TRANE TECHNOLOGIES POST-65 RETIREE MEDICAL HEALTH REIMBURSEMENT ACCOUNT

SUMMARY PLAN DESCRIPTION

Plan Description

Trane Technologies Company LLC (the "Company") offers the Trane Technologies Post-65 Retiree Medical Health Reimbursement Account Plan (the "HRA"), which will reimburse Participants for individual Medicare Supplement and/or prescription drug coverage purchased through VIA Benefits. This HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code ("Code").

This Summary Plan Description, or "SPD," describes the basic features of the HRA for legacy employees/retirees, including the rights and responsibilities of covered individuals, and the Plan Administrator. The HRA constitutes both the SPD and the official Plan Document. The sole benefit provided under this HRA is assisting in the funding of individual Medicare Supplement policies purchased through VIA Benefits. As such, the Plan governs eligibility for reimbursement of VIA Benefits insurance premiums for Medicare Supplement policies only. The individual policies purchased through VIA Benefits, and the benefits thereunder are not part of this HRA.

Part I: Eligibility and Enrollment

A. General Eligibility Requirements for the HRA

To be a "Participant" in the HRA you must satisfy the eligibility requirements under either Schedule A or B listed below. See Schedule A for HRA eligibility requirements for legacy Trane retirees. See Schedule B for eligibility requirements for HRA eligibility requirements for legacy Ingersoll Rand retirees. You must also purchase an individual Medicare supplement policy or prescription drug coverage policy through VIA Benefits to be eligible for the HRA. Retirees who were not eligible for any subsidy or to use the RMSA to offset the cost of such coverage are not eligible for benefits under this HRA.

For Your Dependents

Your eligible dependents who are age 65 or over and were (or would have been) eligible for coverage under the Pre-65 Plan prior to age 65**:**

- "Spouse" – Your spouse is a person to whom you are legally married at the time you retire.

The Company reserves the right to periodically validate your dependents' eligibility. Failure to provide proof may result in termination of coverage (including retroactive termination) and repayment of any erroneously paid claims (in accordance with the Plan's right of recovery provisions).

B. Enrollment

You may participate in the HRA on the first day of the month coinciding with or immediately following the date you lose coverage under the Pre-65 Plan, provided you purchase medical and/or prescription drug coverage through VIA Benefits. You should purchase your coverage through VIA Benefits within 63 days of the date you lose eligibility for coverage under the Pre-65 Plan (or any other employer group health plan) so as to preserve your guaranteed right to coverage and to avoid late enrollment penalties (if applicable).You should refer to documents provided by VIA Benefits for details regarding the purchase of medical and/or prescription drug

coverage through VIA Benefits. Eligible retirees who deferred their retiree medical and/or prescription coverage under the Pre-65 Plan may participate in the HRA upon purchasing medical and/or prescription drug coverage through VIA Benefits. In addition, eligible participants may defer enrollment with VIA benefits for themselves and their eligible dependents until a later time and still be eligible for the HRA upon their subsequent purchase of coverage through VIA benefits.

If You Die

If you cover your eligible Spouse, upon your death the Spouse becomes the account holder and the contribution continues (if applicable). If you have no Spouse covered under the Plan, your estate will have six months after your death to submit claims for reimbursement for any eligible expenses you incurred.

Part II: How the HRA Works

As noted above, the Company has partnered with VIA Benefits to provide post-65 supplemental Medicare coverage through the individual Medicare market. The amount of your annual HRA subsidy will be determined as follows:

Status	Annual Subsidy Per Each Enrolled Retiree and Spouse
Eligible legacy Trane retirees eligible for a Company subsidy of 40% of the cost of pre-65 retiree medical coverage	$920
Eligible legacy Trane retirees eligible for a Company subsidy of 20% of the cost of pre-65 retiree medical coverage	$445
Eligible legacy Trane retirees whose Company subsidy for the cost of pre-65 retiree medical coverage is limited to the	Not eligible for subsidy other than RMSA

remaining balance in their RMSA	
Eligible legacy Trane employees who become eligible to use their RMSA to offset the cost of retiree medical coverage	Not eligible for subsidy other than RMSA
Eligible legacy Ingersoll-Rand employees who retire or have retired (i.e., terminate employment) before 2013	$1,300
Eligible legacy Ingersoll-Rand employees who retire (i.e., terminate employment) during 2013	$700

What is the HRA?

