StanleyBlack&Decker

2024 Changes to Under 65 Retiree Health Plans & Legal Notices

Contents

2024 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 for the 2024 plan year. See changes called out below under each benefit.

Medical

Medical Changes:

- **Cigna Pathwell Bone & Joint Program for Musculoskeletal Concerns**

  Beginning on Jan. 1, 2024, if you are facing pain, treatment or considering surgery for musculoskeletal concerns, the Cigna Pathwell Bone & Joint program can help, available at no additional cost to you. Through this program, you can connect digitally with a personalized clinical care advocate for spine, hip, knee, or shoulder pain support. You'll receive guidance to help you make the best decisions about your care, access high quality providers and learn how to optimally use your benefits. If surgery is recommended, the program includes zero or low-cost surgery benefits, pre-and post-surgery support and a travel benefit. Plus, this new program works in conjunction with the My Medical Ally, formerly ConsumerMedical, Surgery Decision Support program if you do decide to pursue surgery. Remember that completion of the Surgery Decision Support Program is a requirement prior to undergoing an elective surgery for hip, knee, low-back, weight loss or hysterectomy. **You may receive information and direct outreach from Cigna about the Pathwell Bone & Joint program in 2024.** To learn more about this program now, visit CignaPathwellBoneandJoint.com.

- **High Tech Radiology**

  The prior authorization process for high-tech radiology services (e.g., CAT scans, PET scans, MRIs, diagnostic and nuclear cardiology) will now include a review for the appropriateness of the site of care, as well as medical necessity. The site of care review assesses when a service can be performed safely and effectively at locations other than an outpatient hospital setting without compromising quality of care. If your provider requests an outpatient hospital setting for one of these services, they will need to identify the clinical condition that warrants the need for the service to be performed at that location. If your provider is in-network with Cigna, it is their responsibility to obtain the prior authorization. You can access the radiology preauthorization list detailing the applicable procedures on the SBD Benefits Center welcome site at www.sbdbenefitscenter.com/welcome and search using keywords "Cigna Radiology." Failure to obtain the necessary prior authorization for site of care could result in high out-of-pocket costs for you.

- **Enhancements to Infertility Benefits**

  - Increase in Lifetime Fertility Maximum to $25,000, reflecting a modest increase from $20,000 in previous years.
  - Removal of the infertility diagnosis requirement prior to accessing in vitro fertilization treatment. All other exclusions apply.

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

  Cigna Virtual Care (Telehealth) services through MDLIVE range from urgent medical care to preventive wellness screenings, primary care, dermatology and behavioral health care. For the 2024 plan year, all Cigna medical options will continue to cover telehealth preventive care services through MDLive at 100% with no copay ($0) [without needing to meet the plan deductible for HSA options] for medical urgent care, primary care and behavioral health care including both therapy and psychiatrist visits. Virtual dermatological and other specialty care services through MDLIVE will be subject to your medical option's will be subject to your medical option's coinsurance [without needing to meet the plan deductible for HSA options].

If You Do Not Actively Make a 2024 Medical Plan Election

If you do not actively elect 2024 medical coverage during the Annual Enrollment period, your 2023 coverages will roll over into 2024.

Medical Provider Network

All medical options offer quality and affordable coverage provided you utilize in-network providers and facilities for healthcare services. See the chart below for networks associated with each medical option.

Medical Option	Network
Basic HSA, Plus HSA and OAP options	Open Access Plus w/Carelink
LocalPlus OAP	LocalPlus

The LocalPlus OAP option is an in-network only option with a limited network of providers and facilities and eligibility is zip code driven which sets this option apart from the other Cigna medical options. You must use a provider in the limited LocalPlus network for coverage of services to apply if enrolled in the LocalPlus OAP option. Be sure to check that your provider is in the LocalPlus network (or be willing to switch providers), if enrolling in LocalPlus OAP. Visit myCigna.com to find an in-network medical provider and select "Find a Doctor".

Medical Coverage at a Glance

	BASIC HSA		PLUS HSA		OAP[1]		LOCALPLUS OAP[2]	
	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[3]	$4,500	$9,000[3]	$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	

[1]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.

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

[3]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[1]	In-network	Out-of-network[1]	In-network	Out-of-network[1]	In-network	Out-of-network[1]
OFFICE/OUTPATIENT SERVICE (what the plan pays)[2]								
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[3]	70%	50%	80%	50%	100% after $50 copay	50%	100% after $50 copay	N/A
Physical therapy[3]	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%[4]
Urgent care center	70%		80%		$50 copay per visit		$50 copay per visit	N/A
Ambulance	70%		80%		80%		80%	80%[4]
MENTAL HEALTH AND SUBSTANCE USE [5] (what the plan pays)								
Cigna Virtual Care Through MDLive (including primary care, urgent care and behavioral care)	$0	N/A	$0	N/A	$0	N/A	$0	N/A
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.

