StanleyBlack&Decker

2023 Changes to Under 65 Retiree Health Plans & Legal Notices

Contents

2023 Changes to Under 65 Retiree Health Plans

The health plan changes outlined below are being made to active employee plans so we are extending these changes to the under 65 retiree plans that mirror the active plan design.

Medical Options

Here's an "at-a glance" look at what's changing for 2023:

- **More Choices for Great Care – Introducing LocalPlus OAP, a Narrow In-Network Only Medical Option**

  The LocalPlus OAP option has a more limited network that the OAP option and doesn't have an out-of-network component, but otherwise works the same way the OAP option does—with significantly lower contributions. You're only eligible if you live in a place with enough network providers. Current service areas are in Arizona, California, Colorado, Florida, Georgia, Illinois, Kansas, Maryland, Massachusetts, Missouri, Nevada, New Jersey, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah and Washington. If you reside in one of these states and would like to check your eligibility, call the SBD Benefits Center between Nov. 2 – Nov. 16 to confirm if you're eligible for the LocalPlus OAP medical option.

  You must receive care from a health care provider or facility in the LocalPlus Network for services to be covered. If you choose to go outside the LocalPlus Network, your care will not be covered by the plan (except in an emergency). You'll be responsible for the total cost of services if receiving out-of-network services.

  If you are considering this option, be sure to confirm if your provider(s) are in the LocalPlus Network or consider switching to an in-network provider before selecting this coverage option.

  Confirm if your provider(s) are in network one of two ways:
  - Go to Cigna.com and click on Find a Doctor
  - Call Cigna anytime at 800-243-3280

- **Cigna Virtual Care (Telehealth) Benefits through MDLIVE**

  Cigna Virtual Care (Telehealth) services through MDLIVE range from urgent medical and dental care to preventive wellness screenings, primary care, dermatology and behavioral health care. Effective Jan. 1, 2023, telehealth preventive care services through MDLive will continue to be covered at 100% under all Cigna medical options. Medical and dental urgent care, primary care and behavioral health care including both therapy and psychiatrist visits through MDLive will be covered at 100% (after deductible for HSA options). Dermatological services and other specialty care services through MDLIVE will be subject to your medical option's deductible and coinsurance.

- **Prescription Drug Changes**

  Effective Jan. 1, 2023, we will move to Cigna's Preventive Plus Medication Program which includes a full range of drugs including all those required under applicable health care laws. Continuous Glucose Monitors Supplies (CGMs) including readers, receivers, sensors and therapeutic transmitters are included (before deductible under the HSA medical options). This change will not have any impact on the medications you are currently taking. To check which drugs are included in your plan, log on to myCigna.com and use the Price a Medication tool to see how much your medication costs.

If You Do Not Actively Make a 2023 Medical Plan Election

If you do not actively elect 2023 medical coverage during the Annual Enrollment period, your 2022 coverages will roll over into 2023.

Medical Coverage at a Glance

	BASIC HSA		PLUS HSA		OAP*		LOCALPLUS OAP**	
	Employee only	Family	Employee only	Family	Employee only	Family	Employee only	Family
HSA COMPANY CONTRIBUTIONS								
All salary bands	$250	$500	$500	$1,000	N/A		N/A	
MEDICAL DEDUCTIBLE	Plan includes a combined medical/pharmacy deductible.		Plan includes a combined medical/pharmacy deductible.		Deductible applies to some but not all medical expenses.		Deductible applies to some but not all medical expenses.	
In-network	$2,500	$5,000	$1,750	$3,500	$700	$1,400	$700	$1,400
Out-of-network	$5,000	$10,000	$3,500	$7,000	$1,400	$2,800	N/A	N/A
OUT-OF-POCKET MAXIMUM								
In-network	$5,500	$11,000***	$4,500	$9,000***	$3,500	$7,000	$3,500	$7,000
Out-of-network	$11,000	$22,000	$7,000	$14,000	$7,000	$14,000	N/A	N/A
PLAN-YEAR COINSURANCE (what the plan pays)								
In-network	70%		80%		80%		80%	
Out-of-network	50%		50%		50%		N/A	