Generally, the HRA is an employer-provided bookkeeping account (the "Reimbursement Account") established to reimburse certain eligible expenses. Once you become a Participant, a Reimbursement Account is established for you and your eligible Spouse. The Reimbursement Account is a notional bookkeeping account that keeps a record of HRA Dollars allocated to your account and reimbursements made to you under this HRA for coverage that you and/or your post-65 dependent Spouse elect. You have no property rights in the Reimbursement Account. The HRA works as follows:

- The Company establishes a Reimbursement Account for each Participant.
- For non-RMSA Participants, each Plan Year, the Company allocates a specified amount of Company contributions, called "HRA Dollars," to each Participant's Reimbursement Account.
- For those Participants whose subsidy is limited to their RMSA balance, there are no annual allocations.
- Unlike health care flexible spending accounts ("FSAs"), you do not lose HRA Dollars that you do not use during a Plan Year.

How Can I Use My HRA Dollars?

The HRA may be used to reimburse a part of your health care premiums relating to a qualified medical and/or prescription drug policy purchased through VIA Benefits. In addition, the HRA may also be used to reimburse you for qualified medical expenses such as out-of-pocket expenses for deductibles and copayments incurred under the coverage purchased through VIA Benefits.

Who contributes to my Reimbursement Account?

You cannot contribute to your HRA. The Company contributes to your Reimbursement Account (with HRA Dollars) if you are a non-RMSA Participant. If you are an RMSA Participant, then the remaining amount in your RMSA is contributed to the HRA when you and, if applicable, your eligible Spouse attain age 65. If the cost of the coverage you select exceeds the amount of HRA Dollars available, you will be responsible for making up the difference.

How are HRA Dollars allocated to my Reimbursement Account?

If you are a non-RMSA Participant, each Plan Year the Company allocates the subsidy for which you are eligible to your Reimbursement Account. The subsidy applies to each eligible post-65 retiree and dependent who is enrolled in supplemental Medicare coverage through VIA Benefits for that Plan Year. For those Participants whose subsidy is limited to their RMSA balance, there are no annual allocations.

What happens if I do not use all of the HRA Dollars allocated to my Reimbursement Account during the Plan Year?

If you do not use all of the HRA Dollars allocated to your Reimbursement Account, your unused HRA Dollars will remain in your Reimbursement Account during a subsequent Plan Year.

How do I receive reimbursement under the HRA?

You can obtain a reimbursement form from VIA Benefits by submitting a claims form through the Claims Administrator (VIA Benefits). You must complete the reimbursement form and submit it to VIA Benefits. in accordance with the procedures outlined in the documents provided by VIA Benefits. Please refer to the document “Using Your Health Reimbursement Arrangement (HRA)” from VIA Benefits for more information on how to use your HRA.

What happens if I receive overpayments or reimbursements in error from this HRA?

If it is later determined that you and/or your covered dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the amount may be included in your gross income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this HRA.

How can my RMSA funds be used under the HRA?

Legacy Trane retirees who are 65 or over and who are not covering dependents on pre-65 retiree medical coverage under the Pre-65 Plan will be able to use their remaining RMSA balance to reimburse the cost of premiums for coverage purchased through VIA Benefits. Reimbursements will be processed once a month from the individual’s RMSA if funds are still available in the account.

What is Prescription Drug Catastrophic Insurance?

HRA eligible legacy Trane and Ingersoll-Rand retirees that are not eligible for the RMSA are eligible for this coverage. Under this coverage the Company will contribute an annual subsidy to fund a separate HRA specifically for prescription drug catastrophic insurance. Participants may become eligible for reimbursement through this HRA after entering the catastrophic level of a Medicare Part D or MAPD plan. For 2022, the catastrophic level is reached when a participant incurs $7,050 of prescription drug expense. Post-65 eligible retirees and post-65 surviving Spouses who have elected an individual Medicare Advantage or Medigap plan through VIA Benefits may qualify for this benefit. Any reimbursement under this separate HRA account would be done once a year for the preceding calendar year. If the total eligible expenses exceed the amount available in the catastrophic HRA account, reimbursement will be partial and will be done on a pro-rata basis.

