StanleyBlack&Decker

STANLEY BLACK & DECKER

PROCEDURES FOR DETERMINING WHETHER A MEDICAL CHILD SUPPORT ORDER IS QUALIFIED

Section 609(a)(5)(B) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), requires group health plans to establish reasonable written procedures to determine the qualified status of medical child support orders and to administer the provision of benefits under such qualified orders. The procedures set forth in this document are intended to satisfy the requirements of ERISA Section 609(a)(5) and the regulations thereunder and are to be interpreted and administered accordingly. These procedures are subject to change without notice.

1. **Definitions:** Capitalized terms in these procedures carry the same meaning as they do in the applicable group health plan, except that the following terms have the following meanings:

(a) "Alternate Recipient" means any child of a Plan Participant (including an adopted child or child placed for adoption) who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to the Participant.

(b) "Plan Participant" means an individual who is participating in the Plan, including an individual who is eligible to enroll in the Plan but has not yet enrolled.

(c) "Plan" means any one or more group health plan(s) sponsored by Stanley Black & Decker (the "Company") to provide group health benefits to employees and/or former employees, and their beneficiaries, and to which a medical child support order is directed.

2. **Receipt of Instrument**: The Plan Administrator or its designated representative shall log the date of receipt of any instrument purporting to be a qualified medical child support order.

3. **Parties to be Notified**: As soon as is reasonably practicable following receipt of an instrument purporting to be a qualified medical child support order, the Plan Administrator or its designated representative shall notify:

(a) each potential Alternate Recipient specified in the instrument as eligible to receive benefits under the Plan, **and**

(b) the Plan Participant with respect to whom the instrument relates,

by first-class mail at the addresses shown in the instrument, acknowledging receipt of the instrument and enclosing a copy of these procedures.

Note that each potential Alternate Recipient may designate a representative for receipt of copies of notices sent to the potential Alternate Recipient with respect to the instrument.

4. **Medical Child Support Order**: The Plan Administrator or its designated representative, upon receipt of such instrument, shall make an initial determination as to whether the instrument is a medical child support order as defined in Section 609(a)(2)(B) of ERISA. A medical child support order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through a state administrative process that:

- provides for child support related to health benefits with respect to the child of a group health plan participant, or requires health benefit coverage of such child in such plan, and is made pursuant to state domestic relations law (including a community property law), **or**

- is made pursuant to a state medical child support law enacted under Section 1908 of the Social Security Act with respect to a group health plan.

5. **Qualified Medical Child Support Order**: If the Plan Administrator or its designated representative determines that an instrument is a medical child support order, the Plan Administrator or its designated representative shall proceed to determine whether such order is a qualified medical child support order as defined in Section 609(a)(2)(A) of ERISA. A qualified medical child support order is a medical child support order that:

(a) creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Plan Participant or beneficiary is eligible under a group health plan, **and**

(b) includes the following:

- the name and the last known mailing address (if any) of the Plan Participant and the name and mailing address of each Alternate Recipient covered by the order (the name and address of an official of a State or political subdivision may be substituted for the address of the Alternate Recipient),

- a reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined, **and**

- the period to which the order applies.

For purposes of these procedures, a Qualified Medical Child Support Order may include a National Medical Support Notice (described in paragraph 7, below), unless otherwise expressly provided.

6. **Restrictions on New Types or Forms of Benefits:** To be qualified, a medical child support order must not require a Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to satisfy otherwise applicable law.

7. **National Medical Support Notice**: A National Medical Support Notice shall be deemed to be a qualified medical child support order as defined in Section 609(a)(2)(A) of ERISA if the National Medical Support Notice satisfies the requirements of Section 609(a)(5)(C) of ERISA, as amended by the Child Support Performance and Incentive Act of 1998. Specifically, a National Medical Support Notice must be appropriately completed in accordance with instructions promulgated by the Department of Labor (described below) **and** meet the requirements of paragraphs 5 and 6 above.

