SUMMARY PLAN DESCRIPTION

OF

SPECTRUM BRANDS, INC. WELFARE BENEFIT PLAN

Amended/Restated Effective January 1, 2025

This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the notice located on the Spectrum Brands Bookshelf located here for more details.

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INTRODUCTION AND OVERVIEW OF THE PLAN

The intent of this Plan Document (the "Plan") is to assure that the written plan document complies with the requirements of the Employee Retirement Income Security Act of 1974 (also known as "ERISA"), as amended and the Internal Revenue Code for the Plan and each welfare benefit included in this Plan. Spectrum Brands, Inc. (the "Employer" or the "Plan Sponsor") maintains this Spectrum Brands, Inc. Welfare Benefit Plan ("Plan").

The Plan provides a variety of welfare benefits through various programs (referred to as "Component Benefit Plans" or "Components"). The Component Benefit Plans are listed in Schedule A. It is intended that this Plan Document provide an administrative framework for all the Benefits that are provided under the Plan.

This document serves as both the formal plan document and summary plan description as required by ERISA. However, the provisions of the Component Benefit Plans (which may be set forth in an insurance contract, certificate of coverage, employee booklet, other summary plan descriptions and related benefit summaries or schedules, and enrollment materials) are incorporated herein by reference. Accordingly, both this document and all the Component Benefit Plan documents collectively constitute the Plan.

For further information about the benefits provided under the Component Benefit Plans, refer to the specific documents issued by the insurer or administrator for each plan, as outlined in Schedule A, or contact the Plan Administrator.

Except as otherwise indicated by context, masculine terminology used in the Plan also includes the feminine, and terms used in the singular may also include the plural.

For more information, please contact the Plan Administrator.

A. Participation in the Plan

Employees of the Employer ("Employees") shall be considered eligible to participate in this Plan upon meeting the eligibility requirements of any one of the Component Benefit Plans as listed in Schedule A. Eligibility to participate in each Component Benefit Plan is outlined in Schedule B.

B. Affiliates, Divisions, Subsidiaries

The Plan Sponsor has the right to include any other entity, including but not limited to any affiliate, division or subsidiary under common control pursuant to Internal Revenue Code Section 414 in the Plan, and in any Component Benefit Plan (subject to the approval by any insurers and qualification under their underwriting guidelines).

STATEMENT OF RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974 ("ERISA") entitles Plan participants ("Participants") to the following rights and protections:

A. Right to Examine Plan Documents

Participants have the right to examine all documents governing the Plan, including insurance contracts, collective bargaining agreements, and any latest annual reports (Form 5500) filed by the Plan with the United States Department of Labor. The latest annual report can be found at www.efast.dol.gov. The Plan Administrator will tell the Participant where the other Plan documents are available for examination. Participants may examine any documents without charge.

B. Right to Obtain Copies of Plan Documents

Participants have the right to obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, including insurance contracts, collective bargaining agreements, Plan documents and any annual reports (Form 5500) and an updated summary plan description (if any). The latest annual report can be found at www.efast.dol.gov. The Plan Administrator may request a reasonable charge for the copies.

C. Right to Continue Group Health Plan Coverage – Group Health Plans Only

Participants have the right to continue health care coverage for the Participant and the Participant's dependents if there is a loss of coverage under a group health plan (e.g., a medical, dental, or vision plan) as a result of a qualifying event. The Participant or the Participant's dependents may have to pay for such coverage. Participants should review the rules governing COBRA continuation rights in the group health plan Component Benefit Plan Documents.

D. Right to Written Explanation of Denial

If a Participant's claim for benefits under the Plan is denied or ignored, in whole or in part, a Participant has a right to obtain a written explanation of the reason for denial, and to obtain copies of documents related to the decision without charge, and to appeal any denial, all within certain time schedules (which are set forth in the Component Benefit Plan Document).

E. Fiduciaries

In addition to creating rights of Participants, ERISA imposes special obligations and duties upon the people (referred to as fiduciaries) who are responsible for the operation of the Plan. The fiduciaries of the Plan have a duty to operate the Plan prudently and in the interest of Participants and beneficiaries. The fiduciaries also have a duty to protect any Plan assets for the benefit of Participants. No one, including the Employer, a union, or any other person, may fire a Participant or otherwise discriminate against a Participant in any way to prevent a Participant from receiving a Plan benefit or from exercising his, her, or their individual rights under ERISA.

F. Enforce ERISA Rights

Under ERISA, there are steps Participants can take to enforce the above rights. For example, if a Participant requests a copy of Plan documents from the Plan and does not receive them within 30 days, the Participant may file suit in Federal court. In such a situation, the court may require the Plan Administrator to give the Participant the Plan documents requested and pay up to $110 a day until the Participant receives the requested materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. ERISA gives Participants the right to file suit in a Federal court if a claim for benefits under the Plan is denied or ignored, in whole or in part. In addition, if a Participant disagrees with the Plan's decision (or lack thereof) concerning the qualified status of a medical child support order, the Participant may file suit in Federal court.

If the Plan fiduciaries have misused the Plan's money, or if a Participant has been discriminated against for asserting the Participant's rights, then the Participant can ask for help from the U.S. Department of Labor or file suit in a Federal court.

If a Participant files a suit, the court will decide who must pay court costs and legal fees. If a Participant is successful, the court may order the person the Participant sued to pay those fees. If a Participant loses (if, for example, the court finds the claim is frivolous), the court may order the Participant to pay those costs and fees.

G. Assistance with Any Questions

If there are any questions about the Plan, Participants should contact the Plan Administrator. If there are any questions about this statement or about Participant rights under ERISA, or if assistance is needed in obtaining documents from the Plan Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A Participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

TERMINATION / MODIFICATION / AMENDMENT TO THE PLAN

The Plan Administrator has the discretionary authority to amend, modify or terminate the Plan or any portion of the Plan at any time, subject to applicable laws (and the terms of an applicable collective bargaining agreement, if any). The consent of Participants is not required to terminate, modify, amend, or change the Plan. Any such amendment or termination will not affect the benefits that accrued prior to the date of such action taken by the Plan Administrator. A relationship with a Contract/Claims Administrator may be changed or terminated at the Plan Administrator's discretion. A "Contract/Claims Administrator" is a third party hired by the Employer to engage in certain claims processing and other services relating to the Plan. For any fully insured plan, the insurance carrier generally has the right to amend or terminate the insurance contract in accordance with its terms.

Unless specifically excluded, the action of the Plan Administrator in amending, modifying, or terminating a benefit or an entire Component Benefit Plan shall apply to all affiliates, divisions or subsidiaries covered by the Plan or Component Benefit Plan.

PLAN INFORMATION

The Plan identified on the following pages is subject to regulation under ERISA. **All Component Benefit Plans outlined within this document have the following ERISA specifications in common:**

The Name of the Plan:	Spectrum Brands, Inc. Welfare Benefit Plan (the "Plan")
Name and Address and Phone Number of Employer:	Spectrum Brands, Inc. 3001 Deming Way Middleton, WI 53562-1431 (800) 881-2562
The Employer Identification Number (EIN):	22-2423556
Plan Number:	501
Type of Plan:	Welfare Plan providing medical and prescription drug, dental, vision, Section 125 flexible spending plan, disability, and life insurance.
Type of Administration:	Fully insured and self-funded and/or contract administration provided in accordance with plan documents, third party administrative agreements, and group insurance contracts and certificates.
Name of Plan Administrator: Business Address:	Spectrum Brands, Inc. 3001 Deming Way Middleton, WI 53562-1431

Business Phone Number:	(800) 881-2562
Name of Person designated as Agent for Legal Process: Address at which Process may be Served:	Spectrum Brands, Inc. Attn: Legal Department 3001 Deming Way Middleton, WI 53562-1431
Collective Bargaining Agreements	The Plan is maintained, in part, pursuant to one or more collective bargaining agreements. A copy of such agreement(s) may be obtained by Participants and beneficiaries upon request to the Plan Administrator.
Plan Changes or Termination:	The Employer may terminate, suspend, withdraw, amend or modify any portion of the Plan in whole or in part at any time, subject to the applicable provisions of the group benefit contracts, bargaining agreements, corporate minutes and/or bylaws, or other written instrument.
Plan Calendar Year End:	12/31

Administration of the Plan is under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage, benefits and other matters under the Plan. The Plan Administrator will also have the discretion to determine all matters relating to interpretation and operation of the Plan, including but not limited to deciding factual issues. In the absence of clear and convincing evidence that the Plan Administrator (or its authorized delegate) acted arbitrarily or capriciously, any determination by that entity shall be final and binding. Some or all the separate benefit Components (e.g., Medical; Dental; Vision) may have separate summary plan descriptions which are specific to that Component. Please review such Component-specific summary plan descriptions for additional information about that Component benefit.

Description of Types of Funding Arrangements

The Component Benefit Plans are either fully insured, self-funded or partially self-funded. See Schedule A for more information.

A. Fully insured plan

In a fully insured plan, benefits are provided under a group insurance contract entered between the Employer and the Insurer. Claims for benefits are sent to the insurance company. The insurance company, not the Employer, is responsible for paying claims and for the financial risk of paying claims under the applicable Component Benefit Plan. The insurance carrier is also the ERISA fiduciary, with discretionary authority to make decisions on the payment of benefits, including determining claims and appeals, and otherwise administering the terms of the insurance contract. The Plan Administrator is generally responsible for determining who is eligible to participate in a fully insured plan. Insurance premiums for Participants as well as employee contributions (pre-tax and/or after-tax, as applicable) are paid out of the general assets of the Employer, as needed.

Unless superseded by applicable law, if the terms of this document conflict with the terms of the insurance contracts applicable to a fully insured benefit, then the terms of the insurance contract will control.

B. Self-funded plan/Partially Self-funded plan

In a self-funded plan or partially self-funded plan, the Employer hires the Contract/Claims Administrator to process claims under the Plan. The Contract/Claims Administrator does not serve as an Insurer, but merely as a claims processor and administrator. Claims for benefits are sent to the Contract/Claims Administrator.

The Contract/Claims Administrator processes the claims, then requests and receives funds from the Employer to make payment on the claims to Participants or health care providers. The Employer is ultimately responsible for providing benefits under the self-funded plan, not the Contract/Claims Administrator. If the Plan is partially self-funded, the insurance company and the Employer share responsibility for paying benefits.

There is no special fund or trust or insurance from which benefits are paid. Employee contributions (pre-tax and after-tax, as applicable) generally are paid out of the general assets of the Employer, as needed.

C. Special Information Regarding a Section 125 Plan

The Employer has established a "cafeteria plan" under Internal Revenue Code Section 125, which allows eligible employees to pay their portion of the premiums or required contributions for medical and prescription drug, dental, and vision coverages on a pre-tax basis. By enrolling in one or more of these coverages, an employee authorizes the Employer to reduce the employee's wages by an amount equal to the applicable share of the premium for the coverage elected (on a pre-tax basis, when possible).

When an employee's share of the premium is paid on a pre-tax basis, the employee's salary reduction amount is not included in taxable income for purposes of federal and most state and local income taxes. Social Security tax is also not paid, which means contributions may reduce wages reported for Social Security purposes and could ultimately reduce an employee's Social Security benefit amount.

If the employee is paying for coverage on a pre-tax basis through the cafeteria plan, then salary reduction elections will be effective for the entire Plan Year and cannot be changed during the Plan Year, unless an allowable change event occurs, as defined in the Section 125 plan document. Examples of allowable change events include marriage, divorce, birth or adoption of a child, death of a spouse or child, loss of coverage under another employer's group health plan due to termination of employment, change in employment status resulting in gain or loss of eligibility for coverage, or changes in the cost or coverage. The cafeteria plan is not subject to ERISA.

Eligibility and Benefit Termination Specifications

A. Employee Eligibility and Participation

Certain employees and their dependents are eligible to participate in the Component Benefit Plans. Eligibility may vary by Component Benefit Plan. Schedule B contains the eligibility requirements of each Component Benefit Plan, including but not limited to:

a) any job classifications that are eligible to participate in the Plan or a Component Benefit Plan; and
b) any service requirement, generally referred to as a waiting period, that must be satisfied prior to becoming eligible to participate.