Part III: Plan Administration

Filing a Claim and Appealing a Denied Claim

If you are denied coverage for benefits provided under a policy purchased through VIA Benefits, you will need to refer to the VIA Benefits website and any documents relating to the policy in order to appeal this claim. The insurer of the individual Medicare supplement policy (and not VIA Benefits or the Company) is the party responsible for determining benefit claims related to policies it issues. Please see the document "Using Your Health Reimbursement Arrangement (HRA)" from VIA Benefits for instructions on how to submit a claim under your HRA.

If you are denied reimbursement under this HRA, please see the procedures outlined below:

Step 1: *Notice is received from Claims Administrator.* If your claim is denied, you will receive written notice from the Claims Administrator (PayFlex Systems USA, Inc) that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. If the Claims Administrator is unable to adjudicate your claim for reasons beyond the control of the Claims Administrator, the Claims Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Claims Administrator, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and

- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Claims Administrator, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. The Plan has established two levels of appeal; therefore, you should file your appeal with the Claims Administrator. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Claims Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first Notice of Denial provided by the Claims Administrator.

Step 6: *If you still disagree with the Claims Administrator's decision, file a second Level Appeal with the Plan Administrator.* If you do not agree with the Claims Administrator's decision, you may file a written appeal with the Plan Administrator within 45 days after receiving the first level appeal denial notice from the Claims Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim. You will be notified in writing of the Plan Administrator's decision as soon as possible but no later than 30 days after receipt of the appeal.

Extension of Deadlines for COVID-19 National Emergency

The deadlines described above for claims and appeals may be extended, in each case, by up to one year as are result of the COVID-19 National Emergency. If you have questions about the deadline applicable to your individual claim, you should contact the Plan Administrator.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);

- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and

- You cannot file suit in federal court until you have exhausted these appeals procedures.

Continuing Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")

A federal law called COBRA requires most employers sponsoring group health plans to offer covered employees and certain covered family members the opportunity for a temporary extension of health care coverage (called "Continuation Coverage") in certain instances where coverage under the group health plan would otherwise end. These rules apply to the HRA. Below is a description of your rights and responsibilities under COBRA.

When Coverage May Be Continued Under COBRA

Your Spouse has the right to COBRA Continuation Coverage under the HRA if your Spouse loses coverage under the HRA as a result of divorce or legal separation.

These events that result in a loss of coverage are called "qualifying events." Your Spouse that is covered immediately preceding the qualifying event is called a "qualified beneficiary."

Notice and Election Rules

If the covered Spouse loses coverage as a result of a divorce or legal separation, you or the affected qualified beneficiary must send notice to the COBRA Administrator within 60 days of the later of:

- the event; or
- the date coverage is lost as a result of such event

The qualified beneficiary will then be sent a notice of this right to continue participation following receipt of your notice.

Once your qualified beneficiary has been provided notice of the right to elect COBRA Continuation Coverage, an election for COBRA Continuation Coverage under the Plan must be made within 60 days of the later of the date of the notice or the date coverage is lost as a result of the qualifying event. If a qualified beneficiary fails to provide this notice to the COBRA Administrator during this 60-day notice period, the qualified beneficiary will lose the right to COBRA Continuation Coverage and coverage under the Plan will cease as of the last date they were eligible for coverage.

Duration of Coverage

Qualified beneficiaries may continue coverage under the Plan for 36 months.

Note: In all situations in which you or another qualified beneficiary is required to provide notice of a qualifying event (either an initial qualifying event or a subsequent qualifying event), you must identify the qualifying event, the date of the qualifying event, and the qualified beneficiaries impacted by the qualifying event.