**Depending on your home ZIP code, you may be eligible to choose Cigna's LocalPlus® OAP option, an in-network only option (LocalPlus Network) that offers significantly lower contribution rates than the regular OAP.*

***Under the OAP option, copays do not count towards the deductible, but do count towards the out-of-pocket maximum.*

****Once an individual with family coverage meets the individual OOP maximum of $8,150, the plan will pay 100% of all covered expenses for that person, even if the family maximum has not been met. Once the family OOP maximum is reached the plan must pay 100% of all covered expenses for every covered individual — regardless of whether each family member has reached the individual maximum.*

	BASIC HSA		PLUS HSA		OAP		LOCALPLUS OAP	
	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*
OFFICE/OUTPATIENT SERVICE (what the plan pays)**								
Adult preventive care	100%		100%		100%		100%	
Office visit	70%	50%	80%	50%	100% after $25 copay	50%	100% after $25 copay	N/A
Specialist visit	70%	50%	80%	50%	100% after $50 copay	50%	100% after $50 copay	N/A
Prenatal care	70%	50%	80%	50%	80%	50%	80%	N/A
Chiropractic care	70%	50%	80%	50%	100% after $50 copay	50%	100% after $50 copay	N/A
Outpatient therapy***	70%	50%	80%	50%	100% after $50 copay	50%	100% after $50 copay	N/A
Physical therapy***	70%	50%	80%	50%	100% after $25 copay	50%	100% after $25 copay	N/A
Well-child care	100%		100%		100%		100%	N/A
Lab and radiology	70%	50%	80%	50%	100% after copay (doctor's office) 80% (outpatient/ independent facility)	50%	100% after copay (doctor's office) 80% (outpatient/ independent facility)	N/A
HOSPITAL CARE (what the plan pays)								
Inpatient hospitalization	70%	50%	80%	50%	80% after $200 copay	50%	80% after $200 copay	N/A
Outpatient surgery	70%	50%	80%	50%	80% after $100 copay	50%	80% after $100 copay	N/A
Emergency room	70%		80%		80%		80%	80%****
Urgent care center	70%		80%		$50 copay per visit		$50 copay per visit	N/A
Ambulance	70%		80%		80%		80%	80%****
MENTAL HEALTH AND SUBSTANCE USE (what the plan pays)								
Inpatient (unlimited day maximum)	70%	50%	80%	50%	80% after $200 copay	50%	80% after $200 copay	N/A
Outpatient	70%	50%	80%	50%	$25 (doctor's office) 80% (outpatient/ independent facility)	50%	$25 (doctor's office) 80% (outpatient/ independent facility)	N/A
HEARING AID COVERAGE								
Hearing aid equipment/devices	Up to $3,000 maximum every 3 years+	N/A	Up to $3,000 maximum every 3 years+	N/A	Up to $3,000 maximum every 3 years+	N/A	Up to $3,000 maximum every 3 years+	N/A
PRESCRIPTION DRUG COVERAGE								
	30-day supply	90-day supply	30-day supply	90-day supply	30-day supply	90-day supply	30-day supply	90-day supply
Generic	100% after $12 copay	100% after $24 copay	100% after $12 copay	100% after $24 copay	100% after $12 copay	100% after $24 copay	100% after $12 copay	100% after $24 copay
Preferred brand	75% after copay min. $35/max. $95	80% min. $70/max. $190	75% after copay min. $35/max. $95	80% min. $70/max. $190	75% after copay min. $35/max. $95	80% min. $70/max. $190	75% after copay min. $35/max. $95	80% min. $70/max. $190
Non-preferred brand	65% after copay min. $55/max. $115	70% min. $110/max. $230	65% after copay min. $55/max. $115	70% min. $110/max. $230	65% after copay min. $55/max. $115	70% min. $110/max. $230	65% after copay min. $55/max. $115	70% min. $110/max. $230
	(after deductible)		(after deductible)		(no deductible)		(no deductible)	

Note: Pre-existing conditions are covered under all medical plans.