Employees must have a valid U.S. social security number to enroll in Component Benefit Plans.

Eligible employees will be provided enrollment materials which outline the enrollment procedures for each Component Benefit Plan. Online enrollment may be required for all or some of the benefits included in the Plan. Any eligible employee and/or eligible dependent who is properly enrolled in a Component Benefit Plan will be a "Participant" in the Plan.

B. Dependent Eligibility

Eligible employees may enroll their legal spouse, domestic partner and children. Information regarding dependent eligibility requirements can be found in the Component Benefit Plan Documents.

- To enroll eligible dependents in the Plan additional documentation will be required as part of the enrollment process. This may include but is not limited to:
  - Providing marriage certificates for spouses and information about coverage that is available through a spouse's employment.
  - Birth certificate/certificates of adoption for dependent children.
  - Physician's certification of disability for disabled dependents.
  - Proof of dependence on the employee, as may be applicable based on the circumstances and applicable benefit plan.
  - Eligible dependents must have a valid tax identifying number to be enrolled in benefit plans.

C. Benefit Termination

In general, a Participant's coverage under the Plan or any Component Benefit Plan will terminate (subject to any available COBRA or state continuation rights) upon the earliest of the following:

- When the Employee terminates employment, retires, or dies.
- When the Employee or other Participant no longer meets the eligibility requirements for participation in the Plan or a Component Benefit Plan.
- When a Participant fails to timely and/or completely pay the required share of premiums, if any, for the Plan or a Component Benefit Plan (including during a Participant's paid or unpaid leave of absence); or
- When the Participant fails to timely re-enroll in the Component Benefit Plan, if required; or
- When the Plan or a Component Benefit Plan is terminated by the Plan Sponsor or the insurer.

Additionally, more specific information regarding loss of benefits and when benefits terminate can be found in the Component Benefit Plan Documents. Generally, benefits will terminate at the end of the month in which a Participant is no longer eligible. See the specific details of each Component Benefit Plan for more details on eligibility matters (for example, such as when a dependent child ages out of the Plan).

Plan	**Termination Date**
Medical	Last day of the month in which the Participant is no longer eligible for the Plan. In addition, a covered spouse terminates on the date of divorce or death
Prescription Drug	Last day of the month in which the Participant is no longer eligible for the Plan. In addition, a covered spouse terminates on the date of divorce or death
Dental	Last day of the month in which the Participant is no longer eligible for the Plan. In addition, a covered spouse terminates on the date of divorce or death
Health Care FSA & Limited Purpose FSA	Date of termination. A covered spouse terminates on the date of divorce or death
HSA	Date of termination. A covered spouse terminates on the date of divorce or death. Please note this account is an employee-owned account so can be taken with you post-separation from Spectrum Brands.
Vision	Last day of the month in which the Participant is no longer eligible for the Plan. In addition, a covered spouse terminates on the date of divorce or death
Life/Accidental Death & Dismemberment Insurance	The date the insured ceases to be in an eligible class (i.e., last day of employment)
Short Term Disability	The date the insured ceases to be in an eligible class (i.e., last day of employment)

Long Term Disability	The date the insured ceases to be in an eligible class (i.e., last day of employment)
Employee Assistance Program	The date the insured ceases to be in an eligible class (i.e., last day of employment)

The Plan Administrator may, in its sole discretion, cause a Participant's coverage under the Plan or any particular Component Benefit Plan to terminate if such Participant does any of the following: provides false information or makes material misrepresentations in connection with a claim for benefits; covers or enrolls an individual who is not eligible to participate in the Plan (e.g., adding a spouse before the date of marriage or continuing to cover the spouse after a divorce or adding or continuing to cover a child who does not meet the Plan's definition of Dependent); permits a non-Participant or other non-covered individual to use a membership or other identification card for the purpose of wrongfully obtaining benefits; or obtains or attempts to obtain benefits by means of false, misleading or fraudulent information, acts or omissions. To the extent permitted by law, the Plan Administrator may seek reimbursement for all claims or expenses paid by the Plan as a result of the false representation or fraud and may reduce future benefits as an offset for amounts that should be reimbursed or pursue legal action against such individual.

With respect to medical coverage under the Plan, any termination of coverage will generally be effective on a prospective basis. However, in the case of fraud or an intentional misrepresentation, or failure to pay or remit premium, coverage may be terminated retroactively (called a "rescission" of coverage) to the extent permitted by law, in which case the affected individual(s) shall be provided notice of the rescission and with an opportunity to appeal the rescission as required by law.

SPECIAL ENROLLMENT PERIODS

Special Enrollment Rights

If an Employee declines enrollment for themselves or any dependents (including a spouse) because of other health insurance or group health plan coverage, the Employee may be able to enroll themselves and their dependents in the Medical, Dental, Prescription Drug and / or Vision Components (and, where applicable, the Health Care FSA) of this Plan if the Employee and their dependents lose eligibility for that other coverage (or if the Employer stops contributing toward such other coverage). However, the Employee must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

If the Employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll themselves and certain other dependents provided that a request for enrollment is made within 30 days after the marriage, birth, adoption, or placement for adoption.

If the Employee adds coverage under these circumstances, they may add coverage during the Plan year. Coverage will become effective retroactive to the date of marriage, birth, adoption, or placement for adoption. The Plan does not permit additions of coverage during the plan year except for newly eligible persons and special enrollees. Documentation verifying eligibility is required. Coverage for unverified dependents will be terminated (including medical, dental, vision, life and AD&D insurance). Unverified dependents will not be eligible for COBRA coverage (the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended).

To request special enrollment or obtain more information, contact the Plan Administrator.

Special enrollment rights also may exist in the following circumstances: A special enrollment period under this Plan will apply If the Employee or dependent:

1. was covered under Medicaid or a state child health insurance program (SCHIP) and that coverage terminated due to loss of eligibility, or

2. becomes eligible for premium assistance under Medicaid or a state child health insurance program.

The Employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP coverage, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the Plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to Participants when Medical, Dental, Prescription Drug, Health Care FSA and / or Vision coverage would otherwise end. For more information about rights and obligations under the Plan and under federal law, review the separate Summary Plan Description for the Medical, Dental, Prescription Drug, Health Care FSA and / or Vision Components or contact the Plan Administrator.

Other options may be available when group health coverage is lost

For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, an individual may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, a person may qualify for a 30-day special enrollment period for another group health plan for which they are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. To learn more about the Marketplace go to www.HealthCare.gov.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Medical, Dental, Prescription Drug, Health Care FSA and/or Vision coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." The Employee, his/her/their spouse, and any dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

An Employee becomes a qualified beneficiary if he/she/they loses coverage under the Plan because of the following qualifying events:

- His/her/their hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct.

The spouse of an Employee becomes a qualified beneficiary if he/she/they loses coverage under the Plan because of any of the following qualifying events:

- The Employee dies.
- The Employee's hours of employment are reduced.
- The Employee's employment ends for any reason other than his, her, or their gross misconduct.

- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- A divorce or legal separation from the Employee.

In general, only individuals covered by a health benefit noted above immediately prior to the qualifying event may elect COBRA. However, this rule will not apply in the following situations:

- If the Employee cancels a spouse's coverage in anticipation of a divorce, then, if the Plan Administrator receives timely notice of the divorce (as explained below) and determines that the Employee dropped spousal coverage in anticipation of the divorce, then COBRA continuation will be made available to the former spouse effective on (but not before) the date of the divorce.
- If the Employee was covered by a group health plan on the day before the first day of a Family and Medical Leave Act (FMLA) leave of absence, and a qualifying event occurs during or in connection with the FMLA leave of absence (e.g., the Employee does not return to work following the FMLA leave of absence and, therefore, experiences a termination of employment), then COBRA continuation coverage will be made available on the last day of the FMLA leave of absence even if the coverage was cancelled earlier in the FMLA leave period (e.g., for non-payment of premiums).

The Employee's dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his, her, or their gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Death of the Employee; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the Employee must notify the Plan Administrator within 60 days after the qualifying event occurs. The Employee must provide this notice to: Spectrum Brands, Inc.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or a reduction of the Employee's hours of work. Certain qualifying events,

or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If the Employee or anyone in the Employee's family who is covered under the Plan is determined by Social Security to be disabled, and the Employee notifies the Plan Administrator in a timely fashion, the Employee and his/her/their entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If the Employee's family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in the family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the Employee or former Employee dies or becomes entitled to Medicare benefits (under Part A, Part B, or both) or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If there are any questions

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

For more information about rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in the area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan informed of address changes

The Employee can protect his/her/their rights and the rights of his/her/their family by informing the Plan Administrator of any changes in the addresses of family members. The Employee should also keep a copy of any notices sent by the Plan Administrator for his/her/their records.

For more information on COBRA and your rights you may call or make a written request to:

Spectrum Brands, Inc.
Benefits Department
3001 Deming Way
Middleton, WI 53562-1431
(800) 881-2562
benefits@spectrumbrands.com

Shorter maximum coverage period for health flexible spending accounts

The maximum COBRA coverage period for a health care flexible spending arrangement ("Health Care FSA") maintained by the Employer ends on the last day of the cafeteria or flexible benefits plan "plan year" in which the qualifying event occurs. In addition, if at the time of the qualifying event the Employee has withdrawn more from the Health Care FSA than the Employee has had credited to the Health Care FSA during the plan year, no COBRA right is available at all.

Other Rules and Requirements

Same Rights as Active Employees to Add New Dependents

A qualified beneficiary generally has the same rights as similarly situated active Employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, *"Children Born to or Placed for Adoption with the Covered Employee During COBRA Period,"* for information about how certain children acquired by a covered Employee purchasing COBRA coverage may be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator or its designee if changes to COBRA coverage are needed. The Plan Administrator or its designee must be notified in writing within 30 days of the date of a change*** *(adding or dropping dependents, for example).*

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period

A child born to, adopted by, or placed for adoption with a covered Employee or former Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered Employee or former Employee is a qualified beneficiary, the Employee has elected COBRA continuation coverage for themselves. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements). ***Be sure to promptly notify the Plan Administrator or its designee a change to COBRA coverage is needed. The Plan Administrator or its designee must be notified in writing within 30 days of the date such a change is desired.***

Alternate Recipients Under Qualified Medical Child Support Orders (QMCSO)

A child of the covered Employee or former Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Employee's period of employment with the Employer is entitled to the same rights under COBRA as an eligible child of the covered Employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator or its designee if a change to COBRA coverage is needed. The Plan Administrator or its designee must be notified in writing within 30 days of the date such a change is desired.***

PLANS NOT SUBJECT TO COBRA

Life insurance and disability benefits are not subject to COBRA continuation provisions. However, in certain circumstances an existing life or disability insurance conversion period may be exercised within a specific period following the date of termination. If a Participant wishes to learn more about a conversion policy and whether one is available (or any portability option that may be available), Participants should refer to the respective Certificate of Coverage for specific requirements.

CLAIMS PROCEDURES

A. Filing of Claims

This Section shall apply for any claim for benefits under a Component Benefit Plan unless that plan has a claims procedure that is compliant with ERISA Section 503. If the Component Benefit Plan has a claims procedure that is compliant with ERISA Section 503, the claims procedure of the Component Benefit Plan shall apply.

A request for benefits is a "claim" subject to these procedures only if it is filed by the Participant or an authorized representative of the Participant in accordance with these claim filing procedures. Claims must generally be filed in writing with the applicable Component Benefit Plan insurer or administrator. (However, if a claim is an urgent care claim, an oral filing is acceptable.) If a claim is filed and the information is incomplete to prevent the claim from being processed, the Participant will be given notice and an opportunity to complete the claim and refile.

An inquiry is not considered as a claim filing when it relates to general provisions of a plan (such as eligibility for participation, whether a service will be considered for benefits and prior approval of that service is not a requirement), the inquiry must be directed to the Plan Administrator.

Participants may designate an authorized representative if written notice of such designation is provided to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Participant's medical condition may act as an authorized representative with or without prior notice.

B. Timing of Notice of Claim

The Plan Administrator shall notify the Participant of any adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Component Benefit Plan under which the claim for benefits arises.

