independent of all other causes. The injury must occur and full disability must begin while you are covered under this Plan.

Partial Disability—Due to an Injury or Sickness, you:

- Are under the regular care and attendance of a Physician,
- Have already met the Waiting Period of the plan due to Full Disability,
- Are able to return to work on a part-time/modified basis and, thus, earn a wage by performing certain material duties at management's discretion.

Part-time Employee—An employee that is regularly scheduled to work at least 20 paid hours a week for Textron on an ongoing basis, unless otherwise noted in the ***Eligibility*** section of this SPD.

Period of Disability—Any one continuous period of either Full Disability or combination of first Full Disability and then Partial Disability, excluding any claims that have not met the Waiting Period.

Physician—A person who is legally licensed to practice medicine. A licensed practitioner will be considered a physician if:

- There is a law which applies to this Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a physician; and
- The service performed by the practitioner is within the scope of his or her license.
- The services provided are appropriate for treating the disability in accordance with generally accepted medical standards.

Sickness—Illness or disease, which does not arise out of, or in the course of, any work you do for pay or profit, or pregnancy.

Successive Periods of Disability – The number of days between periods of disability. If the periods are separated by a specified number of consecutive days of Active Work at your job, as noted in the applicable Supplement to this SPD, they will be considered as one continuous period of disability.

Waiting Period—The number of consecutive days of full disability before Short Term Disability benefits become payable under this Plan.