**The plan will pay the percentage shown for covered services that do not exceed the plan's maximum reimbursable charge.*

***All coinsurance percentages except 100% are after the deductible.*

****Covers unlimited days of pulmonary rehab, cognitive therapy, physical therapy, speech therapy, occupational therapy and cardiac rehab. Approval is subject to medical necessity review. Chiropractic care is covered up to 20 days per calendar year.*

*****Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider. Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.*

+Includes testing and fitting of hearing aid devices at Physician Office cost share ; in-network benefit only

Medical/Rx ID Card

You will receive a new ID card for 2023 for SBD Cigna medical plan coverage, even if currently enrolled in 2022 and continuing coverage into 2023. ID cards will mail out in mid-December.

Prescription Drug Plan

Effective Jan. 1, 2023, we will move to Cigna's Preventive Plus Medication Program which includes a full range of drugs including all those required under applicable health care laws. With this change, Continuous Glucose Monitors Supplies (CGMs) including readers, receivers, sensors and therapeutic transmitters will be covered (before deductible under the HSA medical options). This change will not have any impact on the medications you are currently taking and there will be no change to the copays for generic, preferred and non-preferred brand prescription drugs.

- Retail (30-day supply)
    - Generic - $12
    - Preferred Brand Name - 25% ($35 min, $95 max)
    - Non-Preferred Brand Name – 35% ($55 min, $115 max)
- Retail 90 and Express Scripts Pharmacy (90-day supply)
    - Generic - $24
    - Preferred Brand Name – 20% ($70 min, $190 max)
    - Non-Preferred Brand Name – 30% ($110 min, $230 max)

To check which drugs are included in your plan, log on to myCigna.com and use the Price a Medication tool to see how much your medication costs.

Save on Your Prescriptions

- Take advantage of convenient money-saving prescription drug programs through in-network retail or home delivery pharmacy options. The **Cigna90 Now program** makes it easier to fill your maintenance medications in a 90-day supply or you may choose the convenience of home delivery through **Express Scripts Pharmacy Home Delivery**. Your plan only allows a certain number of fills in a lesser amount. Once you run out of those fills, your plan coverage will only apply to your medication if you fill it in a 90-day supply.
- Use the **Prescription Drug Price Quote Tool** on myCigna.com to estimate your medication costs and review lower-cost options.
- **Rx Savings Solutions** is ready to assist you with savings opportunities. Enroll in your account at myrxss.com or call 1-800-268-4476 Monday through Friday, 7 a.m. – 8 p.m. CT. Rx Savings Solutions' Pharmacy Support team is staffed with certified pharmacy technicians ready to assist you.
- **Insulin Cost Cap Patient Assurance Program** makes certain diabetes medications more affordable by capping the out-of-pocket costs ($25 for 30-day supply and $75 for 90-day supply via mail order). Contact Cigna at 1-800-243-3280 to learn more and verify which medications are eligible.
- **SaveonSP** is a specialty medication program for those in the OAP/LocalPlus OAP options only, helping to lower out-of-pocket costs on select specialty medications to $0 (requires first specialty fill via mail order with Accredo, a Cigna-owned company).

Dental Options

In 2023, there will be no changes to your Cigna dental options. You may have up to three dental options to choose from, depending on your home zip code — the Cigna Dental PPO Basic Preferred Provider Organization (Basic PPO), the Cigna Dental Plus Preferred Provider Organization (Plus PPO) and the Cigna Dental HMO (DHMO) option. You may receive materials in the mail from Cigna if DHMO providers are in your local area to help you consider your dental options and the cost savings available to you.