In General
Notice will be provided within 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Group Health Plan Claims
The timeframe for benefit determinations under group health plans shall be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this section, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

Disability Plan Claims (or Claims Involving Disability)
Notice will be provided 45 days after receipt of the claim. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies the Participant prior to the expiration of the first 30-day extension period of the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section shall explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Participant shall be afforded at least 45 days within which to provide the specified information.

C. Content of Notice of Denied Claim

If a claim is wholly or partially denied, the Plan Administrator shall provide the Participant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Participant must take if he/she/they wishes to appeal the denial including a statement that the Participant may bring a civil action under ERISA.

In addition, if the wholly or partially denied claim is by a Component Benefit Plan providing group health or disability benefits, the following information must also be included in the written notice: (1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of a wholly or partially denied claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) under a Component Benefit Plan providing group health benefits, the notice must include a description of the expedited review process applicable to such claims. In addition, the information described in this Section may be provided orally within the timeframe required provided that a written or electronic notification is furnished to the Participant not later than 3 days after the oral notification.

In the case of a disability claim or a claim involving disability, any adverse benefit determination shall include a discussion of the decision, with the basis for disagreeing with the views or decisions of any treating health care professionals, vocational experts, or other payers of benefit who granted the claimant's similar claims (including disability determinations by the Social Security Administration (SSA)). Any adverse benefit determination shall also include the plan's specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such plan rules, guidelines, protocols, standards or other similar criteria do not exist. Any adverse benefit determination shall be provided in a culturally and linguistically appropriate manner.

The claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

D. Appeal of Denied Claim

If a Participant wishes to appeal the denial of a claim, he/she/they shall file a written appeal with the Plan Administrator on or before the 60th day after he/she/they receives the Plan Administrator's written notice that the claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Participant shall lose the right to appeal if the appeal is not timely made.

(1) The Participant shall be provided, upon request and free of charge, documents, and other information relevant to his, her, or their claim. A written appeal may also include any comments, statements, or documents that the Participant may desire to provide. The Plan Administrator shall consider the merits of the Participant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances, as the Plan Administrator may deem relevant.

(2) In addition to the requirements of paragraph (A) above, if the claim is under a Component Benefit Plan providing group health or disability benefits, the claims procedures shall be determined in accordance with paragraph (C) and 2560.503-1(h)(4).

The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Participant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal. If the denied claim is by a Component Benefit Plan providing group health or disability benefits, the timing of the Plan Administrator's review shall be determined in accordance with DOL Reg. section 2560.503-1(i)(2) and 560.503-1(i)(3).

In the case of a disability claim or a claim involving disability, a claimant may review the claim file and present evidence and testimony as part of the claims and appeals process. Further, the Plan Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim. Such evidence shall be provided as soon as possible and to the extent possible in advance of the date on which the notice of adverse benefit determination on review is required to give the claimant a reasonable opportunity to respond before that date. Prior to issuing an adverse benefit determination on review based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale. Such rationale shall be provided as soon as possible and to the extent possible in advance of the date on which the notice of adverse benefit determination on review is required to give the claimant a reasonable opportunity to respond before that date.

In the event of any error, a claimant may request a written explanation from the Plan, including a specific description of the Plan's bases, if any, for asserting that the error is *de minimis* and should not result in the deemed exhaustion of administrative remedies. The Plan shall provide this written explanation, if requested, within 10 days.

E. Denial of Appeal

If an appeal is wholly or partially denied, the Plan Administrator shall provide the Participant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Participant's claim for benefits, and (4) a statement describing the Participant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties. In addition, if the claim is under a Component Benefit Plan providing group health or disability benefits, the denial notice shall include additional information required under DOL Reg. section 2560.503-1(j)(5).

F. Exhaustion of Remedies / Venue

Before a suit can be filed in Federal court, claimants must exhaust internal remedies. All lawsuits related to the Plan must be brought in federal district court in Madison, Wisconsin. Provided, however, that if a fully-insured policy provides for a different venue choice, such venue choice will apply for that particular benefit.

G. Additional Claims Processes

Applicability
This Subsection applies to a Component Benefit Plan to the extent the Component Benefit Plan qualifies as a "group health plan" which is subject to these additional legal requirements. Generally, that includes the Medical Plan.

Internal Claims Process
The claims requirements above shall apply as the internal claims process except as provided under DOL Reg. 2590.715-2719 and any superseding guidance.

Adverse Benefit Determination
An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

Expedited Urgent Care Determination
The requirements of DOL Reg. section 2560.503-1(f)(2)(i) apply as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(B) and any superseding guidance. Participants must be notified of benefit determinations (whether adverse or not) with respect to a claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) as soon as possible, considering the medical exigencies, but not later than 72 hours after the receipt of the claim.

Full and Fair Review
A Participant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Participants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Participant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

Notice
A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose, if legally required, the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Deemed Exhaustion of Internal Claims Process
If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the Participant may initiate an external review under Section 6.02(b)(2) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

H. External Claims Process

Federal Process
The Plan must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance.

I. Minor or Legally Incompetent Payee

Benefits may become payable under a Component Benefit Plan to a Participant's estate, or to a minor or person who is not capable of executing a valid release. The Plan may in such an event make payment to one of the following:

- A person who has assumed the care and support of such person or is a designated beneficiary.
- A personal representative of the Participant's estate; or
- Any person related to the Participant by blood or marriage.

Such payment shall fully discharge the Plan Administrator and the Plan from further liability.

J. Missing Payee

After reasonable efforts have been made to identify and/or locate a Participant or beneficiary, if the Plan Administrator is unable to make a payment that is due, such payment and all subsequent payments otherwise due shall be forfeited one day prior to one year after the date any such payment first became due.

K. Forfeitures, Refunds, Rebates and Similar Amounts

All forfeitures, refunds, rebates or other amounts which accrue under the Plan shall be treated as general assets of the Plan Sponsor and not “plan assets”, to the extent allowed by applicable law.

ACA COMPLIANCE

The Plan complies with the requirements of the Affordable Care Act (ACA), including but not limited to the coverage of preventive services without cost sharing, Women’s Care services, Coverage for Clinical Trials, and Emergency Room Access.

ACA Employer Shared Responsibility Rules Compliance

The Employer complies with the ACA Employer Shared Responsibility Rules (the "ESR Rules") requirement to identify which employees are "full-time" in the Employer's records. For purposes of determining which "Ongoing Employees" (as defined under the ESR Rules) are "full-time" under the ESR Rules, the Employer will make this determination by: (1) using a Standard Measurement Period which begins on October 15 of one year and ends on October 14 of the following year; (2) using an Administrative Period which begins on October 15 of a year and ends on December 31 of the same year; and (3) using a Stability Period which begins on the January 1 of the year following the end of a Standard Measurement Period and continuing until December 31 of that same year. The Employer also adopts the following rules to determine which employees are "full-time" under the ESR Rules:

> New, Variable Hour; New, Seasonal; New, Part-Time Employees (all as defined under the ESR Rules) will have their full-time status be determined over a 12-month Initial Measurement Period (as defined under the ESR Rules). The Initial Measurement Period will begin on the first day of the first calendar month after such employee's date of hire. After that, a one-month Administrative Period shall apply. If an employee has a change in employment status such that the ESR Rules require such employee to be considered "full-time" under the ESR Rules, the Employer will treat the employee as "full-time" for ESR Rule purposes only.

An employee who has a termination of employment and a break in service of at least 13 weeks, then is rehired by the Employer, shall be treated as a New Employee to the extent allowed by the ESR Rules.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY AND SECURITY (HIPAA)

These HIPAA Privacy Policies and Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive or maintain as a group health plan. **Spectrum Brands, Inc.** (the “Sponsor”) is the sponsor of the **Spectrum Brands, Inc. Welfare Benefit Plan** (the “Plan”), to whom these Policies and Procedures apply.

Sponsor adopts these policies, along with the attached forms, on behalf of the Plan. The Plan implements these Health Information Privacy Policies and Procedures as a matter of sound business practice, to protect the interests of our enrollees, and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing

Commented [SD1]: Alliant added in the full HIPAA privacy policy (46 pages) Did not add in the HIPAA security program document as that is more of an internal document. Please note a lot of this information is internal information for Spectrum Brands and typically we see employers only including the HIPAA Policy Notice. Please confirm with Kerry he is okay with all of this being added to the document. This section goes from page 16 to page 61. a wrap document is typically a member facing document so the longer the document, the less likely they are to read this. We have included a sample wrap template from our compliance team that other employers typically populate when they don’t have a wrap document. If we want to start from the Alliant Wrap let us know and we are happy to build something that is clean and simple.

Commented [KM2R1]: [JB: KERRY, I agree with Sarah’s comments. This is a long provision (the HIPAA section). You don’t need it in the Wrap. There’s a modest risk in including it (if you violate the HIPAA language, it could turn it into an ERISA violation). But I am not completely opposed to including it. It’s more of a judgment call. I would lean towards taking it out (like what Sarah notes). I did not do that in here, but that could be done]

Commented [KM3R1]: For Jen: I think we keep this in, but we can delete a lot of the other documents included later in this document

Commented [JL4R1]: Removed

regulations at 45 Code of Federal Regulations Parts 160 and 164 ("Privacy Rules"). If we are uncertain of the meaning of a term we will look it up or consult legal counsel.

You are obligated to follow these Health Information Privacy Policies and Procedures faithfully. Failure to do so can result in disciplinary action, including termination of your employment.

If you have questions about any use or disclosure of individually identifiable health information or about your other obligations under these Health Information Privacy Policies and Procedures, the Privacy Rules or other federal or state law, consult our Privacy Official—**Ilene Knobler, Director, Global Benefits**—at

(314) 683-2484 or **ilene.knobler@spectrumbrands.com** before you act.

Ilene Knobler

Ilene Knobler

Director, Global Benefits

Effective Date: July 1, 2024

Last Revised: July 1, 2024

HEALTH INFORMATION PRIVACY POLICIES AND PROCEDURES

I. USE AND DISCLOSURE POLICIES AND PROCEDURES

Short Summary: HIPAA puts limits on when the plan - and you, as someone who helps the plan - can use or disclose "protected health information." In general, you cannot use or disclose any protected health information unless there is a legally-approved reason to do so. Those reasons are discussed in Sections 1-7.

1. Fundamental Policies on Use and Disclosure of Protected Health Information.

Short Summary: There are certain common situations in which you can use or disclose a plan enrollee's protected health information. For example, the plan (or, for example, its third party administrator) can send a $500 check to a hospital and note on the check that the payment was for a particular enrollee's (e.g., "John Smith's") medical expense. This is a disclosure of protected health information but it is for "payment" purposes (discussed further in Section 1(b)(i)).

a) POLICY—No Use or Disclosure. You must not use or disclose protected health information except as these Privacy Policies and Procedures permit or require.

b) Treatment, Payment, Health Care Operations.

i) POLICY—Our Activities. We may use and disclose protected health information, without the individual's permission, for our own payment activities and our own health care operations. As a group health plan, we do not ourselves engage in treatment, though we may be included in the coordination of treatment activities for individuals by health care providers. We may disclose protected health information, without the individual's permission, for any health care provider's treatment activities. We may disclose the minimum necessary protected health information, without the individual's

permission, for the payment activities of another covered entity or any health care provider. Special rules apply for disclosures related to another covered entity's health care operations. If this occurs, we will consult our legal counsel.

ii) **POLICY—Organized Health Care Arrangement's Health Care Operations.** When we participate in an organized health care arrangement, we may disclose the minimum necessary protected health information to other covered entity participants in the organized health care arrangement for the health care operations of the organized health care arrangement. This generally allows us to share protected health information with other health plans of our sponsors.

iii) **POLICY—Underwriting and Other Insurance Function Health Care Operations.** We may use and disclose the minimum necessary protected health information for underwriting, premium rating or other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits. We may also use and disclose the minimum necessary protected health information to cede, secure or place a contract for reinsurance of risk for health care claims (including stop-loss and excess loss coverage).

c) **POLICY—Individual or Personal Representative.** We may disclose protected health information to the individual who is the subject of the protected health information and to that individual's personal representative as relevant to the scope of the representation.

d) **POLICY-No Sale, Marketing, Fundraising, Research or Uses of Genetic Information for Underwriting**. We will not directly or indirectly receive remuneration in exchange for any protected health information of an individual, except as otherwise allowed by applicable law. We will not engage in marketing of protected health information, except if such marketing is permissible under HIPAA and does not require an authorization. We will not use or disclose protected health information for fundraising purposes. We will not use or disclose genetic information which is protected health information for underwriting purposes. We will not use or disclose protected health information for research purposes.

e) **POLICY - Identify Verification.** We will verify the identity and/or authority of someone prior to making a disclosure, if we are uncertain of either.

f) **PROCEDURE.** Document how you verify the identity and authority of any person, unknown to you, requesting protected health information. Provide the documentation to the Privacy Official, who will retain it for at least six years.