   Detailed instructions for administering a National Medical Support Notice are set forth as **an Appendix** to Section 2590.609-2 of the Department of Labor Regulations, and are incorporated herein by reference.

8. **Determination Period and Effect of Determination**: The Plan Administrator or its designated representative is entitled to a reasonable period of time in which to determine whether an instrument is a qualified medical child support order. This time period is 40 business days from the date the Plan Administrator receives the medical child support order. The Plan Administrator or its designated representative shall notify the Plan Participant and each potential Alternate Recipient or representative designated by the Alternate Recipient (and, in the case of a National Medical Support Notice, state agency or other parties indicated), by first-class mail at the addresses shown in the instrument, of its determination of whether an instrument is a qualified medical child support order. In making its determination the Plan Administrator may consult with legal counsel for the Plan and other advisers. The Plan Administrator may request that an order be amended, or may seek written clarification from the Plan Participant and/or Alternate Recipient(s) prior to issuing its final determination.

   If the Plan Administrator or its designated representative determines that an instrument is a qualified medical child support order, any rights under the Plan conferred by such order to the Alternate Recipient shall commence on the later of the day the Plan Administrator or its designated representative determines that the order is a qualified medical child support order or the day stated in the order. An Alternate Recipient generally will be enrolled in the Plan as of the next regular enrollment date under the Plan following the commencement of the Alternate Recipient's rights under the Plan and the Plan Administrator's receipt of any necessary enrollment forms. If a Plan Participant is eligible to enroll in the Plan but has not yet enrolled, the Plan Participant will also be enrolled if his or her enrollment is necessary for the Alternate Recipient to receive the coverage required under the order. If the Plan provides multiple coverage options and an otherwise qualified medical child support order does not designate a particular option or manner for choosing the option, the Plan Administrator will enroll the Alternate Recipient in the same option as the Plan Participant; if the Plan Participant is eligible to enroll in the Plan but has not yet enrolled, the Plan Administrator or its designated representative will enroll the Plan Participant and Alternative Recipient(s) in the Plan's default option(s).

   If the Plan Administrator or its designated representative determines that an instrument is not a qualified medical child support order, the parties (or state agency, in the case of a

National Medical Support Notice) may submit a revised instrument to cure the deficiencies. If a revised instrument is submitted, the evaluation process is repeated.

9. **Disputes**: Within 30 days after the date of the Plan Administrator's notice as to whether an instrument is a qualified medical child support order, the parties will have the right to submit written comments regarding the determination. After considering any comments received, the Plan Administrator will make a final determination as to the qualified status of the instrument. If no comments are received during the 30-day period, the decision will become final.

10. **Additional Cost Withheld**: Any additional cost incurred as a result of providing the Alternate Recipient the right to receive benefits under the group health plan shall be withheld from the compensation of the Plan Participant in accordance with the Company's normal payroll practices and procedures.

    Notwithstanding the foregoing to the contrary, the total amount withheld from a Plan Participant's disposable income may not exceed the applicable state and/or federal limitations on withholding.

11. **Type and Form of Coverage**: Subject to the provisions of paragraph 8, in providing the Alternate Recipient's right to receive benefits under the Plan as a Plan Participant's covered dependent, the Plan Administrator or its designated representative shall make every effort to provide such right at the same or comparable level and in the same and comparable form as currently being received by any covered dependent of the Plan Participant or as a new covered dependent of the Plan Participant.

12. **Determinations Binding**: The applicable claims administrator shall have the sole and complete discretionary authority to determine conclusively for all parties, and in accordance with the terms of the procedures, documents, or instruments governing the Plan, any and all questions arising from the administration of the Plan and interpretation of all Plan provisions, determination of all questions relating to the participation of eligible employees and eligibility for benefits, determination of all relevant facts, the amount and type of benefits payable to any Plan Participant, spouse or beneficiary (including any Alternate Recipient), and construction of all terms of the Plan. Notwithstanding the foregoing, the Company shall have the sole and complete discretionary authority to determine questions relating to the eligibility of Plan Participants for membership in the Plan and to amend or terminate the Plan at any time.