Dental Coverage at a Glance

	Cigna Dental Basic PPO		Cigna Dental Plus PPO		Cigna DHMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Calendar Year Maximum	$1,000	$1,000	$2,000	$2,000	No Maximum
Orthodontia Lifetime Maximum	N/A		$2,500	$2,500	No Maximum
Annual Deductible* (does not apply to Class I services) ▪ Employee Only ▪ All other coverage categories	 $100 $200	 $200 $400	 $50 $100	 $100 $200	None
Class I – Preventive/Diagnostic** (exams, cleaning, etc.)	100%, no deductible	100%, no deductible	100%, no deductible	100%, no deductible	You incur no charge for routine cleaning, x-rays, oral exams, topical fluoride
Class II – Basic Restorative (fillings, root canals, etc.)	80% after deductible	70% after deductible	90% after deductible	80% after deductible	The DHMO sets the cost for services based on a Patient Charge Schedule (PCS). The PCS is a list of fees for each covered service within the plan. Refer to the DHMO Charge Schedule available on uCentral https://ucentral.stanleyblackanddecker.com
Class III – Major Restorative (crowns, dentures, bridges, implants)	50% after deductible	40% after deductible	60% after deductible	50% after deductible	
Class IV – Orthodontia (available for children and adults)	Orthodontia Not Covered		60% after deductible, up to $2,500 lifetime maximum (combined in- and out-of-network)	50% after deductible, up to $2,500 lifetime maximum (combined in- and out-of-network)	
Class V: TMJ	50% after deductible	40% after deductible	60% after deductible	50% after deductible	

**In- and out-of-network deductibles and maximums cross-accumulate. If you receive preventive dental care in a Plan year, your annual dental maximum will increase by $50 in the following year (up to a maximum of $150 after three years).*

***If you have certain chronic medical conditions (such as heart disease, diabetes, kidney disease, etc.), you may be eligible for enhanced dental coverage once you complete a registration form on www.myCigna.com or call Cigna at 1-800-243-3280.*

Support in Choosing Medicare Coordinated Healthcare Coverage

Mercer Marketplace 365+ Retiree

Mercer Marketplace 365+ Retiree offers a service to assist our post 65 retirees in choosing healthcare coverage from a variety of individual health insurance options based on where they live. Under this approach, post 65 retirees (and their post 65 eligible dependents), will be able to choose from a variety of healthcare coverages that best fit their individual needs and their budget. Benefits counselors are available year-round to answer questions, provide support and assist retirees through the entire healthcare coverage decision-making process.

Prior to your turning age 65, Mercer Marketplace 365+ Retiree will send a packet of materials to your home providing instructions on how to connect with a benefits counselor and how to enroll in a benefit plan that fits your needs and your budget. Once you receive your packet of information, you can schedule your benefits consultation by calling 1-855-216-3809. Benefits counselors are available Monday through Friday from 8:00 a.m. to 5:30 p.m. Eastern Time; deaf or hard of hearing individuals should dial 711 for Telecommunications Relay Service.

Important Notice About Your Prescription Drug Coverage and Medicare

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

If you are covered as a retiree or dependent under the Stanley Black & Decker Pre-65 Retiree Medical Plan, your coverage under that plan will terminate at age 65. At that time you should enroll in Medicare. If you do not enroll in Medicare at that time you maybe be subject to late enrollment penalties. If you become covered under Medicare prior to age 65 due to a determination by the Social Security Administration that you are disabled or become covered under Medicare due to end stage renal disability, your coverage under the Stanley Black & Decker Pre-65 Retiree Medical Plan will continue but you should still enroll in Medicare Part B to avoid late enrollment penalties. Furthermore, the Stanley Black & Decker Pre-65 Retiree Medical Plan will pay benefits as if you are enrolled in Medicare Part B and will pay benefits secondary to Medicare, as allowed by law.

If you are entitled to Medicare due to disability or end stage renal disease, you are eligible to enroll in a Medicare prescription drug plan (also known as a Part D plan) . You should enroll in a Part D plan as soon as you are eligible because the Stanley Black & Decker Pre-65 Retiree Medical Plan will pay prescription drug benefits as if you are enrolled in a Part D plan and will pay benefits secondary to the Part D plan, as allowed by law.