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2. Informal Permission for Certain Uses and Disclosures.

Short Summary: Be careful about providing a plan enrollee's protected health information to that enrollee's family member or friend. That disclosure is not allowed unless you satisfy an exception (described further in this Section 2).

POLICY—Informal Permission for Certain Uses and Disclosures. We may use with, and disclose to, an individual's family members, other relatives or close personal friends, and any other person that the individual identifies, the individual's minimum necessary protected health information directly relevant to that person's involvement with the

individual's health care or payment related to that health care if we follow all applicable procedures.

PROCEDURE—Individual Present or Not Present. If the individual is present or available and has the capacity to make health care decisions, you must inform the individual of your intent to disclose the protected health information. You may make the use or disclosure if:

- The individual agrees; or
- The individual does not object after a reasonable opportunity to do so; or
- You infer from the situation that, in your professional judgment, the individual does not object.

If the individual is not present, we may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's care or payment related to the individual's health care or needed for notification purposes.

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3. Authorization for Use or Disclosure.

Short Summary: If you believe you need to make a use or disclosure of protected health information but cannot find any relevant exception, consider asking the plan enrollee to complete an authorization to approve the use of disclosure. This is usually a "safe" choice.

a) POLICY—Authorization. We must have written authorization from the individual (or the individual's personal representative) before we may use or disclose an individual's protected health information for any purpose, except for the following:

- For treatment, payment or health care operations.
- To the individual, the individual's personal representative or Health and Human Services (HHS).
- As permitted for public interest or benefit activities.
- As permitted with a business associate.
- Incidental to otherwise permitted or required uses and disclosures.
- **FORM – Authorization.** Use FORM 3 – Authorization.

b) POLICY—Authorization Revocation or Expiration. We may not rely on an authorization we know has been revoked or has expired. An individual may revoke an authorization at any time. Revocation of an authorization does not affect actions we may have undertaken in reliance on the authorization before we learned of its revocation

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4. Public Interest or Benefit Use and Disclosure.

Short Summary: There are a few unusual situations where the plan (or you, on behalf of the plan) can use and disclose protected health information even though the use or disclosure is not for the Plan's payment or health care operations and even though the health plan enrollee has not signed an authorization. These situations are generally noted in this Section 4. For example, a court may order us to disclose the enrollee's protected health information.

a) POLICY—Public Interest or Benefit Use and Disclosure. We may use or disclose an individual's protected health information for the public health, public interest, public benefit, and law enforcement activities listed in this Section 4, without the individual's permission.

Use FORM 7 - Disclosure Log/Minimum Necessary to assist with and document your determination of the minimum necessary use or disclosure and to log each disclosure for accounting.

b) Workers' Compensation. We may disclose the minimum necessary protected health information authorized by and needed to comply with workers' compensation or similar programs established by law that provide benefits for work–related injury or illness without regard to fault.

c) Required by Law. We may use or disclose protected health information as required by law

d) Health Oversight Activities. We may disclose the minimum necessary protected health information to a health oversight agency as needed for legally authorized health oversight activities, such as audits, civil, criminal or administrative actions or proceedings, inspections, licensure, certification, disciplinary actions, and appropriate oversight of the health care system or government benefits programs (e.g., Medicare and Medicaid) for which health information is relevant to beneficiary eligibility or entities subject to government regulatory programs or civil rights laws.

e) Judicial and Administrative Proceedings. We may disclose the minimum necessary protected health information in the course of a judicial or administrative proceeding:

i) Order. In response to a court or administrative tribunal order, provided we disclose only the expressly ordered protected health information.

ii) Process. In response to a subpoena, discovery request or other lawful process not accompanied by court or administrative tribunal order, if we:

- Make a reasonable effort to provide notice to the individual sufficient to permit the individual to object to, or seek a qualified protective order from, a court or administrative tribunal; or

- We receive "satisfactory assurance" that the information seeker has made reasonable efforts either (a) to ensure the individual has notice, or (b) to secure a qualified protective order from the court or administrative tribunal or by party stipulation that limits the parties' use or disclosure to the purpose of the

proceeding and requires return or destruction of the protected health information (including all copies) at end of the proceeding. Ask our Privacy Official if we have sufficient "satisfactory assurance".

5. Required Disclosures.

Short Summary: Sometimes we must disclose protected health information -- for example, if the U.S. Department of Health and Human Services ("HHS") is auditing our health plan for HIPAA and HHS requests the protected health information.

a) POLICY—Required Disclosures to Individual or Personal Representative. We must disclose all protected health information subject to the right of access or disclosure accounting to an individual (or the individual's personal representative) requesting access or disclosure accounting. See Sections 12-14.

b) POLICY—Required Disclosures to HHS. We must disclose protected health information to HHS as required for complaint investigation or compliance enforcement or review.

6. Minimum Necessary.

Short Summary: When we use or disclose protected health information, we generally can use or disclose the "bare amount" needed. This is called the "minimum necessary" amount for the use or disclosure.

a) POLICY—Minimum Necessary. We must make reasonable efforts to use, to disclose, and to request of another covered entity, only the minimum necessary protected health information to accomplish the intended purpose. This generally will consist of the protected health information contained in a limited data set, although it can be more if needed to accomplish the intended purpose of such use, disclosure or request. There is no minimum necessary limitation for:

- Disclosure to or a request by a health care provider for treatment.
- Use with and disclosure to an individual (or the individual's personal representative).
- Use and disclosure pursuant to an authorization by an individual (or the individual's personal representative).
- Disclosure to HHS for complaint investigation or compliance enforcement or review.
- Use and disclosure required by law.
- Use and disclosure required for compliance with the HIPAA Administrative Simplification Rules.

b) POLICY—Workforce Use. We must make reasonable efforts to limit access to and use of protected health information by our workforce members to the minimum necessary to perform their duties.

 Use FORM 7–Disclosure Log/Minimum Necessary to document your compliance with the minimum necessary limitation. Include the completed Form 7 in the individual's records. Send a copy to our Privacy Official.

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7. De–Identified Health Information.

Short Summary: Protected health information which has been "de-identified" (so no plan enrollee can be identified) is no longer protected health information and is not subject to HIPAA or these Policies and Procedures.

POLICY—De–Identified Health Information. We may use and disclose de-identified health information without restriction. We will treat as protected health information any key or other means to re-identify health information that has been de-identified.

II. RELATIONSHIP RULES

8. Personal Representatives.

Short Summary: In some situations, one person (e.g., a parent) is generally allowed to act on behalf of another person (e.g., a child) and receive that second person's protected health information (e.g., a parent generally can receive a child's protected health information.

a) **POLICY—Personal Representative.** We must consider a personal representative to be the individual for all purposes under these Privacy Policies and Procedures and the Privacy Rules, unless we conclude that the personal representative may be abusive.

b) **POLICY—Personal Representatives of Unemancipated Minors.** We will grant a parent, guardian or person acting "in loco parentis" (which generally means the parent is acting on behalf of the child) access to and control over an unemancipated minor's protected health information if, and to the extent, applicable State or other law (including case law) permits or requires us to give the parent, guardian, or person acting in loco parentis access or control. If the law is unclear, we will discuss the matter with legal counsel.

c) Personal Representatives of Deceased Individuals.

i) **POLICY—Information Protected.** We will accord the protected health information of a deceased individual all of the privacy protections of these Privacy Policies and Procedures and the Privacy Rules until at least 50 years after the death of the individual. If the individual is deceased, we may disclose to a family member, or other relative or close family friend who is involved in the care or payment for health care of the individual prior to the individual's death, the protected health information that is relevant to such person's involvement. However, we will not make this disclosure if it is inconsistent with the individual's prior expressed preference and that preference is known to us.

ii) **POLICY—Rights of Executors.** We will furnish an executor, administrator or other person authorized by applicable law to act for a deceased individual or the deceased individual's estate, the same rights with respect to a deceased individual's protected health information that must be accorded the individual, provided the protected health information is relevant to the scope of the representation.

9. Business Associates.

Short Summary: Our health plan (or the employer on behalf of our plan) may hire third parties who will receive protected health information and use or disclose it on our behalf. Before that occurs, we must make sure that third party has signed a contract in which it agrees to follow HIPAA. This contract is called a "business associate agreement."

a) **POLICY—Uses and Disclosures with Business Associates.** We will not disclose protected health information to a business associate, or allow a business associate to create or receive protected health information on our behalf, unless our Privacy Official or our legal advisers confirms that the business associate has entered into a compliant written contract with us.

The business associate contract requirement does not apply to our permitted disclosures to:

- A health care provider concerning treatment.
- Our plan sponsor.

We will use a Business Associate Agreement that has been reviewed and approved by legal counsel.

b) **POLICY—Business Associate Compliance.** If we learn that a business associate has materially breached the business associate contract, we will require the business associate to promptly cure the breach. If the business associate fails to cure the breach to our satisfaction, we will terminate the business associate contract and our business associate relationship with that business associate.

10. Plan Sponsors and Third Party Administrators.

Short Summary: Under HIPAA an employer generally cannot receive protected health information unless it has agreed to follow HIPAA's requirements. There can be a few exceptions, such as "enrollment information". This exception allows the employer to know which employees are in (or out) of the health plan and which level of coverage (e.g., single or family) those employees have selected.

a) **POLICY—Disclosure of Protected Health Information to Plan Sponsors.** We may not disclose, and we may not permit a health insurance issuer, HMO, third party administrator, or other business associate to disclose on our behalf, protected health information to our plan sponsor—the employer, union or other entity that established and maintains our group health plan—unless we have the authorization or other sufficient permission of each plan participant

and beneficiary whose protected health information is to be disclosed. There are three exceptions:

i) **Enrollment Data to Plan Sponsor.** Our plan sponsor may receive from us, and from a health insurance issuer, HMO, third party administrator, or other business associate on our behalf, the minimum necessary information to determine whether an individual is or is not participating in our group health plan.

ii) **Summary Health Information to Plan Sponsor.** Our plan sponsor may receive from us, and from a health insurance issuer, HMO, third party administrator, or other business associate on our behalf, the minimum necessary summary health information to enable our plan sponsor to either (a) obtain premium bids for providing coverage under our group health plan, or (b) modify, amend or terminate our group health plan. However, notwithstanding the prior sentence, we may not disclose genetic information which is protected health information as part of this summary health information provision.

iii) **Plan Administration Functions by Plan Sponsor.** Our plan sponsor may receive from us, and from a health insurance issuer, HMO, third party administrator, or other business associate on our behalf, the minimum necessary protected health information of our plan participants and their beneficiaries to enable our plan sponsor to perform plan administration functions for us, provided that our plan sponsor furnishes written certification that the group health plan document has been amended to include "satisfactory assurance" that our plan sponsor will appropriately safeguard and limit use and disclosure of the protected health information, including not using or disclosing the protected health information for any employment-related action or decision or in connection with any other benefit or benefit plan.

FORM 3–Plan Sponsor's Group Health Plan Document Amendment contains the mandatory terms for our plan document that the Privacy Rules require to evidence the plan sponsor's "satisfactory assurance."

FORM 4–Plan Sponsor's Certification of Group Health Plan Document Amendment is an example of the certification of "satisfactory assurance" our plan sponsor must make.