Type of Coverage

If a qualified beneficiary chooses COBRA Continuation Coverage, they are entitled to the level of coverage under the HRA in effect for them immediately preceding the qualifying event. At the beginning of each Plan Year that COBRA is in effect, a qualified beneficiary will be entitled to an increase in their Reimbursement Account balance equal to the sum of the HRA Dollars allocated

to similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as the qualified beneficiary continues to pay the applicable premium.

Cost

For the period of COBRA Continuation Coverage, the cost of such coverage will not exceed 102% of the "applicable premium," as determined by the Plan Administrator. The Plan Administrator will notify you of the applicable premium. The notice you receive will describe the premium payment requirements under the Plan (i.e., who you pay the premium to, etc.).

Early Termination of Coverage

Your COBRA Continuation Coverage will end prior to the expiration of the 36-month period for any of the following reasons:

- the Company no longer provides group health coverage to any of its employees,
- the qualified beneficiary does not make the required payments (within the grace period), or
- a qualified beneficiary on COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation with respect to any pre-existing condition of the individual.

HIPAA – Your Right to Privacy

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you and is available upon request from the HIPAA Privacy Office.

For a copy of the notice, if you have any questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact the Trane Technologies HIPAA Privacy Office at bacappeals@tranetechnologies.com or by mail at:

Global Privacy/Trane Technologies Legal
Attention: HIPAA Privacy Official
800 Beaty Street, Building E
Davidson, North Carolina 28036

Plan Continuation and Reservation of Rights

The Company presently intends to continue the Plan described in this SPD, but reserves the right to amend, suspend, discontinue, or terminate the Plan and the subsidy provided under it.

Interpretation of the Plan

The Plan Administrator administers the Plan. The Plan Administrator may appoint/employ the persons necessary to provide advice with respect to any responsibility of the Plan Administrator under the Plan. Additionally, the Plan Administrator may delegate any responsibility under the Plan to Company employees or other persons.

The Plan Administrator has delegated claims administration responsibility to a third party "Claims Administrator." To the extent the Plan Administrator has delegated such responsibility, the Claims Administrator has discretionary authority and responsibility to make factual determinations necessary to administer a Plan's claims administration procedures. This includes claim denial reviews, and working with the Plan Administrator to determine the amount of benefits and interpret the meaning and intention of the terms of the Plan. The Plan Administrator's decision on all such matters shall be final and binding on all parties.

See the "Plan Identification Information" section for the Plan Administrator and Claims Administrator by benefit plan. Correspondence to the Plan Administrator/Claims Administrator should be sent to the addresses listed in this section.

The Plan Administrator and/or its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this SPD, any trust agreements and any other Plan documents. The administrator or designee(s) decides all matters (including factual matters) that arise in connection with the operation or administration of the Plan and any trust agreements.

Without limiting the generality of the above-described authority, the Plan Administrator and/or its duly authorized designee(s) has sole and absolute discretionary authority to:

- Take all actions and make all decisions (including factual decisions) about eligibility and the amount of benefits payable under the Plan

- Formulate, interpret, and apply rules, regulations, and policies necessary to administer the Plan according to the terms of the Plan

- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan

- Resolve and/or clarify any ambiguities, inconsistencies, and omissions (including factual determinations) arising under the Plan, including this SPD or other Plan documents

- Process and approve or deny benefit claims

- Determine the standard of proof required in any legal case or claim

Your ERISA Rights

As a participant in the Plan, you are entitled to certain federal rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all participants shall be entitled to:

1. **Receive Information about Your Plan and Benefits**
    - Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. 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 all documents governing the operation of the Plan, including copies of the latest annual report

(Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.

2. Continue Group Health Plan Coverage

- Continue health coverage for your Spouse if there is a loss of coverage under the Plan as a result of a qualifying event. However, your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

3. 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and beneficiaries. No one, including your Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

4. Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents 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 that 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 relations order or a 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 U.S. 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 (e.g., if it finds your claim is frivolous).

5. Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employment Benefit Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employment Benefit Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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 Employment Benefit Security Administration.