Please note that the prescription drug coverage provided under the Stanley Black & Decker Pre-65 Retiree Medical Plan is expected to pay out, on average, at least as much as the

standard Medicare prescription drug coverage will pay in 2023. This is known as "creditable coverage." You may decide to enroll in a Medicare prescription drug plan and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

Please read this notice carefully. It has information about retiree prescription drug coverage with Stanley Black & Decker and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Why this is important. If you or your covered dependent(s) are enrolled in the Stanley Black & Decker Pre-65 Medical Plan and are, or become, covered by Medicare, you may decide to wait until later to enroll in a Medicare prescription drug plan and not be subject to a late enrollment penalty – as long as you enroll in a Medicare prescription drug plan within 63 days of losing your medical coverage under the Stanley Black & Decker plan. You should keep this notice with your important records.

Notice of Creditable Coverage

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage is available to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan (Part D) 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. Stanley Black & Decker has determined that the prescription drug coverage offered by the Stanley Black & Decker Pre-65 Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. **Because your existing Stanley Black & Decker prescription drug coverage (if enrolled) is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. When you enroll in a Part D Prescription plan, you must enroll within 63 days of losing your Stanley Black & Decker prescription drug coverage.**

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

Your current Stanley Black & Decker coverage pays for other health expenses in addition to prescription drugs. If you are eligible to enroll in a Medicare prescription drug plan, your Stanley Black & Decker coverage may or may not be affected, as follows.

If you enroll in a Medicare prescription drug plan, you and your dependents continue to be eligible for benefits under the Stanley Black & Decker Pre-65 Retiree Medical Plan. You will still be eligible to receive retiree medical and prescription drug coverage if you choose to enroll in a Medicare prescription drug plan. Regardless of whether you enroll in a Part D plan, if you are eligible to, the Stanley Black & Decker Pre-65 Retiree Medical Plan will pay secondary to Medicare, where allowed by law. If you waive or drop Stanley Black & Decker coverage, Medicare will be your only payer.

If you waive or drop Stanley Black & Decker coverage and enroll in Medicare prescription drug coverage, Medicare will be your only payer. You cannot re-enroll in the Stanley Black & Decker plan at annual enrollment or any other time.

If you waive or drop Stanley Black & Decker coverage and enroll in Medicare prescription drug coverage, Medicare will be your only payer. You cannot re-enroll in the Stanley Black & Decker plan at annual enrollment or any other time.

If you are a ***COBRA beneficiary*** and you decide to enroll in a Medicare prescription drug plan, your current Stanley Black & Decker coverage will be terminated. In that case, Medicare will be your only payer, and you will not be able to re-enroll in the Stanley Black & Decker plan. However, other COBRA beneficiaries will not be affected by your enrollment in Medicare. For them, the Stanley Black & Decker plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan, for as long as they remain eligible and pay the premiums for COBRA.

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

You should also know that if you drop or lose your current coverage with Stanley Black & Decker and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

For further information about your current Stanley Black & Decker prescription drug coverage, contact:

The Stanley Black & Decker Benefits Center
1-800-795-3899
www.sbdbenefitscenter.com/welcome

NOTE: You'll get this notice each year. You will also get it before or during the next period you can join a Medicare drug plan, and if this coverage through Stanley Black & Decker changes. You also may request a copy of this notice at any time. The notice is also posted to www.sbdbenefitscenter.com/welcome.

For More Information About Your Options Under Medicare Prescription Drug Coverage

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.ssa.gov or call 1-800-772-1213 (TTY: 1-800-325-0778).

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 a copy of the Medicare & You handbook for the telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date: October 15, 2022
Name of Entity/Sender: Stanley Black & Decker, Inc.
Address: 1000 Stanley Drive
New Britain CT 06053
Phone Number: (860) 225-5111

Summary of Benefits and Coverage (SBC)

A Summary of Benefits and Coverage (SBC) is required under Health Care Reform for each of the medical plan options. SBCs describing each plan are posted at uCentral. The SBCs summarize important plan information in a standard format to help you make a comparison of the features and benefits of each option available to you. To access the SBCs, visit www.sbdbenefitscenter.com/welcome. Search using keyword “SBC.” A Uniform Glossary defining the terms used in the SBCs is also available.