III. INDIVIDUAL'S INFORMATION RIGHTS

11. Privacy Practices Notice.

Short Summary: Our health plan is required under HIPAA to send a notice to plan participants explaining their privacy rights under HIPAA. We must send out that notice to new participants (or arrange to have another entity send it, such as our third party administrator) and then periodically send out reminders about the notice.

a) **POLICY—Privacy Practices Notice.** As a self-funded group health plan, we will maintain a Privacy Practices Notice. That Notice must give individuals written notice of the uses and disclosures of protected health information that we may make, our legal duties with respect to protected health information, and individuals' privacy rights and how to exercise them. We

must use and disclose protected health information consistently with our Notice. Use FORM 7 – Privacy Practices Notice as a template for our Privacy Practices Notice.

b) **POLICY—Revision to Privacy Practices Notice.** We will promptly revise our Privacy Practices Notice whenever there is a material change to our uses or disclosures of protected health information, to our legal duties, to the individuals' rights or to other privacy practices that render the statements in our Notice no longer accurate.

PROCEDURE—Privacy Practices Notice Distribution. Our Privacy Official will distribute (or cause to be distributed) the appropriate Privacy Practices Notice to each individual who is our plan participant. If there is a change to the Privacy Practices Notice and we maintain a web site, we may (in lieu of distributing the revised Notice in paper form) prominently post the change or the revised Notice on our web site. If we do this, we will post the Notice or change by the effective date of the material change. We will also provide the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals then covered by the plan. We will also:

- Disseminate our Notice to each new plan participant at enrollment.
- Notify our then current plan participants, at least once every 3 years, that our Notice is available on request, explaining how the participants may obtain it.
- Ensure that our Notice is prominently posted and electronically available on each web site the health plan maintains (if any) that provides information about our benefits.
- Disseminate any revised Notice to our then current plan participants within 60 days of the material change. We will not implement the material change in our privacy practices before the effective date of our revised Notice (unless earlier implementation is required by law).
- Furnish our Notice to any person on request.
- Email our Notice to any individual who has agreed to electronic notification and not withdrawn that agreement. We must provide a paper copy of our Notice to the individual, if you know the individual failed to get the email transmission of our Notice or if the individual requests a paper copy.

12. Access.

Short Summary: Plan enrollees generally have the legal right to access their protected health information and obtain copies of it. Some new HIPAA rules from 2013 also allow the person to obtain an electronic copy of their protected health information in some situations.

a) **POLICY–Right to Inspect and Copy.** We will allow an individual to inspect and to obtain a copy of their protected health information for as long as we or our business associates maintain that protected health information in designated record sets. We may withhold from an individual only that protected health information specified in Section 12(b) below.

We may charge a fee as allowed by law. We generally must respond to the individual's request for access within 30 days of us receiving the request.

If an individual makes an access request with respect to protected health information which is maintained electronically in our designated record set, the following rules shall apply:

- The individual shall have a right to obtain a copy of such information electronically and, if the individual requests, to provide it in the form and format requested by the individual, if it is readily producible in such form and format. If it is not so readily producible, we will provide it in a readable electronic form and format as agreed to by us and the individual.
- The individual shall have a right to direct us to transmit the copy of protected health information directly to another person designated by the individual. We will follow such a direction if the individual's request is in writing, signed by the individual and clearly identifies the designated person and where to send the copy of protected health information.
- Any fee that we may impose for providing the individual a copy of such information shall not be greater than our direct or indirect labor costs, supply costs or postage costs in responding to the request for the copy or for an explanatory summary of the protected health information.
- We will send the information to an individual in an unencrypted email only if we warn the individual of the risks of unencrypted emails and the individual prefers the unencrypted email. We will provide the information on the individual's own external portable media only if we perform a risk analysis related to the potential use of the media and we conclude that there is an acceptable level of risk.

b) **POLICY—Protected Health Information We May Withhold.** We may deny access to, and a copy of, protected health information compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding. Other exceptions may also apply. We will consult our legal counsel if needed.

c) **POLICY—Designations.** We must identify in writing each designated record set we maintain or that is maintained on our behalf by our business associates, and the titles of persons or offices responsible for receiving and processing access requests. Use FORM 9 – Designated Personnel and Record Sets to identify our designated record sets.

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13. Amendment.

Short Summary: Plan enrollees generally have the legal right to modify their protected health information that we (or our business associates) hold, if that protected health information is incorrect. We must promptly respond to such a request.

a) **POLICY—Right to Amend.** We will allow an individual to request to amend their protected health information for as long as we or our business associates maintain the protected health information in designated record sets. We may deny an amendment request only as specified in Section 13(b) below. We will generally respond to the individual's request within 60 days of its receipt. If we make an amendment, we will notify our business associates that may have and rely on the unamended records.

b) **POLICY—Bases for Denying Amendment Request.** We may decline to amend protected health information if:

- We did not create the information (unless the originator is no longer available to act on the request).
- The information to be amended is not part of a designated record set maintained by us or by a business associate on our behalf.
- The information is accurate and complete.

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14. Disclosure Accounting.

Short Summary: Plan enrollees generally have the legal right to understand how their protected health information has been disclosed. However, as a practical matter the vast majority of the disclosures do not need to be tracked by us or our business associates.

a) **POLICY—Right to Disclosure Accounting.** We will allow an individual to request an accounting of each disclosure that we make of the individual's protected health information for up to 6 years prior to the request. We do not have to account for disclosures that are exempt from accounting as specified in Section 14(b) below. We will respond to the individual's request within 60 days. However, we will not provide a disclosure accounting if a law enforcement official asks us to temporarily not provide it.

☐ We may not charge for an individual's first accounting in any 12-month period. We may charge a reasonable, cost–based fee for other accountings within that same 12-month period.

☐ Use FORM 7 – Disclosure Log/Minimum Necessary to document each accountable disclosure.

☐ The best way to respond to this request is to gather all the required disclosure accounting information from our records and from our business associates' records, then provide all this information to the individual. Alternatively, we may also be able to provide all of the disclosure accounting information we hold, then provide a list of all our business associates, including contact information for those business associates (such as work address, phone number and e-mail address). Before we do this, we would need to ensure the business associate has agreed to directly respond to the individual's request.

b) **POLICY—Exempt Disclosures.** We do not have to account for the following:

- Disclosures made before our Privacy Rules compliance date (generally April 14, 2003 or April 14, 2004). Disclosure relating to an electronic designated record set generally all must be accounted for as of the date specified by HHS.

- Disclosures made to the individual or the individual's personal representative.
- Disclosures made for a payment related to that person's health care, or for health care operations**.**
- Disclosures made pursuant to authorization.
- Disclosures made in a limited data set.

c) **POLICY—Accounting Information.** We will track accountable disclosures. The information that must be tracked to fulfill our disclosure accounting obligations is as follows:

- The disclosure date;
- The name and, if known, address of each person or entity that received the disclosure;
- A description of the protected health information disclosed; and
- A statement of the purpose of the disclosure, or a copy of any written request for the disclosure from HHS or another government agency or organization to which the protected health information was disclosed pursuant to a public interest or benefit activity.

We will hold this information for 6 years.

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15. Restriction Requests.

Short Summary: Plan enrollees generally have the legal right to request that we put restrictions on how their protected health information is used or disclosed. Except in very rare situations, we do not have to agree to this request (that is, we can usually deny the request). If we accept the request, we should inform our business associates of the new restriction.

a) **POLICY—Restriction Requests.** We will allow an individual to request that we restrict our use or disclosure of their protected health information for treatment, payment, health care operations, or with specified family members or others. Except as noted below, we have no obligation to agree to such request. We will comply, and notify our business associates to comply, with any such agreement we make (except in an appropriate medical emergency). We will document any agreed-upon restriction request.

We will comply with a restriction request, and notify our business associates to comply, if:

i. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

ii. the protected health information pertains solely to a health care item or service for which the individual or another person (other than a health plan on behalf of the individual) has paid the covered entity in full.

b) **POLICY—Restriction Termination.** We may terminate a restriction agreement (other than a restriction agreement described in the prior sentence) either (i) with the concurrence of the individual or (ii) unilaterally by written notice of termination to the individual. When we terminate a restriction agreement unilaterally, we will continue to comply with the restriction with respect to protected health information we created or received subject to the restriction.

16. Confidential Communication.

Short Summary: Sometimes, plan enrollees may be in physical danger if we disclose protected health information in a certain way. For example, suppose our health plan wants to send an explanation of benefits ("EOB") to an employee's home. Suppose the EOB contains sensitive information that an employee is trying to keep from the employee's spouse. The employee may inform us that the employee fears for their physical safety if the spouse finds out the employee is being treated for a particular condition (and the EOB would reveal this). So, the employee requests that we (or our third party administrator) send the EOB to the employee's work. We generally must accommodate this type of request.

POLICY—Confidential Communication. We will allow an individual to request confidential communications (that is, the use of alternative means or alternative locations when we communicate protected health information to the individual), if the request is reasonable and in writing, and the individual gives us a clear statement that all or part of the protected health information could endanger the individual if not communicated by the requested alternative means or to the requested alternative location.

IV. ADMINISTRATIVE REQUIREMENTS

17. Privacy Policies and Procedures.

Short Summary: Under HIPAA, our health plan must adopt these policies and procedures. You, as someone who works for the health plan (even if you are employed by the employer) must follow these policies and procedures.

a) **POLICY—Adoption.** We will adopt and implement written privacy policies and procedures for protected health information designed to comply with our obligations under the Privacy Rules. These Privacy Policies and Procedures are intended to satisfy this obligation.

PROCEDURE—Implementation and Compliance. Each member of our workforce with access to protected health information must, at all times, comply with the policies and follow the procedures set out in these Privacy Policies and Procedures.

b) **POLICY—Revisions.** Only a designated person (e.g., plan administrator, plan fiduciary, Privacy Official, etc.) may change these Privacy Policies and Procedures.

18. Privacy Personnel, Training, Workforce Management, Administrative Practices.

Short Summary: There are certain administrative practices we must follow. For example, new employees who begin helping out with the plan and who will see protected health information must be trained on HIPAA. In addition, if an improper use or disclosure of protected health information occurs, we must take actions to minimize the harmful effect of that improper use or disclosure.

a) POLICY—Privacy Personnel.

i) Privacy Official. Our Privacy Official is responsible for developing, maintaining, and implementing these Privacy Policies and Procedures, and for overseeing our full compliance with these Privacy Policies and Procedures, the Privacy Rules, and other applicable federal and state privacy law.

Our Privacy Official is Ilene Knobler, Director, Global Benefits

Telephone: 314-683-2484

E–mail: Ilene.knobler@spectrumbrands.com

Office: One Rider Trail Plaza Drive, Suite 300, Earth City, MO 63045

ii) Contact Offices. We will maintain contact offices for individuals to obtain our Privacy Practices Notice and other information on our privacy practices. Our contact offices will also accept complaints about our privacy practices.

Our contact offices are:

Spectrum Brands, Inc. Attn: Benefits Group One Rider Trail Plaza Drive Suite 300 Earth City, MO 63045	Spectrum Brands, Inc. Attn: Benefits Group 3001 Deming Way Middleton, WI 53562

b) POLICY—Workforce Training. Each member of our workforce who may have access to or use of protected health information will receive training on our Privacy Policies and Procedures, as necessary and appropriate for the member to carry out his or her job functions. Records of such training will be kept by Human Resources and/or Legal.

PROCEDURE—Training Timing.

i) New Members. New members of our workforce will receive privacy training before they may have access to or use of protected health information or as soon as reasonably possible.

ii) Retraining. Existing workforce members must receive retraining within a reasonable period of time after there is material change in their job functions or in our Privacy Policies and Procedures that affects their access to or use of protected health information. We may also require periodic retraining even if there has not been any such change.

c) **POLICY—Workforce Sanctions.** Workforce members who violate our Privacy Policies and Procedures, the Privacy Rules or other applicable federal or state privacy law will be subject to disciplinary action, including employment termination, consistent with the sanctions developed, documented, and disseminated by our Privacy Official and the employer.

d) **POLICY—Mitigation.** We will have and implement contingency plans to mitigate any deleterious effect of an improper use or disclosure of protected health information by a member of our workforce or by our business associates.

e) **POLICY—Retaliatory Acts.** We will not attempt to intimidate, threaten, coerce, discriminate or retaliate against an individual who:

- Exercises any right, including filing complaints, under the Privacy Rules.
- Complains to, testifies for, assists or participates in an investigation, compliance review, proceeding or hearing by HHS or other appropriate authority.
- Opposes any act or practice the individual believes in good faith is illegal under the Privacy Rules (provided the opposition is reasonable and does not involve illegal disclosure of protected health information).

f) **POLICY—Waivers.** We will not require an individual to waive any right under the Privacy Rules, including the right to complain to HHS, as a condition of providing claims payment, enrollment or benefits eligibility to the individual.

g) **POLICY—Documentation and Record Retention.** We will retain the documentation required by our Privacy Policies and Procedures and the Privacy Rules until 6 years after the later of its creation or last effective date. Our Privacy Official will be our repository of documentation regarding our privacy practices and compliance with our Privacy Policies and Procedures and the Privacy Rules.