Timeframe in Which to Bring Legal Action

Legal action to recover under this Plan must be started no later than twelve (12) months from the date of the Plan Administrator's decision on your appeal (or if no decision on your appeal is furnished within 120 days after receipt by the Plan Administrator of your appeal, twelve (12) months from the 120th day after the Plan Administrator receives your appeal). This deadline may be extended for up to one year as a result of the COVID-19 National Emergency. If you have any questions regarding whether an extension applies to you, please contact the Plan Administrator.

Required Plan Information

Name, Address, and Telephone Number of the Company/Plan Sponsor:	Trane Technologies Company 800-E Beaty Street Davidson, NC 28036
Name, Address, and Telephone Number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more committees.	Trane Technologies Company Attn: Benefits Administration Committee 800-E Beaty Street Davidson, NC 28036
Address for Service of Legal Process:	Corporation Service Company 251 Little Falls Drive Wilmington, DE 19808 866-403-5272 Service of legal process can also be made on the Plan Administrator
Company's Federal Tax Identification Number:	13-5156640
Plan Number:	593
Original Effective Date of the HRA:	January 1, 2013
Plan Year:	January 1 – December 31
Third Party Administrator:	VIA Benefits
Claims Administrator	VIA Benefits P.O. Box 981156 El Paso, TX 79998-1156
COBRA Administrator	VIA Benefits
How is the HRA funded?	General Assets

TRANE TECHNOLOGIES COMPANY LLC POST-65 RETIREE MEDICAL HEALTH REIMBURSEMENT

ACCOUNT FOR LEGACY TRANE EMPLOYEES/RETIREES

SCHEDULE A

Eligibility for Company Subsidized Retiree Medical Coverage For Legacy Trane Retirees

Eligibility

Note: The description of eligibility provisions under the pre-65 Trane Technologies Retiree Medical Plan below is reprinted here solely for purposes of eligibility determinations under the HRA benefit described herein.

If you retired prior to January 1, 2004

Generally, you were eligible for Company-subsidized retiree medical coverage if you:

- Were at least age 55 with 10 or more years of service, or age 65 (regardless of years of service), when you retired from the Company, and
- Were a full-time salaried or non-union hourly employee (regularly scheduled to work at least 35 hours per week) on or after the date you first met the age and service requirements.
- If you retired prior to January 1, 2004 and on or after January 1, 1986, the Company paid a portion of the cost for retiree medical for you and your covered dependents determined as follows:
  - If you were at least 55 and had 20 or more years of service when you retired, the Company paid 40% of the cost for retiree medical.
  - If you were at least 55 and had 10 but less than 20 years of service, or were age 65 or older with less than 10 years of service, when you retired, the Company paid 20% of the cost for retiree medical.
- Generally, if you retired prior to 1986 and were eligible for subsidized retiree medical coverage, the Company pays 100% of the cost for your pre-65 retiree medical coverage, and you pay 100% of the cost for post-65 coverage.

If you retire on or after January 1, 2004

You were eligible to participate in Company-subsidized retiree medical coverage, if you were a full-time salaried or non-union hourly employee (regularly scheduled to work at least 35 hours per week) on or after the date you first met the age and service requirements, and

- Retired prior to January 1, 2010 when you were at least 55 years old with three or more years of service, or

- Were employed by the Company or an affiliate (i.e., you had not incurred a break-in-service as defined in the Trane Technologies Pension Plan One ("Plan One")) on January 1, 2010, and

    - participated in the Trane Retiree Medical Choice program on December 31, 2009,

    - met the Rule of 50 on January 1, 2010 (age and "service", as defined below, equal at least 50), and

    - were at least 55 years old with 3 or more years of service when you retired from the Company

Please note that if you were at least 55 years old with at least three, but less than ten years of service when you retired, you are eligible for the retiree medical subsidized plan design (i.e., the PPO design), but you must pay the full cost of such coverage yourself as you are not eligible for any Company subsidy. Because you are not eligible for a Company subsidy under the pre-65 Trane Technologies Retiree Medical Plan you are not eligible to participate in the HRA.