You may also obtain a paper version of the SBCs for any of the medical plan options, free of charge, by contacting the Stanley Black & Decker Benefits Center at 1-800-795-3899. Representatives are available from 8 a.m. to 8 p.m. Eastern Time, Monday through Friday.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924 Email: HIPPcustomerservice@dmas.virginia.gov
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 855-294-2127 or (307) 777-7531

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Outbreak Period Notice

Timing Extensions Expiring For COBRA Coverage and ERISA Claim and Appeals

The U.S. Department of Labor and IRS announced temporary extensions of certain plan deadlines during the COVID-19 pandemic. Under these extensions, plan participants were given extra time to file ERISA claims and appeals, receive notifications about COBRA elections, and make COBRA premium payments.

This temporary extension became effective on March 1, 2020 and created individual extension deadlines.

What this means for you and your family

During the period that began March 1, 2020 to present, individual timing extensions can only be extended for a maximum of 12 months. If the original deadline would have been on or after March 1, 2020, your new deadline will now be one-year from your original deadline. For example, if you would have been required to notify the plan of a COBRA event (i.e., divorce) by July 1, 2021, your deadline to request an election change under the HIPAA rules will now be June 30, 2022.

Your deadline could end sooner than one year once the National Emergency declaration ends. At the time of this notice, the National Emergency declaration remains ongoing. However, the extensions described here will only last for the *shorter* of the following two periods: one year from your original deadline, or the period between your deadline (if after 3/1/20) and 60 days following the end of the National Emergency declaration.

If you delayed any of the following due to your timing extension, **you should act quickly, or you may lose your ability to exercise your rights under the plan for:**

- Filing an ERISA claim or appeal; or
- Enrolling in or making premium payment(s) for your COBRA continuation coverage

If you did not experience a COBRA qualifying event, or did not have the need to file an ERISA claim or appeal, you do not need to take any action.

Contact HealthEquity|WageWorks regarding COBRA coverage at 1-866-747-0039.

Newborns & Mothers Health Protection Rights Notice

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

Women’s Health and Cancer Rights Act Notice

Federal law requires that group health plans provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

All stages of reconstruction of the breast on which the mastectomy has been performed,

Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and related services will be subject to the same deductibles and coinsurance amounts under the Plan.

To obtain a more detailed description of the mastectomy-related benefits available under the Plan, contact Cigna at 1-800-243-3280.

HIPAA Privacy Practices — Notice of Availability

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Stanley Black & Decker healthcare plans (the "Plan") are required to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time of your enrollment in and at certain other times. In addition, the Plan is required to periodically notify you of the availability of the Notice and provide you with information on how to obtain a copy of the Notice.

You may obtain a copy of the Plan's Notice at any time by visiting www.sbdbenefitscenter.com/welcome. To request a paper copy of this notice, contact the Stanley Black & Decker Benefits Center at (800) 795-3899. To the extent that the Plan contains benefits other than those covered under HIPAA's Privacy rules, this reminder relates only to those healthcare benefits that are covered under HIPAA's Privacy rules.

Self-Service Tool – Cigna Medical Plan Options

The Stanley Black & Decker Health & Welfare Plan will provide a self-service cost transparency/price comparison tool (for 500 covered services and items as required by regulators for the plan year beginning on or after January 1, 2023, and for all covered services and items by the 2024 plan year). This internet-based self-service tool:

- Discloses personalized out-of-pocket costs for all covered healthcare items and services (with paper copies available on request)
- Gives participants an estimate of their cost-sharing liability for any in- or out of-network provider, allowing them to compare costs before receiving medical care
- Enables searching by billing code, descriptive terms, in-network provider name and other relevant factors (such as geography)
- Tracks a participant's accruals toward any cumulative treatment limitations (like day or visit limits) as well as deductibles and out-of-pocket maximums
- Must be made available by telephone

Links to the self-service tool will be provided as soon as practicable and will be available on the mycigna.com website beginning Jan. 1, 2023.