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19. Data Safeguards.

Short Summary: We must ensure that protected health information is kept secure. For example, any protected health information on paper generally should be kept locked up at night.

POLICY—Data Privacy Protection. We will implement and comply with reasonable and appropriate administrative, physical, and technical safeguards to secure the privacy of protected health information against any intentional or unintentional use or disclosure in violation of these Privacy Policies and Procedures or the Privacy Rules. These safeguards will include reasonable limits to incidental uses or disclosures of protected health information made as a result of otherwise permitted or required uses or disclosures.

PROCEDURE—Data Privacy Protection. Our Privacy Official, in conjunction with our legal advisers, will augment these Privacy Policies and Procedures with such additional data security policies and procedures as appropriate for our plan to have reasonable and appropriate administrative, physical and technical safeguards to ensure the integrity and confidentiality of the protected health information we maintain against any reasonably

anticipated unauthorized use or disclosure, intentional or unintentional, or any reasonably anticipated threat or hazard to the privacy, security or integrity of the protected health information. These additional data security policies and procedures will ensure compliance by our workforce members with these Privacy Policies and Procedures, the Privacy Rules, and such other policies and procedures as may be adopted to implement our compliance obligations under the Privacy Rules.

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20. Complaints and HHS Enforcement.

Short Summary: Plan enrollees have the legal right to complain if we are not following HIPAA. We must take those complaints seriously and try to resolve them. In addition, the federal government (usually the Office for Civil Rights, a division of the U.S. Department of Health and Human Services) may audit the health plan to verify that we are following HIPAA.

a) POLICY—Complaints. We will timely investigate and appropriately respond to each complaint received by our contact offices or a workforce member regarding our compliance with these Privacy Policies and Procedures or the Privacy Rules.

b) POLICY—HHS Enforcement and Compliance Cooperation. We will cooperate with any compliance review or complaint investigation by HHS, while preserving the rights of our plan.

V. STATE LAW POLICIES AND PROCEDURES

21. State Privacy Law.

Short Summary: In some situations, state privacy laws may go beyond what HIPAA requires. We should carefully consider whether we need to follow those additional requirements. We may take the position that other laws (such as ERISA, a federal law governing many health plans) supersedes those state laws, so that we do not need to follow the state laws. If we do need to follow them, it would be a good idea to modify these Policies and Procedures to reflect those state laws.

POLICY—State Law Compliance. We will comply with state privacy laws to the extent we are required to do so. If our group health plan is subject to ERISA, certain state privacy laws may be preempted. Our Privacy Official and legal advisers will determine which state privacy laws apply to our group health plan, whether those laws conflict with the Privacy Rules and, if so, whether those laws are more stringent than the Privacy Rules and therefore are not preempted by the Privacy Rules.

A state law is more stringent than the Privacy Rules if it provides greater protections or rights to individuals or imposes greater restrictions on our use or disclosure of protected health information than the Privacy Rules.

VI. BREACH RULES

22. Identifying a Breach.

Short Summary: Sometimes we (or a business associate) may experience a "breach" of protected health information (e.g., a former employee takes protected health information with him or her and misuses it). You must promptly report any such breach to the Privacy Official so we can act quickly.

POLICY – Identifying a Breach. We will identify any suspected breach of protected health information and report a suspected breach to our Privacy Official.

FORM – Breach Identification. We will use FORM 10, Breach Identification, to identify a breach. We will record all individuals affected by a breach. We will record the list electronically or by using FORM 11, Log of Individuals Affected by Breach.

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23. Notification Regarding Breach.

Short Summary: If there was a "breach" of protected health information (as discussed in Section 22), the health plan generally must notify the plan enrollees who were affected. The plan (generally, us, on behalf of the plan) must inform the U.S. Department of Health and Human Services of the breach.

POLICY – Notification Regarding Breach. We will notify all relevant parties of a breach of protected health information, in accordance with HIPAA's rules. Relevant parties include the U.S. Department of Health and Human Services, affected individuals and, for certain large breaches affecting 500 or more individuals, local media.

FORM - Breach Notification. We will use FORM 10 – Breach Identification and FORM 12 – Notification to Affected Individuals of Breach when notifying relevant parties. We will create a separate notice to the media if so required. If a law enforcement official requests that we delay notice of a breach, we will document our consideration and, where applicable, acceptance of such delay.

SPECTRUM BRANDS, INC.

AUTHORIZATION

Purpose: This form is used for an individual to authorize use or disclosure of the individual's protected health information for the purposes stated.

SECTION A: Psychotherapy notes.

✓ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Workday ID Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan or eligibility for benefits on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION C: The use and/or disclosure being authorized.

Purpose of this Authorization:

☐ At request of individual (or the individual's personal representative).

☐ For the following purposes:

_____

_____

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information that this authorization will allow to be used and/or disclosed:

_____

_____

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who will be authorized to make use of and/or to disclose the protected health information described above:

_____ _____

_____ _____

Entities Authorized to Receive and Use: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, whom this authorization will allow to receive and use the protected health information described above:

_____ _____

_____ _____

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

☐ On ____/____/_____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this authorization will *not* affect any action we took in reliance on this authorization before we received your written notice of revocation.

Contact Office: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following: Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's records.

Send copy to the Privacy Official.

PLAN DOCUMENT AMENDMENT

Purpose: The amendment in this Form is generally needed if the employer will receive protected health information while performing activities on behalf of the health plan. If we are completing this Form 4, we also must complete Form 5, Certification of Amendment and also must verify that Form 7, Privacy Practices Notice, states that disclosures to the employer are allowed.

SPECTRUM BRANDS, INC. WELFARE BENEFIT PLAN

GROUP HEALTH PLAN DOCUMENT AMENDMENT

ARTICLE
PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

1. Spectrum Brands, Inc. Welfare Benefit Plan Certification of Compliance.

Neither Plan nor any health insurance issuer or business associate servicing Plan will disclose Plan Participants' Protected Health Information to **Spectrum Brands, Inc.** unless **Spectrum Brands, Inc.** certifies that the Plan Document has been amended to incorporate this Article and agrees to abide by this Article.

2. Purpose of Disclosure to Spectrum Brands, Inc.

(a) Plan and any health insurance issuer or business associate servicing Plan will disclose Plan Participants' Protected Health Information to **Spectrum Brands, Inc.** only to permit **Spectrum Brands, Inc.** to carry out the following plan administration functions for Plan

Assisting with claims inquiries, deciding appeals, and general Plan administration activities.

Any disclosure to and use by **Spectrum Brands, Inc.** of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of Sections 3 through 5 of this Article and the specifications and requirements of the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64.

(b) Neither Plan nor any health insurance issuer or business associate servicing Plan will disclose Plan Participants' Protected Health Information to **Spectrum Brands, Inc.** unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan Participants.

(c) Neither Plan nor any health insurance issuer or business associate servicing Plan will disclose Plan Participants' Protected Health Information to **Spectrum Brands, Inc.** for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of **Spectrum Brands, Inc.**

3. Restrictions on Spectrum Brands, Inc.'s Use and Disclosure of Protected Health Information.

(a) **Spectrum Brands, Inc.** will neither use nor further disclose Plan Participants' Protected Health Information, except as permitted or required by the Plan Document, as amended by this Article, or as required by law.

(b) **Spectrum Brands, Inc.** will ensure that any agent, including any subcontractor, to which it provides Plan Participants' Protected Health Information agrees to the restrictions, conditions, and security measures of the Plan Document, as amended by this Article, with respect to Plan Participants' Protected Health Information.

(c) **Spectrum Brands, Inc.** will not use or disclose Plan Participants' Protected Health

Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of **Spectrum Brands, Inc.**.

(d) **Spectrum Brands, Inc.** will report to Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan Document, as amended by this Article**,** promptly upon learning of such inconsistent use or disclosure.

(e) **Spectrum Brands, Inc.** will make Protected Health Information available to Plan or to the Plan Participant who is the subject of the information in accordance with 45 C.F.R. § 164.524.

(f) **Spectrum Brands, Inc.** will make Plan Participants' Protected Health Information available for amendment, and will on notice amend Plan Participants' Protected Health Information, in accordance with 45 C.F.R. § 164.526.

(g) **Spectrum Brands, Inc.** will track disclosures it may make of Plan Participants' Protected Health Information that are accountable under 45 C.F.R. § 164.528 so that it can make available the information required for Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

(h) **Spectrum Brands, Inc.** will make its internal practices, books, and records relating to its use and disclosure of Plan Participants' Protected Health Information available to Plan and to the U.S. Department of Health and Human Services to determine Plan's compliance with the HIPAA Privacy Rule at 45 C.F.R. Part 164, Subpart E.

(i) **Spectrum Brands, Inc.** will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan Participants' Protected Health Information, in whatever form or medium, received from Plan or any health insurance issuer or business associate servicing Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participants' Protected Health Information, **Spectrum Brands, Inc.** will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan Participants' Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

4. Security Measures for Electronic Protected Health Information

(a) **Spectrum Brands, Inc.** will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Plan Participants' Electronic Protected Health Information that **Spectrum Brands, Inc.** creates, receives, maintains, or transmits on Plan's behalf.

(b) **Spectrum Brands, Inc.** will report to Plan, upon Plan's request, any attempted or successful (i) unauthorized access, use, disclosure, modification, or destruction of Plan Participants' Electronic Protected Health Information or (ii) interference with **Spectrum Brands, Inc.** system operations in **Spectrum Brands, Inc.** information systems, of which **Spectrum Brands, Inc.** becomes aware, except any such security incident that results in disclosure of Plan Participants' Protected Health Information not permitted by the Plan Document, as amended by this Article, must be reported to Plan as required by Paragraph 3(d), above.

(c) **Spectrum Brands, Inc.** will support the adequate separation between **Spectrum Brands, Inc.** and Plan, as specified by Section 5, below, with reasonable and appropriate security measures.

5. Adequate Separation Between Spectrum Brands, Inc. and Plan.

(a) The following employees or classes of employees or other workforce members under the control of **Spectrum Brands, Inc.** may be given access to Plan Participants' Protected Health Information received from Plan or a health insurance issuer or business associate servicing Plan:

Select members of Spectrum Brands Human Resources Dept.

Select members of Spectrum Brands Legal, Finance and IT

Depts.

This list includes every employee or class of employees or other workforce members under the control of **Spectrum Brands, Inc.** who may receive Plan Participants' Protected Health Information relating to payment under, the health care operations of, or other matters pertaining to Plan in the ordinary course of business.

(b) The employees, classes of employees or other workforce members identified in Paragraph 5(a), above will have access to Plan Participants' Protected Health Information only to perform the plan administration functions that **Spectrum Brands, Inc.** provides for Plan, as specified in Paragraph 2(a), above.

(c) The employees, classes of employees or other workforce members identified in Paragraph 5(a), above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with **Spectrum Brands, Inc.**, for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this Article. **Spectrum Brands, Inc.** will promptly report such breach, violation or noncompliance to Plan, as required by Paragraph 3(d), above and will cooperate with Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

Adopted: July 1, 2024

_____

Spectrum Brands Welfare Benefit Plan

PRIVACY PRACTICES NOTICE

Purpose: Privacy notices must be given to individuals covered by the plan. A single notice to a covered employee is effective for all covered dependents. Notices must be provided upon enrollment, and within 60 days of a material change to the notice. Plans must notify participants every 3 years that a privacy notice is available. Consistent with other template forms, this Notice assumes the plan does not, with respect to protected health information: (1) engage in fundraising; (2) engage in marketing, where the plan receives financial remuneration for such marketing; (3) sell protected health information;(4) use genetic information for underwriting purposes; or (5) engage in research. If these assumptions are not correct this Notice should be changed.