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

[2] All coinsurance percentages except 100% are after the deductible.

[3] 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.

[4] 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.

[5] Cigna will process claims with a primary mental health/substance use diagnosis under the MH/SU cost share, regardless of the place of service.

+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 2024 for SBD Cigna medical plan coverage, even if currently enrolled in 2023 and continuing coverage into 2024. ID cards will mail out in mid-December.

Prescription Drug Plan

There are no changes to the copays for generic, preferred and non-preferred brand prescription drug as quoted below:

- 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.

Prescription Drug Changes:

- **Cigna Pathwell Specialty Program Requirement for Specialty Medications**

  Effective Jan. 1, 2024, if you're taking specialty medications, the Cigna Pathwell Specialty program may be available to you. This program focuses on providing personalized support for certain specialty medications (e.g., infusion and injectables) to help with both affordability and medication management in certain areas. The Cigna Pathwell Specialty program includes many specialty medications covered under the Cigna medical benefit which may need approval from Cigna (precertification) before they're covered, and some medications have to be administered by a provider in the **Cigna Pathwell Specialty Network** (or ordered from an in-network specialty pharmacy) to be covered. The program includes formulary and care management specialty medications and covers oncology and non-oncology drugs. To check which drugs have this requirement and to view of list of in-network providers for infused and injected medications, go to Cigna.com/pathwellspecialty. **You may receive information and direct outreach from Cigna about this program, if its applicable to you. More information will be available through Cigna starting in January.**

Save on Your Prescriptions

- Fill maintenance medications in 90-day supplies and save money with in-network retail or home-delivery pharmacy options through Express Scripts Pharmacy Home Delivery with the **Cigna90 Now program.** 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.
- The Pharmacy Support team at **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.
- **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

In 2024, you will continue to 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.

Dental Provider Network:

All dental options offer quality and affordable coverage. Keep in mind that for the dental PPO options you must use an Advantage Dental PPO dentist for in-network coverage to apply. The DHMO option is an in-network only option and eligibility is zip code driven which sets this plan apart from the PPO options. You must select a dental provider in the Dental Access Plus (DCAP) provider for DHMO services to be covered. Visit myCigna.com to find a participating dentist or if enrolled in the DHMO, a general dentist will be assigned to you after you enroll.

To request a change to your DHMO general dentist, call Cigna or logon to myCigna.com. You may change the name of your assigned dentist at any time, after you receive your Cigna DHMO ID card(s). If you change your general dentist by the 15th of the month, the change will take effect the first of the following month.

Dental Changes:

- **Enhanced Sealant Coverage.** Sealant coverage is enhanced for the 2024 plan year with coverage extended to dependents to age 19.

Note: Dental urgent care services are available virtually through The Teledentists. Coverage costs are subject to your dental option's deductible and coinsurance. Virtual dental services are accessed online at MyCigna.com or through your MyCigna app.

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)	$100 $200	$200 $400	$50 $100	$100 $200	None

	Cigna Dental Basic PPO		Cigna Dental Plus PPO		Cigna DHMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
▪ Employee Only ▪ All other coverage categories					
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 the SBD Benefits Center Welcome Site (www.sbdbenefitscenter.com/welcome)
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 9:00 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. However, if you are eligible for Medicare and do not enroll in Medicare A and B or a Medicare Part D plan, the Stanley Black & Decker plan will pay benefits secondary to Medicare, including Medicare part D, regardless of whether you enroll in Medicare.

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, 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 are a ***COBRA beneficiary*** and you enroll in Medicare, please contact the Stanley Black & Decker Benefits Center as your current Stanley Black & Decker coverage should be terminated. Once your changes are processed, 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, 2023
Name of Entity/Sender: Stanley Black & Decker, Inc.
Address: 1000 Stanley Drive
New Britain CT 06053
Phone Number: (860) 225-5111

Where to Find Updated Benefit Plan Documents

Important benefit plan documents including Summary Plan Descriptions (SPDs) and legal notices are posted electronically. SPDs, which contain important information about covered benefits and your rights and responsibilities as a Plan member, are posted on the Stanley Black & Decker Enrollment Site. Visit the SBD Benefits Center Welcome Site (www.sbdbenefitscenter.com/welcome), select Enroll Here and enter your user ID and password. Legal notices are posted on the SBD Benefits Center Welcome Site. You may request a hard copy of the SPD, free of charge, by sending an email HRBenefits@sbdinc.com.

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).

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 has provided a self-service cost transparency/price comparison tool for 500 covered services and items for the plan year beginning on or after January 1, 2023, and the tool will include 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 are available on the mycigna.com website.