- Years of service for eligibility and the Rule of 50 is defined under Trane Technologies Company Pension Plan Number One ("Plan One") as Years of Vesting Service. Generally, you earn a year of service for each year you are employed by the Company or an affiliate. You earn 1/12 of a year of service for each month where you work at least one day. Service also includes any periods of absence of less than one year. It also includes service with an acquired company prior to the date of acquisition to the extent either Plan One or the applicable sales agreement specifically provides that service with the acquired company counts as service under this Plan or Plan One.

- Service prior to January 1, 2010 is as defined under the Trane Savings Plan. Service with Trane (as defined under the Trane Savings Plan) is only treated as years of service for retiree medical eligibility to the extent you were an employee of Trane (or one of its ERISA affiliates) on June 5, 2008.

- Your age and years of service while disabled and receiving Company provided long-term disability benefits also count towards eligibility for retiree medical provided your disability started prior to January 1, 2010.

Ineligible classes of Employees/Retirees:

- You were not eligible for Company provided subsidized retiree medical coverage if:

    - You were an employee or former employee of a business sector that was sold and the terms of the sale agreement provided for the buyer to assume all responsibility for providing retiree medical benefits

    - Effective January 1, 2013, you (or your eligible dependents) are age 65 or over.

In addition, only those individuals who are your dependents (as defined below) as of the later of December 31, 2010 or the date you terminate employment are eligible dependents.

Retiree Medical Subsidy Account (RMSA)

For those legacy Trane employees who retire on or after January 1, 2004 and are not eligible for the "Transitional Alternative" subsidy described below, the Company's subsidy for the cost of Company provided retiree medical benefits is limited to the value of your Retiree Medical Subsidy Account (the "RMSA"). You (or your dependents) may use your RMSA balance to offset part of the cost of your retiree medical coverage through Trane Technologies or, effective January 1, 2013 to offset the cost of post-65 individual Medicare supplemental coverage purchased through VIA Benefits, provided on the date you terminate employment you are:

- Age 55 with at least 10 years of service, or
- Age 65 with at least three years of service.

There are circumstances where your RMSA may be forfeited. You should consult the RMSA SPD for further information on the circumstances under which you will forfeit your entitlement to your RMSA.

You should also consult the RMSA SPD for information about how the value of your RMSA is determined.

Transitional Alternative

If you retired prior to January 1, 2009, and on or after January 1, 2004, you were eligible for the RMSA described above, provided you met the eligibility requirements for use of the RMSA. You were also eligible for a "Transitional Alternative" in lieu of the RMSA if you chose to participate in the RMSA during the July 2003 retirement choice election period. Under the Transitional Alternative, the Company pays a portion of the cost for retiree medical for you and your covered dependents as follows:

- If you were at least 55 and had 20 or more years of service when you retired, the Company pays 40% of the 2003 cost for retiree medical plus a portion of any increase in cost in subsequent years, with the Company's contribution not to increase by more than 5% in any year.
- If you were at least 55 and had 10-19 or more years of service, or were age 65 or older with less than 10 years of service when you retired, the Company pays 20% of the 2003 cost for retiree medical plus a portion of any increase in cost in subsequent years, with the Company's contribution not to increase by more than 5% in any year.

What Happens if You are Rehired While Enrolled in Retiree Medical Coverage:

If you are rehired by the Company or an affiliate while you are enrolled in retiree medical coverage, you and your eligible dependents will not be eligible to participate in this Plan during the period that you are re-employed by the Company, or an affiliate.

If You Transferred To/Or From A Union Position

If you transferred to a union position, you were no longer eligible for this Plan. If you transferred from a union position to a salaried position after January 1, 2010 you will be eligible for subsidized retiree medical only to the extent: (1) the union offered subsidized retiree medical on January 1, 2010; (2) you met the Rule of 50 on that date; and (3) you subsequently retired having met the age and service requirements for the business unit from which you retire.

If You Terminate Employment and are Rehired

If you met the eligibility requirements described above but terminated employment before meeting the age and service requirements applicable to the subsidized retiree medical coverage, you remain eligible for the subsidized retiree medical options provided you:

- Were rehired as a non-union employee, and
- Met the age and service requirements for the subsidized retiree medical coverage when you subsequently terminated employment with the Company.