SPECTRUM BRANDS, INC.

PRIVACY PRACTICES

NOTICE

(Version 05/01/2013)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Contact Office.

Spectrum Brands, Inc. Attn: Benefits Group One Rider Trail Plaza Drive Suite 300 Earth City, MO 63045	Spectrum Brands, Inc. Attn: Benefits Group 3001 Deming Way Middleton, WI 53562

Health Plans Covered by this Notice

This notice applies to the privacy practices of the health plans listed below. They may share with each other your medical information, and the Spectrum Brands, Inc. Welfare Benefit Plan medical information of others they service, for the health care operations of their joint activities.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **July 1, 2024**, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar

reinsurance for our health coverage obligations; and

- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de- identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies; for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request **in writing** to our Contact Office.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request **in writing** to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

REIMBURSEMENT/SUBROGATION

A. Self-funded Component Benefit Plan Provisions

These provisions shall apply if a Component Benefit Plan does not have terms which address this subject matter. To the extent that a Component Benefit Plan does have such terms, those terms will control for that Component Benefit Plan.

Right of Reimbursement/Subrogation

If a Participant is injured or becomes ill due to the actions of any third party and becomes entitled to receive any benefit covered under a Component Benefit Plan, the Participant must assist the Component Benefit Plan in recovering from the responsible third party (or its insurer). By filing a claim for payment of benefits under a Component Benefit Plan or by receiving benefit payments from a Component Benefit Plan for an injury or illness for which a third party may be responsible, the Participant gives the rights that the Participant has to recover from the third party (or insurer) to the Component Benefit Plan and the Employer, to the extent of the benefits paid by (or owed to the Participant) by that Component Benefit Plan. The Plan Administrator or the Employer has the right to sue, compromise or settle with any responsible third party (or its insurer) on behalf of the Participant. The Component Benefit Plan can recover from a third party or any liability insurer or other insurer covering the third party, including the Participant's own uninsured/underinsured motorist coverage and any medical or no-fault benefits that are paid or payable, to the extent that the third party may be liable. For purposes of this Reimbursement/Subrogation section, the term "Participant" shall include their dependents and, if applicable, beneficiaries.

Rights of Component Benefit Plans

Where a third party may be responsible for a Participant's injury or illness, the Component Benefit Plans reserves the right to either:

- Pay all or part of the benefits covered under the Component Benefit Plans and be reimbursed from a settlement or judgment against the responsible third party; or
- Delay payment of all or part of the benefits covered under the Component Benefit Plans and require the third party to pay the benefits as part of a settlement or judgment.

Participant Cooperation

Participants must cooperate with the Plan Administrator and the Employer in all matters under the Plan, including but not limited to reimbursement/subrogation matters and in efforts to help the Plan Administrator / Employer recover benefits. Each Participant may be required to sign a reimbursement/subrogation agreement prior to payment of any benefits. However, if the Component Benefit Plan pays any benefits prior to obtaining a signed reimbursement/subrogation agreement, such payment will not operate as a waiver of the reimbursement/subrogation right or of the right to require the Participant to sign a reimbursement/subrogation agreement prior to receipt of any further benefit payments. The reimbursement/subrogation agreement is binding on the Participant regardless of whether:

- The payment received from the third party (or its insurer) is the result of a legal judgment, arbitration award, compromise settlement or any other arrangement;
- The third party has admitted liability for the payment; or
- Medical expenses are itemized in the third party (or its insurer) payment.

Participant Notification Requirement

Participants are required to notify the Plan Administrator, in writing, of any injury or illness that provides or may provide the Component Benefit Plan subrogation and/or reimbursement rights under this provision. This notice must be provided to the Plan Administrator as soon as reasonably possible after occurrence of the injury or illness. The Plan Administrator may, in its sole discretion, at that time or any other time:

- Instruct the Participant to seek, not to seek, or to discontinue seeking payment or reimbursement on behalf of the Plans; and
- Pursue such payment or reimbursement independently in the same or a separate lawsuit or other proceeding or may abandon such payment or reimbursement altogether.

Reimbursement of Component Benefit Plans

If a Participant makes or files a claim, demand, lawsuit or other proceeding against a third party who may be liable, the Participant must seek payment or reimbursement on behalf of the Component Benefit Plans for the amount of benefits covered by the Component Benefit Plans (whether or not paid). The Participant must notify the Plan Administrator prior to making or filing any such claim, demand, lawsuit, or other proceeding. Any compromise or settlement entered into by a Participant which attempts to reduce or limit the amount of the payment for medical or any other expenses covered by the Component Benefit Plans (whether or not paid) to an amount that is less than the benefits covered by the Component Benefit Plan (whether or not paid) shall not be effective unless the Plan Administrator consents to the compromise or settlement in writing. If the Participant receives a recovery, failure to reimburse the Component Benefit Plans according to the reimbursement/subrogation agreement may result in civil action against the Participant and/or their attorney.

The Plan shall be considered to have an equitable lien against monies received by the Participant (or any individual, trust or other person or entity acting on behalf of the Participant) and shall be reimbursed first and fully to the extent of all benefits paid by it from any monies received, with the balance, if any, retained by such individual. Pending reimbursement, the Participant (or such individual's representative who receives any such recovery) shall be deemed to hold such amounts in constructive trust for the benefit of the Plan. The Component Benefit Plans have the right to be reimbursed in full before any amounts (including attorney's fees incurred by the Participant) are deducted from the proceeds, judgment, settlement, or award, even if the Participant is not "made whole". If a Participant receives a settlement, judgment or recovery which does not cover all the Participant's damages (including Plan benefits), the Plan Administrator may on behalf of the Component Benefit Plans accept less than the full amount of Plan benefits, such as a percentage of the amount recovered; however, this is within the Plan Administrator's discretion.

Offsets to STD and LTD Benefits

Benefits under Component Benefit Plans that provide either short-term disability or long-term disability benefits will be offset or reduced to the extent the Participant receives income from: (a) sources identified in any applicable insurance contract as resulting in offset; and/or (b) the Employer pursuant to any judgment or settlement of a lawsuit by, or on behalf of, the Participant against the Employer (or its subsidiary) for damages to compensate for the illness or injury for which the short-term or long-term disability benefits are payable.

Fully insured Component Benefit Plan Provisions

Component Benefit Plan Document(s) will set forth the insurance carrier's rights to reimbursement or to subrogate a recovery for that plan.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- made in error; or
- made after the date the person should have been terminated under this Plan; or
- made to any Participant or any party on behalf of a Participant where the Plan Sponsor determines the payment to the Participant, or any other party is greater than the amount payable under this Plan.

The Plan has the right to recover from Participants if the Plan has paid them or any other party on their behalf.

NO GUARANTEE OF TAX CONSEQUENCES

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes, or that any other federal, state or local tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

NO ASSIGNMENT OF RIGHTS OR BENEFITS

Except to the extent specifically provided under the terms of a Component Benefit Plan, the rights of a Participant under the Plan (including but not limited to the rights to appeal a benefit determination or payment, to bring a suit for benefits, or other remedies under ERISA) may not be sold, transferred, assigned, or pledged to any other person or entity. In addition, the benefits payable under the Plan shall not be subject to sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, and charge or otherwise dispose of any right to benefits payable under the Plan shall be void. The Employer shall not in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

SEVERABILITY

If any provision of the Plan is determined to be invalid or unenforceable, it shall not influence the remainder of the Plan. The Plan shall be construed and enforced as if such provision had not been included.

APPLICABLE LAW

Any provision of the Plan that conflicts with federal law or an applicable state law that requires precedence, shall be amended to conform to the minimum requirements of those laws. Where state law could apply, the laws of the state of Wisconsin (including but not limited to its privacy or data security laws) shall be the only state law which applies. Such Wisconsin law shall apply without regard to whether such laws of Wisconsin allow or incorporate other state laws.

NOT AN EMPLOYMENT CONTRACT

None of the Plans or benefits discussed on the preceding pages are to be considered contracts for employment between the Employee and the Employer. The Plans do not guarantee the Employee the right of continued employment, limit the Employer's right to discharge the Employee, or alter in any way the mutually understood "employment at will" relationship between the Employer and the Employee.

INDEMNIFICATION

The Employer shall indemnify and hold harmless any person serving as the Plan Administrator from any and all losses, claims, damages, expense (including court costs and attorneys' fees) incurred in connection with the duties and responsibility delegated to them under the Plan to the extent not covered by insurance, unless due to the person's own gross negligence, willful and intentional misconduct or lack of good faith.

ADOPTION PAGE

Spectrum Brands, Inc. establishes a program of benefits that is an "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, called the Spectrum Brands, Inc. Welfare Benefit Plan (the "Plan"), Plan number 501, effective January 1, 2025. By signing below, Spectrum Brands, Inc. adopts this Summary Plan Description.

Spectrum Brands, Inc.

By: _____
Authorized Representative

Date: _____

Witnessed:

By: _____

Date: _____

SCHEDULE A
PLAN BENEFITS

Listed below are the names, addresses, and phone numbers of the organizations that provide insurance and/or administrative services, including as Contract/Claims Administrators. These services include administering claims and providing customer service.

Non Union Plans				
Type of Plan	**Policy No. or Group No.**	**Type of Funding**	**Contribution**	**ERISA Status**
• **Medical Plan** *Anthem BlueCross BlueShield* P.O. Box 105187 Atlanta, GA 30348 (855) 206-8436	3320034	Self-funded	Employer and Employee Contributions	Yes
• **Prescription Drug Plan** *CVS Caremark* P.O. Box 52136 Phoenix, AZ 85072 (844) 431-4885	BIN: 004336 PCN: ADV Grp: Rx0470	Self-funded	Employer and Employee Contributions	Yes
• **Dental Plan** *Delta Dental of Wisconsin* P.O. Box 828 Stevens Point, WI 54481 (800) 236-3712	50304	Self-funded	Employer and Employee Contributions	Yes
• **Vision** *Vision Service Plan Insurance Company* 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195	12298041	Fully Insured	Employee Contributions	Yes
• **Basic Life Insurance/AD&D and Voluntary Life** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (800) 351-7500	GL 162679 GL 162680 VAR 209301	Fully insured	Basic Life and AD&D Coverage - Employer Contribution Voluntary Life Insurance - Employee Contributions	Yes

• **Short-term Disability** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (877) 202-0055	DBL 252644	Self-funded	Employer Contributions	Yes
• **Long-term Disability** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (877) 202-0055	LTD 132364	Fully insured	Basic Benefit - 100% Employer Contributions. Buy-up Benefit - Employee Contributions	Yes
• **Business Travel Accident** *AIG – National Union Fire Insurance Company of Pittsburgh, PA* 175 Water Street, 15th Floor New York, NY 10038 (212) 458-5000	MTA 0009159561	Fully insured	Employer Contributions	Yes
• **Section 125 Plan (Health Care and Dependent Care FSA)** *Optum Financial* P.O. Box 622337 Orlando, FL 32862-2337 (877) 292-4040	102818	Self-funded	Employee Contributions	
• **Voluntary Benefits – Accident Insurance, Critical Illness, Hospital Indemnity** *Voya* *5780 Powers Ferry Road* *Atlanta, GA 30327* (877) 236-7564	69396-1	Fully Insured	Employee Contributions	Yes
• **Wellness Plan** *Personify Health*	N/A	Fully Insured	Employer contributions	No

Commented [SD5]: What do we say here?

Commented [SD6]: Personify Health confirmed same address and number as VP.

75 Fountain Street Providence, RI 02902 (888) 671-9395				
• **Employee Assistance Program** *CuraLinc* 314 W Superior St. Chicago IL 60654 (888) 881-5426	N/A	Fully Insured	Employer contributions	Yes

Union Plans				
Type of Plan	**Policy No. or Group No.**	**Type of Funding**	**Contribution**	**ERISA Status**
• **Medical Plan** *Anthem BlueCross BlueShield* P.O. Box 105187 Atlanta, GA 30348 (855) 206-8436	3320034	Self-funded	Employer and Employee Contributions	Yes
• **Prescription Drug Plan** *CVS Caremark* P.O. Box 52136 Phoenix, AZ 85072 (844) 431-4885	BIN: 004336 PCN: ADV Grp: Rx0470	Self-funded	Employer and Employee Contributions	Yes
• **Dental Plan** *Delta Dental of Wisconsin* P.O. Box 828 Stevens Point, WI 54481 (800) 236-3712	50304	Self-funded	Employer and Employee Contributions	Yes
• **Vision** *Vision Service Plan Insurance Company* 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195	12298041	Fully Insured	Employee Contributions	Yes
• **Basic Life Insurance/AD&D** *Reliance Matrix* 2001 Market Street Suite 1500	GL 162679 GL 162680 VAR 209301	Fully insured	Basic Life and AD&D Coverage - Employer Contribution	Yes

Philadelphia, PA 19103 (800) 351-7500				
• **Short-term Disability** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (877) 202-0055	GL 167931	Fully insured	Employee Contributions	Yes
• **Business Travel Accident** *AIG – National Union Fire Insurance Company of Pittsburgh, PA* 175 Water Street, 15th Floor New York, NY 10038 • (212) 458-5000	MTA 0009159561	Fully insured	Employer Contributions	Yes
• **Wellness Plan** *Personify Health* 75 Fountain Street Providence, RI 02902 • (888) 671-9395	N/A	Fully Insured	Employer contributions	Yes
• **Employee Assistance Program** *CuraLinc* 314 W Superior St. Chicago IL 60654 (888) 881-5426 •	N/A	Fully Insured	Employer contributions	Yes

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SCHEDULE A
PLAN BENEFITS – Puerto Rico

Listed below are the names, addresses, and phone numbers of the organizations that provide insurance and/or administrative services, including as Contract/Claims Administrators. These services include administering claims and providing customer service.

Type of Plan	Policy No. or Group No.	Type of Funding	Contribution	ERISA Status
• **Medical Plan** *Triple-S Salud, Inc.* 1441 F, D, Roosevelt Avenue P.O. Box 363628 San Juan, PR 00936-3628 (787) 774-6060	SP0000641	Fully insured	Employer and Employee Contributions	Yes
• **Dental Plan** *Triple-S Salud, Inc.* 1441 F, D, Roosevelt Avenue P.O. Box 363628 San Juan, PR 00936-3628 (787) 774-6060	SP0000641	Fully insured	Employer and Employee Contributions	Yes
• **Vision** *Vision Service Plan Insurance Company* 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195	12298041	Fully Insured	Employee Contributions	Yes
• **Basic Life Insurance/AD&D and Optional Life/AD&D** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (800) 351-7500	GL 162679 GL 162680 VAR 209301	Fully insured	Basic Life and AD&D Coverage -Employer Contributions. Optional Life Insurance - Employee Contributions	Yes
• **Short-term Disability** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (877) 202-0055	DBL 252644	Self-funded	Employer Contributions	Yes
• **Long-term Disability** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (877) 202-0055	LTD 132364	Fully insured	Basic Coverage - Employer Contributions Buy-up Benefit - Employee Contributions	Yes

• **Business Travel Accident** *AIG – National Union Fire Insurance Company of Pittsburgh, PA* 175 Water Street, 15th Floor New York, NY 10038 (212) 458-5000	ETB 15401	Fully insured	Employer Contributions	Yes
• **Employee Assistance Program** *CuraLinc* 314 W Superior St. Chicago IL 60654 (888) 881-5426	N/A	Fully Insured	Employer contributions	Yes

SCHEDULE A
PLAN BENEFITS - HAWAII

Listed below are the names, addresses, and phone numbers of the organizations that provide insurance and/or administrative services, including as Contract/Claims Administrators. These services include administering claims and providing customer service.

Type of Plan	Policy No. or Group No.	Type of Funding	Contribution	ERISA Status
• **Medical Plan** *Hawaii Medical Service Association – Blue Cross Blue Shield of Hawaii* P.O. Box 860 Honolulu, HI 96808-0860 (800) 776-4672	30465	Fully insured	Employer and Employee Contributions	Yes
• **Dental Plan** *Hawaii Medical Service Association – Blue Cross Blue Shield of Hawaii* P.O. Box 860 Honolulu, HI 96808-0860 (800) 776-4672	30465	Fully insured	Employer and Employee Contributions	Yes
• **Vision** *Vision Service Plan Insurance Company* 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195	12298041	Fully Insured	Employee Contributions	Yes
• **Basic Life Insurance/AD&D and Optional Life/AD&D** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (800) 351-7500	GL 162679 GL 162680 VAR 209301	Fully insured	Basic Life and AD&D Coverage - Employer Contributions. Optional Life Insurance - Employee Contributions	Yes
• **Short-term Disability** *Reliance Matrix* 2001 Market Street Suite 1500 Philadelphia, PA 19103 (877) 202-0055	DBL 252644	Self-funded	Employer Contributions	Yes
• **Long-term Disability**	LTD 132364	Fully insured	Basic Benefit - Employer Contributions.	Yes

Reliance Matrix 2001 Market Street Suite 1500 Philadelphia, PA 19103 (877) 202-0055			Benefit Buy-up - Employee Contributions	
• **Business Travel Accident** *AIG – National Union Fire Insurance Company of Pittsburgh, PA* 175 Water Street, 15th Floor New York, NY 10038 (212) 458-5000	ETB 15401	Fully insured	Employer Contributions	
• **Section 125 Plan (Health Care and Dependent Care FSA)** *Optum Financial* P. O. Box 622337 Orlando, FL 32862-2337 (877) 292-4040	102818	Self-funded	Employee Contributions	
• **Voluntary Benefits – Accident Insurance, Critical Illness, Hospital Indemnity** *Voya* 5780 Powers Ferry Road Atlanta, GA 30327 (877) 236-7564	69396-1	Fully Insured	Employee Contributions	
• **Wellness Plan** *Personify Health* 75 Fountain Street Providence, RI 02902 (888)-671-9395	N/A	Fully Insured		Employer contributions
• **Employee Assistance Program** *CuraLinc* 314 W Superior St. Chicago IL 60654 (888) 881-5426	N/A	Fully Insured		Employer contributions

Commented [SD8]: Personify Health confirmed same address and number as VP.

SCHEDULE B
ELIGIBILITY AND EFFECTIVE DATE FOR COVERAGE

Eligibility for coverage under the Plan may vary by the type of benefit. Unless otherwise listed below, employees will be eligible based on satisfaction of the following requirements.

Employer and the Affiliates, Divisions, Subsidiaries Included	Effective Date	Termination Date
Spectrum Brands, Inc.	January 1, 2025	December 31, 2025

Eligible Employees	Work Hour Requirement	Line of Coverage	Waiting Period	Coverage Start Date
All Non-Bargained Employees	Full-time, regular scheduled to work at least 30 hours or more per week	Medical and Prescription Drug; Dental; Vision; Life Insurance and Accidental Death and Dismemberment; Wellness Plan; Employee Assistance Program	None	Date of Hire
All Non-Bargained Employees	Full-time, regular scheduled to work at least 30 hours or more per week	Short Term Disability (STD) & Long Term Disability (LTD) and LTD Buy-up,	60 days of continuous employment – STD None – LTD	First of the month following waiting period
Employees of Spectrum Brands, Inc., Hawaii	20 or more hours per week or more	Medical and Prescription Drug (HMSA Plan)	None	Date of hire
Employees of Spectrum Brands, Inc., Hawaii	Full-time, regular scheduled to work at least 30 hours or more per week	Dental; Vision; Life Insurance and Accidental Death and Dismemberment; Wellness Plan; Employee Assistance Program	None	Date of hire
Employees of Spectrum Brands, Inc., Hawaii	Full-time, regular scheduled to work at least 30 hours or more per week	Short Term Disability (STD) & Long Term Disability (LTD) and LTD Buy-up,	60 days of continuous employment	First of the month following waiting period
St. Louis Employees Subject to a Bargained Agreement	Full-time, regular scheduled to work at least 30 hours or more per week	Medical and Prescription Drug; Dental; Vision; Life Insurance and Accidental Death and Dismemberment, Wellness Plan; Employee Assistance Program	None	Date of hire

Commented [IK9]: Is this accurate throughout?

Commented [SD10R9]: When you say throughout, do you mean all eligibility like all benefits? Or throughout the SPDs and Open Enrollment Guide? All of the benefits coverage start date are listed here.

Commented [IK11R9]: I didn't know STD and LTD were the first of the month following the 60 days. Is this accurate? When I said "throughout", I meant this wrap doc and all other docs.

Commented [SD12R9]: Checked with Reliance Standard - STD is 60 days waiting period and LTD is no waiting period, however, there is a 90 elimination period with a 3/12 pre-existing condition. The way the Reliance Standard policy is strange not having the same waiting period for both and think is something we can address in the RFP this next year. I have adjusted the waiting period to match how this plan is being administered.

St. Louis Employees Subject to a Bargained Agreement	Full-time, regular scheduled to work at least 30 hours or more per week	Voluntary Short Term Disability (STD)	60 days of continuous employment	First of the month following waiting period
All Puerto Rico Employees	Full-time, regular scheduled to work at least 30 hours or more per week	Medical and Prescription Drug; Dental; Vision; Life Insurance and Accidental Death and Dismemberment; Wellness Plan; Employee Assistance Program	None	Date of hire
All Puerto Rico Employees	Full-time, regular scheduled to work at least 30 hours or more per week	Short Term Disability (STD) & Long Term Disability (LTD) and LTD Buy-up,	60 days of continuous employment	First of the month following waiting period
All Full-time and Part-time Employees		Business Travel Accident	None	Date of hire

Reinstatement of Benefits:

Rehired employees who were regular, full-time employees and who have had a break in service with Spectrum Brands for 13 weeks or less will have their original date of hire used to determine their seniority, benefit, and vacation eligibility.

SCHEDULE C
HEALTH LAW NOTICES APPLICABLE TO THE MEDICAL COMPONENT ONLY (UNLESS OTHERWISE NOTED)

Benefits During Family Medical Leave

The Employer will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. An employee and any dependents covered under a health benefit Component Benefit Plan may be eligible to continue the coverage under that plan for a certain period.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage because of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he, she, or they would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

Important Disclosures

Maternity Coverage Length of Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not more than 48 hours (or 96 hours).

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by Participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the Affordable Care Act took effect in 2014, a new way to buy health insurance became available: The Health Insurance Marketplace ("Marketplace"). To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The 2023 open enrollment period for health insurance coverage through

the Marketplace began on Nov. 1, 2022 and ended on Dec. 15, 2022. Individuals must have enrolled or changed plans prior to Dec.15, 2022, for coverage starting as early as Jan. 1, 2023. After Dec. 15, 2022, individuals can get coverage through the Marketplace for 2023 only if they qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her/their employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.12% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit. *

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in the area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

SPECTRUM BRANDS, INC.
MEDICAL PLANS
PRIVACY PRACTICES NOTICE

Commented [IK13]: JL, check with Kerry for updated HIPAA policy. It would list me as the privacy officer.

Commented [SD14R13]: Sarah asked Jen L if they want all of the HIPAA policy to be updated

Commented [SD15R13]: Updated accordingly.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Our Privacy Practices

We, the health plans sponsored by Spectrum Brands, Inc., may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact Spectrum Brands Service Center.

Spectrum Brands, Inc.: 3001 Deming Way, Middleton, WI 53562-1431

Telephone: (800) 881-2562

Health Plans Covered by this Notice

This notice applies to the privacy practices of the components of this Plan that, if they were considered individually, would constitute a "group health plan" under the HIPAA rules. This includes the Medical, Dental, Prescription Drug and Vision components.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2022 and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

Uses and Disclosures of Your Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing, and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, if the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization; we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend, or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. **Health-Related Products and Services:** We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits, and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect, or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials regarding crime victims and criminal activities;

- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Your Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our Contact Office.

We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Contact Office for information about our fees.

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If not, we will produce it in a readable electronic form and format as mutually agreed upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

Disclosure Accounting: You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the beginning of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

Amendment. You have the right to request that we amend your medical information. You should submit your request in writing to the contact at the beginning of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment, or health care operations, or with family, friends, or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the beginning of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and

2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the beginning of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so, required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services