However, if you terminated employment on or after January 1, 2010, you must return to active employment with the Company within 12 months of the date you terminated employment to remain eligible for satisfying the requirements of subsidized retiree medical coverage.

Your prior age and service will not be considered for purposes of qualifying for retiree medical coverage (i.e., you are treated as a new hire for retiree medical) if you terminated employment with Trane (or one of its affiliates) prior to June 5, 2008 and were rehired by the Company after that date. This rule does not apply to you however if you were receiving Company provided long term disability benefits on your date of termination and continued to receive Company provided long term disability benefits through June 5, 2008.

- If both you and your Spouse are retired from the Company, either you or your Spouse may enroll as a dependent, or you may each enroll as a retiree, but you may not be covered both as a retiree and as a dependent.
- You may be covered under only one Company-sponsored retiree medical plan (e.g., you were eligible for both a union retiree medical plan plus this Plan).
- No person may be covered as a dependent of more than one eligible retiree.
- If your Spouse is an employee of the Company or one of its affiliates and also eligible for their own HRA, they cannot be covered as an eligible Spouse for purposes of the HRA.

ACCOUNT FOR LEGACY INGERSOLL RAND EMPLOYEES/RETIREES

SCHEDULE B

Note: The description of eligibility provisions under the pre-65 Ingersoll Rand Retiree Medical Plan below is reprinted here solely for purposes of eligibility determinations under the HRA benefit described herein.

You were eligible to participate in Company-subsidized retiree medical options prior to attaining age 65, if you:

- Were actively employed by the Company or an affiliate (including being on an approved leave of absence, receiving short- or long-term disability benefits or on layoff as defined in under the Ingersoll-Rand Pension Plan One (Plan One) on January 1, 2003 and were working for a business unit that offered subsidized retiree medical coverage on that date; and
- Met the Rule of 50 age and service requirements as of January 1, 2003 (i.e., age and "service:, as defined below, equal at least 50) , and
- Were at least age 55 with 15 or more years of service when you retire from the Company; and You are not a member of an Ineligible Class of Employees as defined below.

Special Age & Service Rules for Thermo-King Employees

If you were a Thermo-King employee on January 1, 2003, your age and service requirements for subsidized retiree medical coverage were:

- Age 58 with 30 or more years of service,
- Age 60 with 10 or more years of service, or
- Age 65 with 3 or more year of service

You were also eligible if you terminated employment prior to January 1, 2003, worked for a business unit that offered subsidized retiree medical coverage when you terminated employment, met the age and service requirements in effect for your business unit at that time and either enrolled in coverage upon retirement or exercised your one time right to defer coverage until a later date.

Ineligible Classes of Employees/Retirees:

You were not eligible for retiree medical if:

- You retired prior to January 1, 2011 and you were first enrolled in Company-sponsored COBRA coverage;
- You retired prior to January 1, 2010 and you were not enrolled in a Company-sponsored medical plan for active employees immediately prior to the date you retired;
- You were an employee of a business sector that was sold and you were not retired from the Company on or before the date of the sale; or
- You were an employee or former employee of a business sector that was sold and the terms of the sale agreement provided for the buyer to assume the responsibility for providing retiree medical benefits.
- Effective January 1, 2013, you (or your eligible dependents) are age 65 or over.

Dependents acquired after you retire or terminate employment are not eligible dependents. If you terminated employment prior to January 1, 2010, only those dependents who you covered under the Company's active medical coverage at the time you terminated employment were eligible dependents for purposes of retiree medical coverage.

What Happens if You were Rehired While Receiving Retiree Medical Coverage
If you are rehired by the Company, or an affiliate, while you are enrolled in retiree medical coverage, you and your eligible dependents will not be eligible to participate in this Plan during the period that you are re-employed by the Company, or affiliate.

Years of Service Defined:
Years of Service for purposes of eligibility and the Rule of 50 is defined under the Trane Technologies Pension Plan Number One ("Plan One") as "Years of Vesting Service." Generally, you earn a year of service for each year you are employed by the Company or an affiliate. You earn 1/12 of a year of service for each month where you work at least one day. Service also includes any periods of absence of less than one year. It also includes service with an acquired company prior to the date of acquisition only to the extent either Plan One or the sales agreement specifically provides for such service to count as Years of Vesting Service, as determined solely by the Company. Your age and years of service while disabled and receiving company provided long-term disability benefits also count towards eligibility for retiree medical, provided your long-term disability payments started prior to January 1, 2004.

If You Transferred to Another Business Unit on or After January 1, 2003
Your eligibility is based on the rules that apply to the business sector where you were employed on January 1, 2003. For example, if you were employed at Corporate Center on January 1, 2003 and subsequently transferred to Thermo-King or a business sector that did not offer Company-subsidized retiree medical (e.g., Club Car), you would be subject to the age 55 and 15 years of service requirement that applies to Corporate Center employees when you retire.

If You Transferred To / Or From A Union Position
If you transfer to a union position prior to meeting the age and service requirements, you were no longer eligible for coverage under this Plan. If you transferred from a legacy Ingersoll Rand union position to a salaried position on or after January 1, 2003 you would be eligible for subsidized retiree medical only to the extent the union offered subsidized retiree medical on January 1, 2003, you met the Rule of 50 on that date and you subsequently retired having met the age and service requirements for the business unit from which you retire.

If You Terminate Employment and are Rehired
If you met the eligibility requirements described earlier but terminated employment (including pursuant to a divestiture) before meeting the age and service requirements (as defined above), you remain eligible for the subsidized retiree medical coverage provided you:

- Were rehired* as a full-time non-union employee, and
- Met the age and service requirements when you subsequently terminate employment with the Company.

*If you terminate employment on or after January 1, 2012, you must return to active employment with the Company within 12 months of the date of your termination to remain eligible for subsidized retiree medical coverage.
If both you and your spouse are retired from the Company, either you or your spouse may enroll as a dependent, or you may each enroll as a retiree, but you may not be covered both as a retiree and as a dependent.

- You may be covered under only one Company-sponsored retiree medical plan (e.g., you were eligible for both a union retiree medical plan plus this Plan).
- No person may be covered as a dependent of more than one eligible retiree.
- Your child(ren) may be covered as an eligible dependent of you or your spouse, but not both.
- If your child is an eligible employee, he or she cannot be covered as a dependent under this Plan.

Important Notice from the Trane Technologies Post-65 Retiree Medical Health Reimbursement Account 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 Trane Technologies Post-65 Retiree Medical Health Reimbursement Account and about your options under Medicare's prescription drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are three 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. **The Trane Technologies Post-65 Retiree Medical Health Reimbursement Account is a health reimbursement account only, and it does not constitute creditable prescription drug coverage. The individual Medicare supplement coverage that you can purchase using your Reimbursement Account may offer creditable prescription drug coverage.** You should review such policy very carefully to determine whether the prescription drug coverage offered can be expected to pay out as much as standard Medicare prescription drug coverage pays. Your coverage under the Trane Technologies Post-65 Retiree Medical Health Reimbursement Account, which does not take into account coverage you may receive under the Medicare supplement insurance you purchase, is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Trane Technologies Post-65 Retiree Medical Health Reimbursement Account. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Trane Technologies Post-65 Retiree Medical Health Reimbursement Account. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join a Medicare Drug Plan?

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

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

Since the coverage under the Trane Technologies Post-65 Retiree Medical Health Reimbursement Account, is not, by itself, creditable, depending on whether and, if so how long, you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current Trane Technologies Post-65 Retiree Medical Health Reimbursement Account coverage will not be affected. You will still be entitled to the Reimbursement Account benefits described above.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact VIA Benefits at 1-866-322-2824 (TTY: 711), Monday – Friday 8am-7pm EST.

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).

Contact Information:

Date: April 1, 2022

Name of Entity/Sender: Benefits Administration Committee of Trane Technologies Company LLC

Contact--Position/Office: Chair, Benefits Administration Committee of Trane Technologies Company LLC

Address: Benefits Administration Committee of Trane Technologies Company LLC
800-E Beaty Street
Davidson, NC 28031

Phone Number: 1-866-472-6793